July14, 2023

Richard Revesz
Administrator, Office of Information and Regulatory Affairs
Office of Management and Budget
New Executive Office Building
725 17th Street, NW.
Washington, DC 20503

Dear Mr. Revesz:

As your office reviews the Department of Labor, Employee Benefits Security Administration's (EBSA) Notice of Proposed Rulemaking (NPRM) regarding the Mental Health Parity and Addiction Equity Act and the Consolidated Appropriations Act, 2021 (RIN: 1210-AC11), the HR Policy Association respectfully urges you to consider the following comments. The HR Policy Association has also submitted an E.O. 12866 meeting request and we look forward to working with you and the Department of Labor on improving compliance with MHPAEA.

The HR Policy Association is the leading organization representing the chief human resource officers of over 375 of the largest employers in the United States. Collectively, their companies provide health care coverage to over 20 million employees and dependents in the United States. The American Health Policy Institute, which was created by the Association, serves to examine the challenges employers face in providing health care to their employees and recommends policy solutions to promote the provision of affordable, high-quality, employer-based health care.

To Achieve Compliance, DOL Must Propose Comprehensive Parity Guidance for Employers

Congress recognized that employers needed substantially more guidance to implement the complicated mental health parity requirements for nonquantitative treatment limitations (NQTLs) when it enacted the Consolidated Appropriations Act of 2021 (CAA). In fact, Congress stressed the importance of providing comprehensive guidance by devoting about four pages of text in the CAA to compliance assistance instructions, compare to less than two pages describing ERISA plan compliance requirements.[1]

Specifically, Congress required DOL to publish a "compliance program guidance document" that provides "illustrative, de-identified examples" of previous findings of compliance and noncompliance, including:

- Examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and

[1] Public Law 116-260. Available at: https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf, pages 1724 to 1731.

- Descriptions of the violations uncovered during the course of such investigations.[2]

Importantly, the CAA requires the examples to "provide sufficient detail to fully explain such finding, including a full description of the criteria involved for approving medical and surgical benefits and the criteria involved for approving mental health and substance use disorder benefits."[3]

Congress also required DOL to publish "additional guidance" that "shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers … may use for disclosing information to ensure compliance" with their parity requirements.[4] Specifically, "[s]uch guidance shall include information that is comparative in nature with respect to —

> (I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;
>
> (II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and
>
> (III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits."[5]

Regarding nonquantitative treatment limitations, the CAA also requires DOL to publish guidance that provides clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health insurance issuers may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with their parity requirements, "including —

> (i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to —
>
> > (I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;
> >
> > (II) limitations with respect to prescription drug formulary design; and
> >
> > (III) use of fail-first or step therapy protocols;
>
> (ii) examples of methods of determining —
>
> > (I) network admission standards (such as credentialing); and

[2] 29 U.S.C. 1185a(a)(6)(B)(i).

[3] 29 U.S.C. 1185a(a)(6)(B)(ii).

[4] 29 U.S.C. 1185a(a)(7)(B)(i).

[5] 29 U.S.C. 1185a(a)(7)(B)(ii).

(II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;

(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;

(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;

(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that additional guidance is necessary to improve compliance…"[6]

The need for comprehensive guidance is abundantly clear from DOL's 2022 MHPAEA Report to Congress. That report showed none of the 134 self-funded employer plans' NQTL comparative analyses "contained sufficient information" despite the nine sets of FAQs, draft and final Disclosure Templates, and several enforcement fact-sheets DOL has published. When not one employer plan has a sufficient comparative analysis, it is not because none of them want to comply. It is because they do not know how to comply, which makes comprehensive compliance guidance critical.

Employers have innovated and invested in significant new behavioral health benefits during the COVID pandemic. Addressing the current mental health care crisis and achieving mental health parity compliance will require significant efforts in partnership between employers, providers, government, patient groups and other stakeholders.

[6] 29 U.S.C. 1185a(a)(7)(C).

To achieve mental health parity compliance, OMB should:

- Require DOL to publish the comprehensive guidance required by the CAA and additional de-identified examples of comparative parity analyses that are compliant under a final determination letter; and
- Urge DOL to consider adding a "safe harbor" or model parity analysis/template that creates a less burdensome way to achieve good faith compliance with the law.

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The HR Policy Association has submitted an E.O. 12866 meeting request and we look forward to working with you and the Department of Labor on improving compliance with MHPAEA.

Sincerely,

D. Mark Wilson
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