Business Group on Health

October 17, 2023

Submitted Electronically via: www.regulations.gov

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N–5653
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
Attention: 1210–AC11

Re: Comments on Proposed Requirements Related to the Mental Health Parity and Addiction Equity Act and Nonquantitative Treatment Limitations

To whom it may concern:

Business Group on Health appreciates the opportunity to comment on the Proposed Rule, "Requirements Related to the Mental Health Parity and Addiction Equity Act," as published in the Federal Register by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the "Departments") on August 3, 2023 (88 Fed. Reg. 51552).We appreciate the Departments' attention and effort in this rulemaking and wish to partner further in order to reach final rules that work for all stakeholders.

Business Group on Health represents a network of more than 440 of today's largest and most progressive employers and industry partners including 72 Fortune 100 companies, providing health coverage for 60 million workers, retirees and their families in 200 countries. Business Group members – innovative employer plan sponsors – are leading the way and encouraging others by providing strong health plan offerings, adopting alternative payment models, managing the total cost of care, promoting health equity, furthering population health, and keeping people well.

For many years, even preceding the enactment of the Paul Wellstone and

Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), large employers worked to help support the mental health and substance use disorder (MH/SUD) needs of their employees and families. In recent years, based on our own data, the strong majority of large employers view health and well-being as an important, and increasing, consideration to overall workforce strategy. Additionally, employers generally recognize or anticipate MH/SUD issues as the top prolonged impact resulting from the COVID-19 pandemic. Employers continue to focus on and invest in expanded access to and robust coverage of MH/SUD support and services, including improved navigation assistance and tele/virtual health services for access to MH/SUD providers. We expect large employers to continue to provide these benefits and help support employees and families, but do have concerns about these proposed rules, the amount of resources that would be expended to satisfy ministerial elements and documentation versus providing substantive benefits, and the feasibility/applicability of some of the proposals.

Business Group on Health has worked in concert with other stakeholders regarding additional comments and is signatory to a coalition letter with comments that will be filed separately. Here we provide additional focus on several important fundamental challenges for ERISA plan sponsors presented by the proposals that we believe require additional input or revisions, or that we are concerned will be unworkable and thus are flawed expectations to set and chase with limited resources at a time of continued health care inflation. We hope the Departments will take our comments in good faith as an invitation to find the right balance between employers' vital investments to help ensure individuals with MH/SUD issues receive the support they need and expending resources on documenting and reporting such efforts.

I. The proposed named fiduciary certification regarding the NQTL comparative analyses is not required by statute and is excessive, wasteful, and disruptive to long-standing principles. We respectfully request the Departments remove and not finalize this proposal.

The Consolidated Appropriations Act, 2021 (CAA) requirement to provide specific findings and conclusions regarding the health insurance coverage and the comparative analysis does not require or naturally imply that any individual named plan fiduciary independently review the comparative analysis or certify whether they found it to be compliant. In principle ERISA empowers plan sponsors to self-administer all aspects of plan administration. However, modern plans and their fiduciaries exercising appropriate oversight, selection, and decision-making are generally expected to retain and rely on professionals with expertise in the various areas a plan may cover. Requiring any individual named fiduciary(ies) to certify as to the compliance of each of the plans' comparative analyses upsets this long-standing administration, oversight, and delegation principle. Functionally, it seems as though it would require at least one (although

potentially more) named fiduciary(ies) to individually possess the requisite expertise specifically in MHPAEA, NQTLs, and the comparative analysis in order to make such a certification. Requiring that level of specific expertise is not supported by the CAA or ERISA generally, would be extremely burdensome on plans to engage such fiduciaries, and we believe is not necessary to appropriately demonstrate compliance with the relevant requirements. As such, we respectfully request that the Departments do not include this requirement in any finalization of the proposed rules.

II. The CAA ratified the Departments' 2013 final rules' foundation and standards for NQTLs, and directed the Departments to work in-line with those understandings. The departure from those standards is surprising and may present significant challenges/be infeasible or have other chilling effects on otherwise desirable medical/surgical (M/S) and MH/SUD reforms and innovations. We respectfully request that the Departments revert to the prior approach and standards under the 2013 final rules and CAA for NQTLs and not finalize these proposals.

Prior to the CAA, the Departments issued guidance implementing MHPAEA including interim final rules in 2010[1] and final rules in 2013[2] in which NQTLs were unequivocally separated from Quantitative Treatment Limitations (QTLs). Similarly, the parity standard applied to NQTLs was distinct and separate from that which applied (and still applies) to QTLs.

