Introduction

The recent wave of submissions to the Employee Benefits Security Administration (EBSA) regarding the proposed changes to the Mental Health Parity and Addiction Equity Act (MHPAEA) has raised significant concerns. Notably, major stakeholders such as UnitedHealth Group (UHG) and others have put forth nearly identical recommendations, particularly in their definition of "meaningful benefits" and their approach to Nonquantitative Treatment Limitations (NQTLs). While this uniformity may suggest a coordinated effort to influence regulatory outcomes, it also highlights a troubling lack of diversity in thought and a potential vulnerability in the collective arguments presented.

When multiple stakeholders rely on the same narrow definition of "meaningful benefits" or propose identical solutions for NQTL compliance, they risk having their entire position undermined if regulators find any of these recommendations lacking. This approach not only diminishes the credibility of their submissions but also fails to engage with the complex and nuanced issues at the heart of MHPAEA compliance. The repetitive nature of these proposals may lead regulators to perceive these arguments as self-serving and lacking in genuine concern for achieving true parity between mental health and medical/surgical benefits. By not offering diverse perspectives or robust, evidence-based alternatives, these stakeholders may inadvertently weaken their case, potentially resulting in stricter regulations that could have been better tailored with more thoughtful input.

Examination of Stakeholder Submissions

In this document, we will examine the submissions from five major stakeholders, all of whom are represented by Groom Law Group. While these groups ostensibly present individual comments, there are central suggestions across their letters that are not only repetitive but also fundamentally flawed. Among these, the most glaring issue is their proposed definition of "meaningful benefits" under the Mental Health Parity and Addiction Equity Act (MHPAEA).

1. Coalition Represented by Groom Law Group
   EBSA Case Number: EBSA-2023-0010-0260
   Quote: "If the Tri-Agencies retain the 'meaningful benefits' proposal, the Coalition recommends that the Tri-Agencies find that a plan or issuer provides 'meaningful benefits' for a MH/SUD condition in each classification if the plan or issuer provides at least one primary treatment for the condition or disorder in a classification."
   Explanation and Critique: The coalition proposes this narrow definition under the pretext of simplifying compliance. However, this approach is shortsighted and ignores the

complexity of mental health and substance use disorder (MH/SUD) treatments. By limiting the requirement to just one primary treatment per classification, this proposal risks significantly reducing the range of care options available to individuals, undermining the very intent of MHPAEA, which is to ensure parity between MH/SUD and medical/surgical benefits.

2. UnitedHealth Group (UHG)

EBSA Case Number: EBSA-2023-0010-0275

Quote: "If the Tri-Agencies decide to retain the 'meaningful benefits' proposal, the Coalition recommends that the Tri-Agencies adopt the standard that a plan or issuer will be deemed to satisfy the 'meaningful benefits' requirement if the plan or issuer covers at least one primary treatment for a MH/SUD condition or disorder in a classification as determined by evidence-based clinical standards."

Explanation and Critique: UHG echoes the coalition's stance, arguing that a single primary treatment per condition is sufficient to meet the 'meaningful benefits' requirement. This suggestion is problematic because it oversimplifies the diverse needs of patients. Mental health care is not a one-size-fits-all scenario; different patients may respond differently to treatments. By endorsing a minimalistic approach, UHG risks marginalizing patients who require more than just the 'primary' treatment, effectively creating a disparity in care.

Leukemia Hypothetical: Consider a patient diagnosed with both heart disease and high-risk acute lymphoblastic leukemia (ALL). In such a complex case, a single 'primary' treatment would not suffice—treatment plans must consider multiple interacting conditions, potential contraindications, and various treatment stages, including chemotherapy and potential stem cell transplants. Similarly, in mental health care, a single treatment approach cannot address the varied and complex needs of all patients. This is especially true for patients with co-occurring conditions, where a narrowly defined 'primary treatment' would fail to provide comprehensive care.

3. Anthem, Inc.

EBSA Case Number: EBSA-2023-0010-0225

Quote: "We recommend that the Tri-Agencies define the term 'meaningful benefits' to mean that the plan or issuer provides at least one primary treatment for the condition or disorder in a classification."

Explanation and Critique: Anthem’s proposal mirrors that of the other stakeholders. By advocating for a definition that hinges on a single treatment option, Anthem disregards the broad spectrum of treatments that might be necessary for different MH/SUD conditions. This approach is not only reductive but also risks setting a dangerous precedent where the bare minimum is considered acceptable, potentially leading to insufficient care for those with complex or treatment-resistant conditions.

