October 17, 2023

Amber Rivers
200 Constitution Ave NW, Suite N-5653
Washington, DC 20210
Submitted via Email: mhpaea.rfc.ebsa@dol.gov

Re: Request for Comments on Technical Release 2023-01P

Dear Ms. Rivers,

HR Policy Association ("HR Policy" or "Association") welcomes the opportunity to provide comments on the Employee Benefits Security Administration's (EBSA) Proposed Relevant Data Requirements for Nonquantitative Treatment Limitations (NQTLs) Related to Network Composition and Enforcement Safe Harbor for Group Health Plans and Health Insurance Issuers Subject to the Mental Health Parity and Addiction Equity Act that was posted by EBSA on July 25, 2023.[1] We are particularly concerned about the comparators for reimbursement rates and the likelihood that employer plans and their third-party administrators will not use the proposed safe harbor.

Separately, the Association has also submitted comments regarding EBSA's proposed changes to the regulations implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) that were published in the Federal Register on August 3, 2023.[2]

HR Policy Association is the leading organization representing the Chief Human Resource Officers (CHROs) of over 380 of the largest corporations doing business in the United States and globally. Collectively, their companies provide health care coverage to over 21 million employees and dependents in the United States and spend over $100 billion per year on that coverage. The American Health Policy Institute, a division of 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.

Over the past three years, large employers have taken several steps to improve access to mental health and substance use disorder (MH/SUD) providers. Many employers have added a supplemental network for virtual or in-person care to broaden access and are providing enhanced employee assistance programs in addition to their health plan mental health benefits. Employers have also expanded mental health navigation programs, tele-behavioral health benefits, and digital or in-person resources for managing stress and building resiliency. Although these efforts

[1] The Request for Comment was posted on the internet at: https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/guidance/technical-releases/23-01.pdf.

[2] 88 Fed. Reg. 51552.

have substantially increased access to and the utilization of employer provided MH/SUD benefits,[3] the fundamental problem remains – a severe shortage of MH/SUD providers that is projected to continue for the next 13 years.[4]

The Association appreciates EBSA recognizes the challenges the shortage of MH/SUD providers pose to employer health benefits and the service providers that provide MH/SUD provider networks.[5] According to the Health Resources and Services Administration, 163.4 million Americans live in 6,546 Mental Health Professional Shortage Areas and 8,251 additional behavioral health (BH) practitioners[6] are needed to fill these provider gaps.[7] Moreover, given the elevated need for MH/SUD services post-Covid and the current homeless/fentanyl crisis, by 2035, the U.S. is projected to have a significant shortage of adult psychiatrists, child and adolescent psychiatrists, psychologists, addiction counselors, mental health counselors, and marriage and family therapists.[8] It will be years, if not decades, before the shortage can be adequately addressed despite the best efforts of all stakeholders.

Technical Release Comments

According to the Technical Release, plans and issuers have asserted that, in some geographic areas, the scarcity of in-network MH/SUD providers is frequently attributable to an overall shortage of MH/SUD providers that are able and willing to participate in provider networks. In some cases, this may be due to a shortage of MH/SUD providers in a geographic area.

- Comment: This is not an assertion. This is a statement of fact that even provider groups agree with. See the Health Resources and Services Administration data above.

However, disproportionately high use of out-of-network MH/SUD providers by participants, beneficiaries, and enrollees, as compared to out-of-network medical/surgical (M/S) providers, is

[3] What's Working to Expand Behavioral Healthcare Access: 5 Best Practices, Tracy Watts, Mercer, October 5, 2023. More people are getting behavioral healthcare and the number visits per 1,000 plan members have also increased.

[4] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of June 30, 2023, available at: https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport.

[5] 88 Fed. Reg. 51577.

[6] Behavioral health providers are health care practitioners or social and human services providers who offer services for the purpose of treating mental disorders including: psychiatrists, clinical social workers, psychologists, counselors, credentialed substance use specialists, peer support providers, and psychiatric nurse providers.

[7] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of June 30, 2023, available at: https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport.

[8] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Behavioral Health Workforce Projections, 2020-2035, November 2022, available at: https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Projections-Factsheet.pdf.

evidence that MH/SUD providers may be available in those geographic areas but joining provider networks is not sufficiently appealing to them.

- Comment: There are many reasons why providers do not join networks besides the reimbursement rates that are offered to them.

Reimbursement Rates

In the proposed rule, the Departments solicit comments on whether provider reimbursement rates should be compared to Medicare reimbursement rates as an alternative to billed charges or another external benchmark.[9] Further, the Technical Release says if the proposed rules are finalized, the Departments are considering specifying the relevant data that plans and issuers would be required to collect and evaluate for NQTLs related to network composition which would include in-network payments and billed charges for inpatient MH/SUD and M/S benefits, outpatient office visit MH/SUD and M/S benefits, and all other outpatient MH/SUD and medical/surgical (M/S) benefits.

