COMMITTEE ON
EDUCATION AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
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October 17, 2023

The Honorable Julie Su
Acting Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Janet L. Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

RE: Requirements Related to the Mental Health Parity and Addiction Equity Act (RINs: 1210-AC11; 0938-AU93; 1545-BQ29)

Dear Acting Secretary Su and Secretaries Becerra and Yellen:

We write in support of the Proposed Rules by the Departments of Labor, Health and Human Services, and the Treasury (jointly, the Departments) entitled, "Requirements Related to the Mental Health Parity and Addiction Equity Act" (the Proposed Rules).[1] The Proposed Rules will enhance compliance with the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA)[2] and advance our shared goal of removing barriers to care. We applaud the Biden Administration and the Departments for their leadership on this important issue and look forward to continuing to work together to further expand access to high-quality behavioral health care.

[1] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51,552 (proposed Aug. 3, 2023) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pts. 146–47), https://www.federalregister.gov/documents/2023/08/03/2023-15945/requirements-related-to-the-mental-health-parity-and-addiction-equity-act (hereinafter "Proposed Rules").
[2] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, Pub. L. No. 110-343, div. C, title V, subtitle B, 122 Stat. 3,861, 3,881 (2008).

Improving Parity in Coverage of Mental Health and Substance Use Disorder Benefits

In the more than two decades following the enactment of the *Mental Health Parity Act of 1996*,[3] federal law has sought to address the discriminatory treatment of behavioral health by group health plans and insurers through the principle of parity—that coverage of behavioral health care should be no more restrictive than coverage of medical and surgical care. In 2008, MHPAEA was enacted to extend the principle of parity to specifically include substance use disorder benefits and address nonquantitative treatment limitations (NQTLs) such as prior authorization, step therapy, network design, and other barriers to care. The *Patient Protection and Affordable Care Act* (ACA)[4] further strengthened behavioral health coverage by requiring small employer plans to cover treatment of mental health and substance use disorders (MH/SUD) as an "Essential Health Benefit" and by applying parity to coverage purchased in the individual market.

Despite this historic progress, the Departments and state enforcement agencies continue to face challenges in making parity a reality, particularly with respect to discriminatory NQTLs imposed on MH/SUD benefits. The Department of Labor's Employee Benefits Security Administration has found that violations of parity often involve NQTLs imposed by group health plans, requiring corrective actions such as removal of impermissible prior authorization requirements and the recalculation of out-of-network reimbursement rates.[5] In an effort to improve oversight of NQTLs, the *Consolidated Appropriations Act, 2021* (CAA, 2021)[6] required group health plans and issuers to perform comparative analyses that document NQTLs imposed on MH/SUD benefits and make such analyses available to regulators upon request.[7] However, reports to Congress issued in 2022[8] and, most recently, July 2023[9] show widespread noncompliance with these requirements.

The Statement of Purpose Articulated by the Proposed Rules Will Help Improve Meaningful Compliance with MHPAEA

The Proposed Rules make a valuable addition to the current MHPAEA regulations by, for the first time, articulating a clear statement of the "fundamental purpose" of federal parity law and instructing plans and issuers to interpret the statute and its implementing regulations consistent with this purpose. In doing so, the Proposed Rules affirm the principle that health plans and issuers that cover MH/SUD benefits may not impose financial requirements or treatment

[3] Mental Health Parity Act, Pub. L. No. 104-204, title VII, 110 Stat. 2874, 2944 (1996).
[4] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010) (as amended by Pub. L. No. 111-152).
[5] *See* U.S. Dep't of Lab., Emp. Benefits Sec. Admin., Fact Sheet, FY 2022 MHPAEA Enforcement, Enforcement Overview: Ensuring Parity (2022), https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2022.
[6] Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, div. BB, title II, 134 Stat. 1182, 2900 (2020).
[7] 29 U.S.C. § 712(a)(8)(B)(i); 42 U.S.C. § 27269(a)(8)(B)(i); I.R.C. § 9812(a)(8)(B)(i).
[8] U.S. Dep'ts of Lab., Health and Hum. Servs. and the Treasury, 2022 Report to Congress on the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (2022), https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.
[9] U.S. Dep'ts of Lab., Health and Hum. Servs. and the Treasury, MHPAEA Comparative Analysis Report to Congress (July 2023), https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis.pdf.

limitations that are more restrictive than those that are "applied to substantially all medical/surgical benefits covered by the plan or coverage."[10]

