October 17, 2023

Amber Rivers
200 Constitution Ave NW, Suite N-5653
Washington, DC 20210
Attention: 1210-AC11
Submitted electronically at www.regulations.gov

Re: Comments on the Proposed Requirements Related to the Mental Health Parity and Addiction Equity Act (RIN 1210-AC11)

Dear Ms. Rivers,

HR Policy Association ("HR Policy" or "Association") welcomes the opportunity to provide comments to the Employee Benefits Security Administration (EBSA) regarding the agency'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.[1] We are particularly concerned about:

- The impact the provider shortage will have on the ability for employers to meet the expanded requirements including the required use of outcomes data and network composition NQTLs;
- The new application of the substantially all/predominant test;
- The lack of definition for "meaningful benefits;" and
- The new certification requirement.

Separately, the Association has also submitted comments regarding the Request for Comment on 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.[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.

[1] 88 Fed. Reg. 51552.

[2] 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.

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 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]

Provider Shortage, Required Use of Outcomes Data and Network Composition NQTLs

The Association appreciates that the Departments recognize the challenges the shortage of MH/SUD providers pose to employer health benefits and the service providers that provide MH/SUD provider networks in the preamble.[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 still 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 to meet their parity obligations in the proposed rule.

In the preamble to the proposed rule, the Departments state that it is their view that relevant outcomes data *should* be collected and evaluated as part of analyzing whether an NQTL is more restrictive, in operation, than the predominant medical/surgical NQTL that is applied to substantially all medical/surgical benefits in a classification.[9] It is also the Departments view that it is *necessary* for employer plans to review and consider quantitative outcomes data to get a sense of how a NQTL functions in the context of the plan's administration and provision of

[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.

[9] 88 Fed. Reg. 51575.

benefits,[10] and it is *critical* for employer plans to collect information to assess relevant data that show the outcomes that result from the application of an NQTL, evaluate those outcomes, and take reasonable action as necessary to address any material differences in access.[11]

- Comment: The preamble language is not consistent with proposed 29 CFR 2590.712(c)(4)(iv)(A), which states that when an employer plan is designing and applying a NQTL, the plan *must* collect and evaluate relevant data in a manner reasonably designed to assess the impact of the NQTL on access to MH/SUD benefits. Therefore, to avoid confusion, the preamble to the final rule should replace "should" with "must" in order to be consistent with the regulatory text.

Under the proposed rule, when an employer plan is designing and applying a NQTL, the plan must collect and evaluate relevant data in a manner reasonably designed to assess the impact of the NQTL on access to MH/SUD benefits and medical/surgical benefits, and consider the impact as part of the plan's analysis of whether the limitation, in operation, complies with proposed (c)(4)(i) and (ii).[12] Relevant data includes, but is not limited to, the number and percentage of claims denials and any other data relevant to the nonquantitative treatment limitation required by State law or private accreditation standards.[13] To the extent the relevant data show material differences in access to MH/SUD benefits as compared to medical/surgical benefits, the differences will be considered a strong indicator that the plan has a parity violation; and the plan must take reasonable action to address the material differences in access to ensure compliance, in operation, and document the action that has been or is being taken by the plan to mitigate any material differences in access to MH/SUD benefits as compared to medical/surgical benefits.[14]

However, under the special proposed rule for NQTLs related to network composition, notwithstanding proposed 29 CFR 2590.712(c)(4)(iv)(B), when designing and applying one or more NQTLs related to network composition standards, an employer plan fails to meet the requirements of 29 CFR 2590.712(c)(4)(i) and (ii), in operation, if the relevant data show material differences in access to in-network MH/SUD as compared to in-network medical/surgical benefits in a classification.[15]

Further, the preamble to the final rule states: "The Departments recognize that shortages of mental health and substance use disorder providers could pose challenges to employer plans and their service providers. If, despite taking appropriate action, the relevant data continues to reveal material differences in access, such as, because of provider shortages that the plan cannot effectively address through no fault of its own, the Departments would not cite the plan for failure to comply with 29 CFR 2590.712(c)(4)(iv) with respect to the plan's NQTLs related to network composition if the plan otherwise complied with the other applicable MHPAEA

[10] *Id*.

[11] 88 Fed. Reg. 51575.

[12] Proposed 29 CFR 2590.712(c)(4)(iv)(A), 88 Fed. Reg. 51643.

[13] *Id*.

[14] Proposed 29 CFR 2590.712(c)(4)(iv)(B), 88 Fed. Reg. 51643.