> Under both the interim final regulations and [the] final regulations, a plan or issuer may not impose an NQTL with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification **are comparable to, and are applied no more stringently than**, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the same classification. (Emphasis added.)[3]

Meanwhile, QTLs were (and still are) subject to their own standards including the "substantially all" and "predominant" tests.[4] Notably, in the 2013 final rules, the Departments explicitly declined to apply "the same quantitative parity analysis for

[1] 75 FR 5410
[2] 78 FR 68240
[3] 78 FR 68244
[4] 78 FR 68278

NQTLs" as were applied to QTLs. Further, the Departments expressed their understanding and finalized rules providing "**different parity standards with respect to [QTLs] and NQTLs, because although both kinds of limitations operate to limit the scope or duration of [MH/SUD] benefits, they apply to such benefits differently.**" (Emphasis added.)[5]

With the CAA, Congress did not disturb the underlying foundation or understanding of the Departments with respect to the standards applicable to NQTLs or QTLs, respectively. Indeed, the CAA purports to ratify the Departments' 2013 NQTL standard into statute by establishing a documentation scheme in the form of required comparative analyses by repeating the pertinent and foundational component that distinguishes the standard of the NQTLs from the QTLs:

> (iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, **are comparable to, and are applied no more stringently than**, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification. (Emphasis added.)[6]

In our view, Congress intended in the CAA to acknowledge and accept the Departments' 2013 final rulemaking, standards, and understandings related to NQTLs, to build group health plan documentation requirements around that foundation, and to direct the Departments to provide further guidance, examples, and compliance support in-line with the 2013 final rules. We did not expect and believe it to be technically and practically infeasible for the Departments to set aside the established foundation of NQTL parity standards, as ratified by the CAA, and propose to substitute an augmented (and not fully enunciated) version the QTL requirements, previously determined to be unworkable for NQTLs.

If the Departments were to finalize the proposed parity standard for NQTLs as proposed here, we anticipate meaningful challenges to designing and operationalizing appropriate and compliant medical management techniques for both M/S and MH/SUD that are important for plan administration and patient safety. Additionally, we are concerned that group health plans and their service providers in both M/S and MH/SUD may suffer a chilling effect in access improvements, innovation, and alternative reimbursement arrangements that are expected to drive value, affordability, and sustainability for employer plans as well as employees and their families. As one example, our recent data

[5] 78 FR 68245

[6] P.L. 116-260, Sec. 203

shows an uptick in late-stage cancer diagnoses in the last two years with COVID-19 deferred screenings as a driving factor. Many employers have been working to develop additional, targeted, specialized support for cancer-related services and screenings, in some cases, outside of the larger network arrangements with third-party administrators (e.g., direct contracting). But, it is unclear under these proposed rules (and could be for several years of implementation) whether and how these types of arrangements may be handled or considered and thus whether they could cause a plan to be "noncompliant" or to recalculate the tests/redesign the entire plan (and bear that expense and disrupt enrollees) despite an urgent need to take action on an emergent trend, whether M/S or MH/SUD related.

For these reasons we respectfully request that the Departments not finalize the application of the substantially all and predominant tests but instead revert to the prior approach and engage stakeholders in discussion and development of guidance in-line with the 2013 final rules and the CAA.

III. Additional note and conclusion.

The absence of certain definitions and the parallel consideration of the Technical Release 2023–01P that appears to potentially have a meaningful influence on elements under the proposed rule make it seemingly impossible to provide confidently complete, fully informed, and helpful responses to the proposed rules. We truly wish to partner with the Departments and other stakeholders to develop reasonable and workable standards to comply with the important objectives of MHPAEA. We earnestly hope that the Departments will take all stakeholder input, including the technical release, and issue additional proposed rules (aligned with our views of the NQTL foundations and standards from the CAA and 2013 final rules) with a more holistic and complete set of elements, and allow all stakeholders to engage in comments with a full view of the proposed component parts and requirements.

Thank you for your consideration. We would welcome the opportunity to discuss these comments or any other matters impacting employer plan sponsors. Please feel free to contact me (kelsay@businessgrouphealth.org) or Garrett Hohimer, Vice President, Policy and Advocacy (hohimer@businessgrouphealth.org) to discuss further.

Sincerely,

Ellen Kelsay
President and CEO