Most importantly, the proposed statement of purpose clarifies the policy intent of MHPAEA to prevent discriminatory restrictions on coverage of behavioral health care by explicitly stating that plans and issuers "must not design or apply financial requirements and treatment limitations that impose a greater burden on *access* (that is, are more restrictive) to mental health and substance use disorder benefits under the plan or coverage than they impose on *access* to generally comparable medical/surgical benefits."[11] The Proposed Rules' emphasis on access to behavioral health care is a welcome improvement that will help to ensure parity is measured by the actual outcomes delivered to consumers, rather than as a box-checking exercise by group health plans and issuers. This will help meaningfully improve the quality of behavioral health coverage, and we urge the Departments to finalize this change.

The Proposed Rules Strengthen the Standards Governing NQTLs

Restrictions on coverage through NQTLs such as prior authorization, step therapy, and network design frequently present barriers to MH/SUD care and are often applied in an impermissible manner that violates the principle of parity. The Departments propose a three-part standard that will allow plans and issuers to determine if an NQTL discriminates against MH/SUD benefits in violation of MHPAEA.[12] Under the Proposed Rules, an NQTL may not be imposed unless three requirements are met: (1) the NQTL is "no more restrictive" with respect to MH/SUD than it is with respect to medical/surgical benefits; (2) the "design and application" of the NQTL satisfy MHPAEA; and (3) the group health plan or issuer engages in collection, evaluation, and consideration of data and takes "reasonable action" to rectify "material differences in access" based on the data collected.[13] These requirements are consistent with the statutory purpose of MHPAEA and will help ensure compliance by plans and issuers and facilitate meaningful access to behavioral health care for individuals.

With respect to the "no more restrictive" requirement, it is especially encouraging that the Departments propose ensuring that NQTLs are evaluated against the predominant limitations imposed on "substantially all" medical/surgical benefits. This is a major improvement over the 2013 Final Rules,[14] which applied the "substantially all" test only to financial requirements and quantitative treatment limitations (QTLs) and instead relied instead on a complex analysis of the processes, strategies, and evidentiary standards in the application of NQTLs. In addition, the data collection requirement in the Proposed Rules is a marked improvement over the 2013 Final Rules, as it will require plans and issuers to rely upon empirical evidence when evaluating the

[10] Proposed Rules at 51,564.
[11] *Id*.
[12] *Id*. at 51,568.
[13] *Id*.
[14] *See* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68240 (Nov. 13, 2013), https://www.federalregister.gov/documents/2013/11/13/2013-27086/final-rules-under-the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act.

impact of NQTLs on access to MH/SUD, consistent with the fundamental purpose of MHPAEA and its implementing regulations.

Importantly, the Proposed Rules show that the Departments recognize the harmful impact of NQTLs that arise in the form of limited and phantom provider networks. As witness testimony before the Committee on Education and Labor has shown, inadequate provider networks present a serious barrier to accessing behavioral health care that force individuals to pay for expensive out-of-network treatment or forgo care entirely.[15] The Proposed Rules would take transformational steps by making clear that reimbursement and network design decisions may violate MHPAEA "if the relevant data show material differences in access to in-network mental health or substance use disorder benefits as compared to in-network medical/surgical benefits in a classification."[16] This standard will help increase the reliance by plans and issuers on evidence when designing provider networks, improving access to in-network care. We urge the Departments to finalize this proposed change.

Clarifications Made by the Proposed Rules Will Improve Implementation of the Comparative Analyses Requirements of the CAA, 2021

Under guidance issued by the Departments, health plans and issuers have long been encouraged to perform and document comparative analyses of MH/SUD and medical/surgical coverage to ensure that any NQTLs placed on MH/SUD benefits are in compliance with parity.[17] With enactment of the CAA, 2021, such comparative analyses became mandatory under federal law rather than a best practice.[18] Although this requirement has been in effect for more than two years, the Departments have repeatedly found that health plans and issuers routinely fail to perform adequate analyses of their NQTLs.[19] By codifying the requirements of the CAA, 2021 in MHPAEA's implementing regulations and providing detailed instructions to plans and issuers, the Proposed Rules will facilitate compliance while further improving access to MH/SUD benefits for consumers.