[15] Proposed 29 CFR 2590.712(c)(4)(iv)(C), 88 Fed. Reg. 51643.

requirements. Plans and issuers should be prepared, however, to document the actions they have taken and to demonstrate why any disparities are attributable to provider shortages in the geographic area, rather than their NQTLs related to network composition."[16]

- Comment: As noted above, HR Policy appreciates the Departments recognize the access challenges that the shortage of MH/SUD providers pose to employer health benefits and their service providers. The Association also appreciates the regulatory approach for NQTLs not related to network composition, whereby a material difference in relevant access data is just an indicator of a potential violation and employers are provided an opportunity to address the material difference by taking reasonable action and documenting that action before a violation is issued.

- Comment: Given the substantial shortage of MH/SUD providers and the Departments' recognition that despite taking appropriate action, employer plans, through no fault of their own, may not be able to address material differences in access data, the Association strongly recommends for the final rule that the Departments take the same regulatory approach for network composition related NQTLs that they take in the proposed rule for NQTLs not related to network composition. That is, a material difference in relevant access data is just a strong indicator of a potential violation of proposed 29 CFR 2590.712(c)(4)(i) and (ii) and not an automatic violation, and employers are provided an opportunity to address the material difference by taking reasonable action and documenting that action before a violation is issued. HR Policy also strongly recommends the Departments add language to the final regulatory text and preamble that explicitly recognizes that if, despite taking appropriate action, relevant data continue to show material differences in access because of provider shortages that the plan or issuer cannot address on their own, the Departments will not cite such plan or issuer for failure to comply with 26 CFR 54.9812–1(c)(4)(iv), 29 CFR 2590.712(c)(4)(iv), and 45 CFR 146.136(c)(4)(iv) with respect to the plan's or issuer's NQTL(s) related to network composition.

- Comment: The Association further recommends that material differences for NQTLs not related to network composition be considered an "indicator" of a potential parity violation, and a material difference for network composition related NQTLs be considered an "strong indicator" of a potential parity violation in the final rule.

- Comment: The Association strongly recommends the Departments explicitly clarify in the final rule and its preamble that "any other data relevant to the nonquantitative treatment limitation required by state law or private accreditation standards" does not apply to ERISA covered health plans. Regulatorily requiring ERISA covered health plans to sort through the maze of state law requirements for any other relevant data required by state law is statutorily at odds with Congressional intent to preempt the application of state laws to ERISA covered health plans. ERISA covered health plans do not collect behavioral health related data relevant to NTQLs that are required by state law. The final

[16] 88 Fed. Reg. 51577.

rule should enable ERISA covered plans to determine what data they consider to be relevant unincumbered by any state law requirements or private accreditation standards.

- Comment: HR Policy also recommends changing the preamble language for the final rule to reflect the comments above.

Future Guidance on the Type, Form, and Manor of Relevant Data Collection

Proposed 29 CFR 2590.712(c)(4)(iv)(A) states: "The Secretary, jointly with the Secretary of the Treasury and the Secretary of Health and Human Services, may specify in guidance the type, form, and manner of collection and evaluation for the data required under this paragraph (c)(4)(iv)(A)."[17]

- Comment: Given the importance of material differences related to network composition NQTLs (automatic MHPAEA violation with no ability to cure) and the significant cost in collecting all of the data that is being contemplated in the proposed rule and Technical Release, the type, form, and manner of collection and evaluation of the data required under (c)(4)(iv)(A) *must be specified through notice and comment rulemaking and plans must be afforded three years to implement such data collection and evaluation before any violation is determined by the Departments*.

- Comment: The Departments also solicited comments on whether provider reimbursement rates should be compared to Medicare reimbursement rates as an alternative to billed charges or another external benchmark. According to Milliman, the "percentage of Medicare FFS rates is one of the most widely accepted commercial reimbursement benchmarks when evaluating provider reimbursement level and comparing contracts in the healthcare industry. It can reflect the mix of services across providers and plans while removing impacts from billed charges that can vary widely across providers and regions."[18] Given the wide variation in billed charges, health plans should have the option of comparing reimbursement rates to cash rates from providers and Medicare reimbursement rates for parity purposes.