Redefining Medical Necessity: This narrow definition also threatens to distort the concept of medical necessity. Traditionally, "medical necessity" means that care must be appropriate

and effective based on a patient's specific circumstances. However, Anthem's proposal could lead to a scenario where only the 'primary' treatment is deemed necessary, potentially excluding other, more suitable options. This would undermine the principle of tailoring care to the individual needs of patients, a core tenet of effective healthcare delivery.

4. Blue Cross Blue Shield Association (BCBSA)
EBSA Case Number: EBSA-2023-0010-0237
Quote: "BCBSA recommends that the Departments adopt the following definition of 'meaningful benefits': A plan or issuer provides 'meaningful benefits' for a condition or disorder in each classification if the plan or issuer provides at least one primary treatment for the MH/SUD condition or disorder in a classification."
Explanation and Critique: BCBSA's recommendation reflects the same flawed logic as the others. By reducing the definition of 'meaningful benefits' to just one primary treatment, BCBSA ignores the importance of comprehensive care that addresses the full range of patient needs. This narrow definition may lead to situations where patients are denied access to necessary treatments simply because one 'primary' option is available, which might not be effective for everyone.

Implications for Parity: This definition fails to meet the parity standard set by MHPAEA. For medical/surgical benefits, there is no assumption that a single treatment is sufficient for all patients with a given condition. Instead, a range of treatments is typically covered, reflecting the complexity and variability of medical conditions. By proposing a different, more restrictive standard for mental health care, BCBSA's recommendation violates the very essence of parity, treating mental health as less deserving of comprehensive coverage.

5. America's Health Insurance Plans (AHIP)
EBSA Case Number: EBSA-2023-0010-0252
Quote: "If the Departments move forward with the 'meaningful benefits' requirement, AHIP recommends the Departments define 'meaningful benefits' to mean those benefits that, in combination across settings, constitute the most common safe and effective methods of treatment for a given condition. Additional alternatives include: (1) considering a plan or issuer to satisfy the 'meaningful benefits' requirement if they cover at least one primary treatment for a MH/SUD condition or disorder in a classification as determined by evidence-based clinical standards."
Explanation and Critique: AHIP's stance is slightly more flexible, suggesting that 'meaningful benefits' could also consider common treatment methods across settings. However, the core of their proposal still relies on the single primary treatment approach, which is fundamentally flawed. While AHIP's variation acknowledges multiple settings, it still promotes a restrictive view of what constitutes meaningful care, which could leave patients with inadequate treatment options.

Patient Impact: AHIP's proposal, while slightly broader, still fundamentally fails to recognize the individualized nature of mental health treatment. By focusing on the 'most

common' methods, it risks excluding less common but clinically appropriate treatments that might be necessary for certain patients. This approach could disproportionately affect those with complex or treatment-resistant conditions, effectively denying them access to the full spectrum of care they need.

Why This Approach is Problematic

These stakeholders propose a uniform, minimalistic definition of 'meaningful benefits' that is rooted in providing the least possible coverage while maintaining technical compliance. This approach is not only short-sighted but also undermines the purpose of MHPAEA, which is to ensure that mental health and substance use disorder benefits are on par with medical/surgical benefits. By reducing 'meaningful benefits' to just one primary treatment, these proposals ignore the complex and individualized nature of mental health care, potentially leaving many patients without access to the treatments they need. This homogeneity in recommendations could also backfire if regulators view this collective stance as self-serving and inadequate, leading to stricter and less favorable regulations for the insurance industry.

Fiduciary Certification

All five stakeholders uniformly oppose the proposed fiduciary certification requirement, which would mandate that plan fiduciaries certify compliance with MHPAEA requirements.

Example Quotes:
- Coalition: "The fiduciary certification requirement imposes an unnecessary burden on plan fiduciaries and could lead to legal complications. We recommend that this requirement be removed."
- UHG: "The proposed fiduciary certification requirement is overly burdensome and could expose plan fiduciaries to undue legal risk. It should be removed or significantly revised."
- Anthem: "We oppose the fiduciary certification requirement as it imposes an unnecessary and potentially harmful burden on plan fiduciaries. This requirement should be reconsidered."
- BCBSA: "The fiduciary certification requirement is unnecessary and could lead to increased legal risks for plan fiduciaries. We recommend that this provision be eliminated."
- AHIP: "We believe that the fiduciary certification requirement is overly burdensome and could result in increased legal liability for plan fiduciaries. This requirement should be removed or significantly altered."