The Proposed Rules specify in detail all documentation that is necessary to ensure that a CAA, 2021-compliant comparative analysis provides meaningful justification for NQTLs. Such clarity is key in assisting plans and issuers in understanding their obligations under the statute, while helping to ensure that individuals are not subject to impermissible NQTLs. In addition, the

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[15] *Meeting the Moment: Improving Access to Behavioral and Mental Health Care: Hearing Before the Subcomm. on Health, Emp., Lab., and Pensions,* 117th Cong. 6 (2021) (statement of Meriam Bendat, J.D., Ph. D., Founder of Psych-Appeal, Inc.), https://democrats-edworkforce.house.gov/imo/media/doc/BendatMeiramTestimony041521.pdf ("[P]lan participants must often wait protracted periods or travel extensive distances to receive mental health and substance use treatment, or to obtain authorizations for out-of-network care, which are inconsistently granted. Given the prevalence of narrow and phantom networks, it is unsurprising that mental health and substance use treatment is disproportionately rendered out-of-network or forsaken altogether.").
[16] Proposed Rules at 51,576.
[17] U.S. Dep'ts of Lab., Health and Hum. Servs. and the Treasury, FAQs About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act Part 45 (2021) at 3, https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf ("The MHPAEA Self-Compliance Tool was last updated in 2020, before the enactment of the Appropriations Act, and it recommends that plans and issuers analyze NQTLs and document those analyses as a best practice.).
[18] *Id*.
[19] *See* U.S. Dep'ts of Lab., Health and Hum. Servs. and the Treasury, *supra* note 8 and U.S. Dep'ts of Lab., Health and Hum. Servs. and the Treasury, *supra* note 9.

Proposed Rules require plans and issuers to include, as part of these analyses, an evaluation of standards regarding network composition and reimbursement rates for out-of-network providers, helping ensure that network design decisions are appropriately scrutinized to verify that they do not impermissibly limit access to behavioral health care.

Further, the Proposed Rules implement the CAA, 2021's requirement that health plans and issuers institute a corrective action plan when they are found to impose an impermissible NQTL. Importantly, the Proposed Rules require notice be provided to individuals who are impacted by a claims denial and may be eligible for benefit redetermination under their plan or coverage. While this is a welcome improvement that will limit the harm caused by MHPAEA violations, the Departments should also consider avenues of reducing burdens on individuals to challenge benefit denials that relied upon an impermissible NQTL. Specifically, we encourage the Departments, to the extent feasible within their statutory authority, to also ensure that plans and issuers automatically reprocess denied claims without action by an individual consumer.

The Departments Should Reconsider the Proposed Exceptions to the NQTL Requirements Contemplated by the Proposed Rules

Although the Proposed Rules take historic steps to greatly strengthen parity and provide needed clarity for plans and issuers that will improve compliance, we are concerned that two exceptions contemplated by the Proposed Rules could have unintended consequences. As the Departments consider how to further strengthen this proposal, we encourage careful consideration of whether the exceptions provided may inadvertently undermine the goals of MHPAEA and its implementing regulations.

First, the Departments propose an exception that would allow for the imposition of certain 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."[20] Although incorporating medical and clinical standards into the application of parity is an understandable goal, it is unclear why a wholesale exception from the requirements of MHPAEA is warranted on this basis. This exception could create a loophole that allows plans and issuers to impose potentially discriminatory restrictions on MH/SUD benefits that undermine the purpose of MHPAEA. Instead, the Departments should consider a narrower approach that does not create an exception from parity but instead incorporates independent professional medical or clinical standards as a factor when evaluating an NQTL for compliance with MHPAEA.

Similarly, the proposed exception for "fraud, waste, and abuse," may allow health plans and insurers to impose otherwise impermissible restrictions on MH/SUD benefits, contrary to the fundamental purpose of MHPAEA and its implementing regulations. While combatting fraud, waste, and abuse is important, we are concerned that this exception could allow health plans and

[20] Proposed Rules at 51,578.

insurers to severely restrict or exclude coverage of behavioral health benefits and undermine access to necessary care. Moreover, there is no clear statutory basis for establishing such an exception, as Congress has never included similar language in numerous amendments to federal parity law, including in the most recent amendments enacted in the CAA, 2021.

We encourage the Departments to reevaluate the inclusion of these exceptions in the Proposed Rules and consider ways in which they can be further narrowed to limit the risk of creating loopholes or undermining the goals of MHPAEA.