No More Restrictive than the Predominant NQTL that Applies to Substantially All Medical/Surgical Benefits

The proposed rule would illogically impose quantitative requirements on nonquantitative treatment limitations. For the first time, the NPRM would impose the substantially all/predominant quantitative tests to assess the parity of NQTLs for MH/SUD benefits. Specifically, the NPRM would require employer plans to: 1) determine the portion of plan payments (based on dollar amounts) for medical/surgical benefits subject to an NQTL in a classification; then 2) determine if the NQTL applies to substantially all medical/surgical benefits (at least two-thirds) in the classification; then 3) determine the predominant variation of the NQTL that applies to medical/surgical benefits in the classification and whether the NQTL,

[17] 88 Fed. Reg. 51643.

[18] Commercial Reimbursement Benchmarking, Andy McBeth, et.al., Milliman, November 1, 2022.

as applied to MH/SUD benefits in the classification, is more restrictive than the predominant variation of the NQTL as applied to substantially all medical/surgical benefits. The NPRM also allows employer plans to use "any reasonable method" to determine the dollar amount expected to be paid under the plan or coverage for medical/surgical benefits.

Under the proposed rule, if an NQTL does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that NQTL would not be permitted to be applied to MH/SUD benefits in that classification. The Departments also propose that the term "predominant" would mean the most common or most frequent variation of an NQTL within a benefit classification.

Employer health plans would not be required to perform the parity analysis each plan year under proposed 29 CFR 2590.712 (c)(4)(i) unless there is a change in plan benefit design or utilization that would affect an NQTL within a classification.[19]

- Comment: The final MHPAEA rules published in 2013 created NQTLs and recognized that NQTLs are just that – not quantifiable. Accordingly, the final 2013 rule set forth a different way for employer plans to assess parity with respect to NQTLs. This differentiation is significant and was recognized by Congress when it codified the NQTL requirements set forth in the final 2013 rule in the Consolidated Appropriations Act, 2021 (CAA, 2021). Congress could have added the substantially all/predominant tests for assessing NQTL parity, but it explicitly didn't. Indeed, the entire premise for applying quantitative testing to NQTLs in the NPRM is based on the brief that it is "more consistent" with the text of the statute despite the clear congressional intent expressed in CAA, 2021. Therefore, HR Policy strongly recommends the Departments do not include the proposed test in the final rule as it appears to exceed the Departments' statutory authority.

- Comment: Non-quantitative treatment limitations are not quantifiable, and quantifiable data metrics should not be used to determine parity. They would be unworkable, or at best, the costs would far outweigh the benefits. Although the Departments recognize this to some degree because the NPRM does not require the parity analysis to be performed every plan year, plan benefit designs and/or utilization rates change almost every year for many, if not most, employer plans. Practically speaking, employers will be required to repeatedly conduct costly parity analyses. Further, when the proposed rule is finalized, it is likely to impact plan design and utilization in every covered employer plan every year for the next five years. Moreover, it often takes a year or two for plan design changes to materially show up in any access data. Therefore, the Association strongly recommends the Department's only require employers to redo their parity analyses no more frequently than every three to five years.

[19] 88 Fed. Reg. 51570.

Independent Professional Medical or Clinical Standards and Standards to Detect or Prevent and Prove Fraud, Waste and Abuse

The proposed rule provides two exceptions from the substantially all/predominant test for independent professional medical or clinical standards and standards used to detect or prevent fraud, waste, and abuse. The first exception is for NQTLs that "impartially apply generally recognized independent professional medical or clinical standards (consistent with generally accepted standards of care) to medical/surgical benefits and mental health or substance use disorder benefits. Under these proposed rules, the exception would not be available to any plan or issuer with respect to an NQTL that fails to impartially apply such standards, or deviates from those standards in any way, such as by imposing additional or different requirements."[20]

The second exception applies for "NQTLs reasonably designed to detect or prevent and prove fraud, waste and abuse based on indicia of fraud, waste and abuse that have been reliably established through objective and unbiased data."[21]

- Comment: The Association appreciates the Departments' acknowledgement that "the application of generally recognized independent professional medical or clinical standards and appropriately designed and carefully circumscribed fraud, waste, and abuse measures generally improve care and outcomes for participants and beneficiaries, rather than restrict access to benefits."[22] One of the main reasons employers and carriers use independent professional medical or clinical standards is to ensure employees are receiving the highest quality, "gold-standard" of care. While the Association believes these exceptions to be an important step, we have concerns regarding the fact that the proposed rule states the "plan or issuer would still be required to comply with the design and application requirements and the relevant data evaluation requirements." In these cases, the Association requests clarification on what would be considered the appropriate steps for a plan to take to ensure compliance with the design and application requirements. We also request that the Departments provide detailed examples of the appropriate application of these exceptions.