Why They Oppose It:
The stakeholders argue that the fiduciary certification requirement imposes an unnecessary burden on plan fiduciaries and could increase their legal liability. They claim that existing oversight mechanisms are sufficient to ensure compliance with MHPAEA, and that adding

this certification requirement would create more complications than benefits. Their main concern appears to be the potential for increased legal risk and administrative burdens.

Why This Argument Is Flawed:
The opposition to the fiduciary certification requirement is misguided because the only significant legal risk posed by this certification is if the fiduciaries fail to comply with the law. If plan fiduciaries are indeed ensuring compliance with MHPAEA, as they are required to do, then the certification should not pose any additional legal risk. Rather, it would serve as a mechanism to enhance accountability and transparency in the management of MH/SUD benefits, aligning with the broader goals of MHPAEA.

Furthermore, there is a significant ethical concern regarding the uniform opposition to this requirement across all five stakeholders. These diverse employer plans, all represented by the same law firm, have used nearly identical language in their submissions, despite having potentially conflicting interests. This raises questions about whether the law firm is truly representing the unique needs and circumstances of each client or merely pushing a uniform approach that might not adequately address the specific concerns of each plan.

For instance, employer plans should be raising concerns about the practical challenges of fiduciary certification, such as the fact that they often do not write the plan's NQTLs themselves and may struggle to obtain necessary information from Third-Party Administrators (TPAs). They should also be concerned about the fairness of being held liable for the actions of TPAs over which they have limited control. The failure to address these critical issues suggests a lack of thorough consideration in these collective comments, potentially compromising the interests of the stakeholders they represent.

Nonquantitative Treatment Limitations (NQTLs)

The stakeholders uniformly emphasize the importance of managed care techniques, such as prior authorization, utilization review, and step therapy, as essential tools for controlling costs and ensuring that care is clinically appropriate. They express concern that the proposed NQTL requirements—particularly the need for detailed comparative analyses—could impose excessive administrative burdens and limit the use of these critical tools.

Example Quotes:
- Coalition: "The proposed rule's expansion of NQTL requirements could significantly hinder the use of managed care techniques, which are critical for ensuring that care is appropriate and for controlling costs."
- UHG: "Managed care tools like prior authorization and step therapy are vital for maintaining the affordability and quality of care. The proposed NQTL requirements could

undermine the effectiveness of these tools, leading to increased costs and reduced access to care."
- Anthem: "Prior authorization and utilization review are essential components of our managed care strategy. The proposed rule's NQTL requirements threaten to make these tools less effective, which could have adverse effects on both costs and patient outcomes."
- BCBSA: "Managed care techniques are critical for ensuring that patients receive the most appropriate care at the most appropriate time. The proposed expansion of NQTL requirements could create significant barriers to the use of these techniques, ultimately harming patients."
- AHIP: "The ability to apply managed care tools like prior authorization is essential for maintaining high standards of care while controlling costs. The proposed rule's requirements for NQTLs could severely restrict our ability to use these tools effectively."

Why They Say They Need It:
The stakeholders argue that managed care techniques are crucial for ensuring that care is both clinically appropriate and cost-effective. They claim that the proposed NQTL requirements would impose significant administrative burdens, potentially leading to higher costs and reduced access to care. Their primary concern is that the detailed comparative analyses required by the proposed rule would make it more difficult to apply these tools to mental health and substance use disorder (MH/SUD) benefits, thereby reducing their ability to manage these benefits effectively.

Why This Argument Is Flawed:
While it's true that managed care techniques can be valuable for controlling costs and ensuring appropriate care, the stakeholders' arguments largely miss the point of the proposed NQTL requirements. The core issue that the proposed rule seeks to address is ensuring parity between MH/SUD and medical/surgical benefits. Historical data shows that NQTLs have often been applied more restrictively to MH/SUD benefits, limiting access to necessary care. The comparative analyses required by the proposed rule are designed to prevent these disparities and to ensure that MH/SUD benefits are treated equitably.

By opposing these requirements, the stakeholders risk perpetuating the disparities that the Mental Health Parity and Addiction Equity Act (MHPAEA) is designed to eliminate. If managed care techniques are applied more stringently to MH/SUD benefits than to medical/surgical benefits, it undermines the principle of parity and leaves patients with inadequate access to necessary care. The argument that these requirements would impose excessive burdens fails to recognize the importance of transparency and accountability in the application of NQTLs. These analyses are not just bureaucratic hurdles; they are essential for ensuring that all patients receive fair and equitable treatment.