Oversight of Third-Party Administrators and Other Group Health Plan Service Providers is Critical

The Departments request comment on how to incentivize compliance by entities that contract with group health plans to administer their behavioral health benefits.[21] This is a critical issue, as many plan sponsors do not directly administer their group health plans, but rather delegate these functions to entities such as third-party administrators, issuers, managed behavioral care organizations, and other service providers.[22] The Departments have long recognized that this delegation does not relieve plan sponsors of their obligations to comply with MHPAEA and other requirements of federal law.[23] To that end, we applaud the Departments for obtaining corrective actions by service providers and bringing enforcement actions directly against service providers who cause or contribute to violations of the statute.[24] The Departments, particularly the Department of Labor, should build upon this work by making clearer their authority to directly enforce requirements against service providers—including third-party administrators who purport to be acting in a non-fiduciary capacity—and taking action to improve transparency through enforcing group health plan disclosure requirements under Section 408(b)(2) of the *Employee Retirement Income Security Act* (ERISA).[25]

The Departments Should Maintain Consumer Protections with Respect to Telehealth

Additionally, the Departments request comment regarding guidance[26] issued during the COVID-19 Public Health Emergency (PHE) that provided for non-enforcement of requirements of federal law with respect to certain standalone telehealth benefits offered by large employers. Although this non-enforcement policy was terminated following the conclusion of the PHE

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[21] *Id*. at 51,590.
[22] *See* U.S. Dep'ts of Lab., Health and Hum. Servs. and the Treasury, *supra* note 14 at 68,250.
[23] *Id*. ("The fact that an employer or issuer contracts with one or more entities to provide or administer mental health or substance use disorder benefits does not, however, relieve the employer, issuer, or both of their obligations under MHPAEA. The coverage as a whole must still comply with the applicable provisions of MHPAEA, and the responsibility for compliance rests on the group health plan and/or the health insurance issuer, depending on whether the coverage is insured or self-insured.").
[24] *See, e.g.,* Acosta v. MagnaCare Admin. Servs., LLC and MagnaCare, LLC, Civil Action No. 1:16-cv-07695-DAB, (S.D.N.Y. filed Jul. 13, 2017); Walsh v. United Behav. Health and UnitedHealthcare Ins. Co., Civil Action No. 21-cv-4519 (E.D.N.Y. filed Aug. 11, 2021).
[25] 29 U.S.C. § 1108(b)(2). *See* Letter from Rep. Robert C. "Bobby" Scott and Rep. Virginia Foxx to the Honorable Lisa M. Gomez (Dec. 14, 2022), https://democrats-edworkforce.house.gov/imo/media/doc/bipartisan_scott-foxx_letter_to_ebsa_re_health_transparency.pdf.
[26] U.S. Dep'ts of Lab., Health and Hum. Servs. and the Treasury, FAQs About Families First Coronavirus Response Act And Coronavirus Aid, Relief, And Economic Security Act Implementation Part 43 (2020), https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-43.pdf.

earlier this year, some have called for its reinstatement or expansion as a way of providing access to behavioral health care. We have serious concerns with such proposals, which would effectively exempt standalone telehealth plans from consumer protections under ERISA and other laws while failing to meaningfully expand access to care. We urge the Departments to continue to enforce all consumer protections under federal law with respect to coverage of telehealth by group health plans and not to reinstate the temporary policy adopted during the PHE.

The Proposed Rules Appropriately Implement the Repeal of the Opt-Out for Nonfederal Governmental Plans

Finally, we applaud the Department of Health and Human Services for its actions to implement the repeal of the opt-out for self-insured, non-federal governmental plans. The *Consolidated Appropriations Act, 2023*[27] made the long-overdue change of eliminating a statutory loophole that previously allowed states to elect not to comply with parity requirements with respect to certain group health plans sponsored by governmental entities.[28] We are pleased that the Biden Administration has promptly implemented this reform and ensuring the broader application of parity to public servants and their families in all states. Moving forward, we encourage continued oversight of the implementation of this change to ensure full compliance in states that had previously opted out of MHPAEA.

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We appreciate the opportunity to comment on the Proposed Rules. We applaud the Departments and the Biden Administration for your leadership on this important issue, and we hope that these comments are of assistance as you work to finalize these regulations.

Sincerely,

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[27] *See* Consolidated Appropriations Act of 2023, Pub. L. No. 117-328, 136 Stat. 4459.
[28] *See* 42 U.S.C. § 300gg-21(b)(1)(B).