No Definition of Meaningful Benefits

The proposed rule significantly expands the requirement for plans regarding MH/SUD benefits. The 2013 MHPAEA final rule requires that if a plan provides a MH/SUD benefit in one of the classifications outlined by MHPAEA, then that plan must provide that MH/SUD benefit in all classifications that medical/surgical benefits are provided.[23] The proposed rule greatly expands this requirement by stating that when a plan covers a MH/SUD condition in a benefit classification, then the plan must provide "meaningful benefits" for that condition in all classifications as compared to the medical/surgical benefits.[24] Moreover, the Departments only

[20] 88 Fed. Reg. 51578.

[21] *Id.*

[22] *Id.*

[23] 78 Fed. Reg. 68278.

[24] 88 Fed. Reg. 51586.

provide two examples of what they mean by meaningful benefits.[25] Notably, the Departments recognize that the proposal to require meaningful benefits for MH/SUD services in a classification is related to scope of services and request comments on whether additional guidance is needed regarding how this proposed requirement would interact with the approach related to scope of services adopted under the 2013 final regulations.[26] Further, the Departments ask whether it would be more practical to require plans and issuers to provide "substantial coverage" of mental health and substance use disorder benefits or benefits for the "primary or most common or frequent types of treatment for a covered condition or disorder" in each classification in which medical/surgical benefits are provided, and if so, how to define and make comparisons about what constitutes "substantial coverage" or the "primary or most common or frequent types of treatment" for medical/surgical and mental health or substance use disorder benefits.

- Comment: While the Association appreciates the two examples regarding "meaningful benefits" in the proposed rule, they are insufficient.[27] HR Policy strongly recommends the Departments do not use difficult to define terms such as "meaningful benefits" or "substantial coverage" in the final rule. HR Policy is concerned these terms could be interpreted as mandating nearly every recognized treatment of a MH/SUD condition regardless of how effective it is. Instead, the Departments should use "primary evidence-based treatment based on independent standards of current medical practice." In the 2013 final rule, the Departments stated they "did not intend to impose a benefit mandate through the parity requirement that could require greater benefits for mental health conditions and substance use disorders than for medical/surgical conditions."[28] The Departments should reiterate this position in the final rule and provide several new examples and guidance on when MH/SUD benefits would meet and do not meet the "primary evidence-based treatment based on independent standards of current medical practice" standard. The Association also strongly urges the Departments to provide examples of when an employer plan can limit MH/SUD benefits to evidence-based treatments that require measurement-based care when providing a larger, but similar, range of medical/surgical benefits.

- Comment: HR Policy also urges the Departments to also consider the impact provider shortages may have on access data when attempting to provide "meaningful benefits" in every classification. Flexibility should be provided in cases where plans have documented shortages of MH/SUD providers that specialize in specific types of evidence-based treatment but there are larger numbers of medical/surgical providers.

Telehealth

The expansion of telehealth services during the Covid-19 pandemic allowed employers to provide employees with access to providers in a safe and convenient manner. This was

[25] 88 Fed. Reg. 51639.

[26] 88 Fed. Reg. 51587.

[27] 88 Fed, Reg. 51639.

[28] 78 Fed. Reg. 68246.

particularly helpful for employees in need of behavioral health services. As tele-behavioral health services became more common it was clear to employers that telehealth increased access for many employees who previously would not seek out mental health or substance use services.[29]

Despite the increase in use of telehealth services for MH/SUD benefits, the lack of behavioral health providers remains an issue in administering these benefits and ensuring providers are available via telehealth for MH/SUD benefits at the same level they are for medical/surgical benefits may prove difficult. This is especially true depending on the geographic area of a particular plan.

Additionally, there is no separate classification for telehealth. "The departments expect plans and issuers to treat telehealth benefits the same way they treat those benefits when provided in person in determining the classification or sub-classification in which a particular benefit belongs."[30] There are often different quantitative treatment limits (copays and co-insurance) that apply to telehealth and often the MH/SUD benefits offered through telehealth might be more limited than those offered for medical/surgical benefits, raising NQTL issues.

- Comment: The Association is committed to the expansion of telehealth services, particularly to treat MH/SUD conditions. The proposed rules as written do not address the many road-blocks employers face in order to expand telehealth benefits. Passing license reciprocity laws or expanding membership of the interstate licensing compact, which allows out-of-state psychiatrists to provide telepsychiatry, are two steps the Association believes could have a real impact on the number of providers available via telehealth.