- Comment: Reimbursement rates should never, ever, be compared to billed charges, which are notoriously inflated. They should only be compared to median in-network rates. The phenomenon of excess charges, where health care service providers bill beyond the limit allowed for a medical procedure or treatment is quite well known in the United States. According to one JAMA report, psychiatry charges were 1.7 times the Medicare reimbursement rate, about the same as dermatology (1.8), allergy/immunology (1.7), and family practice (1.8).[10] Geriatric psychiatry and neuropsychiatry charges were two times Medicare reimbursement rates. Importantly, these rates are far below, anesthesiology (5.8), neurosurgery (4.0), pain management (3.4) and many other MS provider specialties. The Departments need to be very careful about which MS providers are used as a comparator for MH/SUD providers lest the final rule only marginally improves access but significantly increases MH/SUD costs.

  "Understanding the reasons for out-of-network mental health care use is critical to determine whether additional policy intervention is necessary and, if so, to identify adequate policy solutions. Out-of-network use may be higher for mental health services compared to general health services for several reasons. From a provider's perspective, provider shortages may give mental health providers the market power to opt not to participate in networks."[11] Moreover, from a patient perspective, continuity of care may be more valued for mental health treatment compared to general medical treatments,

[9] 88 Fed. Reg. 51576

[10] Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region, Ge Bai, PhD, and Gerard F. Anderson, PhD, JAMA Network, January 17, 2017.

[11] Out-of-Network Provider Use More Likely in Mental Health than General Health Care Among Privately Insured, Kelly A. Kyanko, MD, Leslie A. Curry, PhD, and Susan H. Busch, PhD, NIH, National Library of Medicine, January 11, 2016.

particularly for patients being treated with psychotherapy. Patients may be willing to pay more out-of-pocket to complete treatment with a trusted provider who may no longer have in-network status.[12]

High administrative costs, audits, and uncompensated burdens that all providers face is another reason MH/SUD providers refuse to participate in networks, despite reasonable reimbursement rates (1.7 times Medicare). Health care administrative tasks have grown exponentially resulting in psychiatrists, particularly those in solo or small practices, spending an inordinate amount of time on uncompensated tasks, leaving far less time for treating patients.[13] While this is a good economic reason for MH/SUD provider practices to consolidate, MHPAEA and its implementing regulations should not be used to tilt reimbursement rate negotiations in favor of providers without some countervailing requirement for providers to join some networks.

The Departments should also take into consideration provider workloads as another reason that providers may remain out of network. Sixty percent of psychologists reported having no openings for new patients, slightly down from 65% in 2021.[14] Nearly four in 10 psychologists (38%) maintained a waitlist, with a large variation in length. Out-of-network providers with waiting lists have very little incentive to join a network if they have a waiting list of cash paying patients given the increase in administrative costs they may also face.

Technical Release Safe Harbor

According to the Technical Release, the Departments expect the safe harbor standards would set a high bar to ensure that enforcement relief is provided only to plans that clearly demonstrate, through the data provided as part of their comparative analysis, that participants have equal access to in-network MH/SUD benefits. The safe harbor *could* include a variety of metrics, based on data such as in-network and out-of-network utilization rates (including data related to provider claim submissions), network adequacy metrics (including time and distance data, and data on providers accepting new patients), reimbursement rates (including as compared to billed charges), and others. Only the NQTLs related to network composition would be covered by the safe harbor, including standards for provider and facility admission to participate in a network or for continued network participation, methods for determining reimbursement rates, credentialing standards, and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide covered services under the plan or coverage. DOL would not take enforcement action for two calendar years (or some other period) against a plan, if all the future standards are satisfied, *and those standards could be changed in future guidance.*

[12] *See footnote 11*.

[13] American Psychiatric Association, Letter to Secretary Walsh, May 25, 2022.

[14] Psychologists struggle to meet demand amid mental health crisis, American Psychological Association, APA 2022 COVID-19 Practitioner Impact Survey.

It would only be available if, during the two-year or other identified period, the plan or issuer has not made a change in benefit design or to the processes, strategies, evidentiary standards, and other factors used to design or apply the plan's NQTLs related to network composition.

- Comment: Given all of the proposed requirements for the proposed safe harbor, its limited applicability and duration (two years), the frequency that many employer plans change the benefit design of their health plans, and proposed ability for DOL to change the terms of the safe harbor in future guidance, the Association believes that very few, if any, employers will seek to take advantage of the proposed safe harbor. HR Policy recommends DOL repropose an easier to comply with safe harbor that lasts for at least five years.

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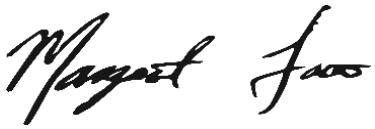
The HR Policy Association urges the Departments to consider these comments when considering Technical Release 2023-01P rule and we look forward to working with you on improving compliance with MHPAEA.

Sincerely,

D. Mark Wilson
President and CEO, American Health Policy Institute
Vice President, Health & Employment Policy
HR Policy Association



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