Furthermore, the argument that these requirements would hinder the use of managed care techniques is misleading. The rule does not prevent the use of managed care techniques; it simply requires that they be applied fairly. If a technique like prior authorization is truly

necessary and appropriate for a given MH/SUD treatment, it should be justifiable through the required analysis. What the stakeholders seem to fear is the exposure of inequities in how these techniques have been applied, which could reveal systemic biases against mental health care.

Lack of Supporting Evidence:
Moreover, the stakeholders' argument fails to provide factual support for the effectiveness of prior authorization in reducing unnecessary costs. Available data suggests that MH/SUD claims constitute a relatively small component of all claims submitted. Despite this, comparative analyses often show that a larger proportion of MH/SUD claims are subjected to prior authorization compared to medical/surgical claims. However, the denial rate for these MH/SUD claims is very low, indicating that, despite the aggressive application of prior authorization, these tools have relatively little impact on reducing "unnecessary costs." This undermines the stakeholders' argument that prior authorization is a critical tool for cost control in MH/SUD care and raises questions about the true purpose of its application in these cases.

The Questionable Claim: "We May Stop Offering Mental Health Benefits"

1. Unlikely and Impractical Collective Action:

The idea that a significant number of employers would collectively decide to stop offering MH/SUD benefits is both unlikely and impractical. Mental health benefits are now widely recognized as essential components of comprehensive healthcare coverage, and the demand for these services has only increased, particularly in the wake of the COVID-19 pandemic. Employers understand that mental health is closely tied to overall productivity, employee satisfaction, and retention. Therefore, the notion that they would collectively withdraw these benefits due to increased compliance costs does not align with current trends in workplace benefits and would likely be met with significant backlash from employees, healthcare advocates, and the public.

2. Competitive Disadvantage:

If one employer were to drop mental health benefits while others maintained them, it could lead to a competitive disadvantage in attracting and retaining talent. Employees increasingly expect comprehensive health benefits, including mental health coverage, as part of their compensation packages. Companies that fail to offer these benefits risk losing employees to competitors who do provide them. Therefore, the suggestion that employers would universally eliminate MH/SUD benefits is not only unrealistic but also counterproductive from a business perspective.

3. Legal and Reputational Risks:

Stopping the provision of mental health benefits could expose employers to significant legal and reputational risks. While it is true that large employers are not legally required to provide MH/SUD benefits under the ACA or MHPAEA, completely eliminating these benefits could result in employee grievances, potential discrimination claims, and a loss of public trust. Companies are increasingly held accountable for their social responsibility, and cutting mental health benefits could be seen as a failure to support the well-being of employees, damaging a company's reputation and brand.

4. Undermining Employee Well-being and Productivity:

Employers who remove MH/SUD benefits would likely see a decline in overall employee well-being and productivity. Mental health issues are a leading cause of absenteeism and decreased productivity. Without access to adequate mental health services, employees might experience worsening mental health conditions, leading to higher overall healthcare costs for the employer and a more significant impact on workplace productivity. Therefore, the argument that employers would remove these benefits due to increased costs is short-sighted and fails to consider the broader implications of such a decision.

5. Collective Action Unlikely and Potential Collusion:

The claim that employers might collectively stop offering MH/SUD benefits also raises concerns about potential collusion or anti-competitive behavior. If multiple employers were to simultaneously reduce or eliminate these benefits, it could be interpreted as an attempt to manipulate the market or reduce competition for talent, which could attract scrutiny from regulatory bodies. Moreover, such coordinated action is highly unlikely in practice, given the diverse interests and competitive nature of the marketplace.

Conclusion

The assertion that employers may stop offering mental health benefits due to increased regulatory burdens is not only impractical but also undermines the core principles of workplace health and productivity. This argument appears to be more of a scare tactic than a realistic response to the proposed regulations. Employers who truly value the well-being of their employees and understand the importance of mental health in the workplace are unlikely to eliminate these benefits, regardless of the regulatory landscape. Instead, they should be focusing on how to comply with MHPAEA in a way that ensures parity and promotes the overall health and productivity of their workforce. Moreover, any suggestion of collective action to reduce or eliminate benefits should be carefully scrutinized for potential anti-competitive behavior, as it could lead to severe legal repercussions and damage the reputation of the companies involved.