Certification Requirement

Under the proposed rule, employer health plans subject to ERISA would be required to include a certification by one or more named fiduciaries who have reviewed the comparative analyses, stating whether they found the comparative analyses to be in compliance with the content requirements of the proposed rule.[31] According to DOL, this requirement, along with the requirement that the plan provide named fiduciaries with a written list of all NQTLs and a general description of any existing documentation relied on by the plan or issuer in preparing the comparative analysis for each NQTL, would help ensure that plan fiduciaries meet their obligations under ERISA to review the comparative analyses and properly monitor their plans for compliance with MHPAEA.[32]

In addition, the Departments assume that TPAs and other service providers would fulfill the requirements for the vast majority of self-insured group health plans. Moreover, in DOL's

[29] Bulkes NZ, Davis K, Kay B, Riemann BC. Comparing efficacy of telehealth to in-person mental health care in intensive-treatment-seeking adults. J Psychiatr Res. 2022 Jan;145:347-352. doi: 10.1016/j.jpsychires.2021.11.003. Epub 2021 Nov 3. PMID: 34799124; PMCID: PMC8595951.

[30] 88 Fed. Reg. 51588.

[31] 88 Fed. Reg. 51593 and 51651.

[32] 88 Fed. Reg. 51593.

review of comparative analyses, the reliance on insurance companies, TPAs, and other service providers for much or all of the work has been nearly universal.[33] The Departments also requested comments on the percent of self-insured group health plans that would rely on analyses that TPAs and other service providers have already performed for their other plans and all aspects of the proposed rule.[34]

- Comment: HR Policy agrees with DOL that all self-insured plans will rely on TPAs and other service providers to perform the parity analyses required by the current and proposed rules. Even the largest employers do not have the expertise, data, information, and requisite knowledge to comply with and fulfill all of the current and proposed MHPAEA regulatory compliance. Only the insurance carriers, TPAs, and service providers that play a role in designing plans, administering networks, managing claims, providing plan services, and maintaining and holding the data relevant for the comparative analyses have the expertise to comply with and fulfill all of the current and proposed MHPAEA regulatory compliance. Large self-insured employers may also utilize outside legal counsel to assist with ensuring compliance.

- Comment: Given these facts, it is completely unreasonable for DOL to require one or more named fiduciaries to certify the comparative analyses that are completed by these outside entities to be in compliance with the content requirements of either the current or proposed rule. Even after reviewing the comparative analyses, employers do not have the expertise and requisite knowledge to assess and determine if the comparative analyses are fully compliant with the content requirements of the current or proposed rules. While employers may attempt to get the outside entities to certify to them that the parity analyses they provide to the employer are compliant with the content requirements of the current or proposed rules, the proposed rule does not allow employers to rely on such a third-party certification. Therefore, the Association strongly urges DOL to drop this proposed requirement in the final rule.

The Consolidated Appropriations Act, 2021, and Related Guidance

The preamble to the proposed rule describes the MHPAEA comparative analysis requirements group health plans and health insurance are obligated to comply with under the CAA 2021.[35] It also describes the process by which the Departments must evaluate the requested NQTL comparative analyses and enforce the comparative analyses requirements, and then share information on findings of compliance and noncompliance with the State where the plan is located or the State where the issuer is licensed to do business.[36] It also notes the Departments are required to submit an annual report to Congress and make publicly available a report summarizing the comparative analyses requested by the Departments.[37] The preamble then

[33] 88 Fed. Reg. 51613.

[34] 88 Fed. Reg. 51613 and 51558.

[35] 88 Fed. Reg. 51560 – 51562.

[36] 88 Fed. Reg. 51561.

[37] *Id.*

summarizes the compliance guidance FAQs Part 45 (April, 2, 2021) provide to employer plans and issuers.[38]

- Comment: Notably, the preamble fails to discuss what the CAA 2021 requires the Departments to do regarding NQTLs. Specifically, the CAA 2021 requires the Departments 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

  (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;

[38] 88 Fed. Reg. 51561 – 51562.

(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…"[39]

- Comment: While the Association appreciates the additional guidance and examples the proposed rule provides, in the preamble to the final rule, the Departments should describe in a separate section what their statutory CAA obligations are and how the final rule explicitly meets those obligations.

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The HR Policy Association urges the Departments to consider these comments when considering the final parity 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

Margaret Faso
Director, Health Care Research and Policy
HR Policy Association, American Health Policy Institute

[39] 29 U.S.C. 1185a(a)(7)(C), emphasis added.