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Employee Benefits Security Administration
Department of Labor

Internal Revenue Service
Department of Treasury

Centers for Medicare & Medicaid Services
Department of Health and Human Services

Attention: 1210-AC11

Re: Requirements Related to the Mental Health Parity and Addiction Equity Act; Proposed Rules [1210–AC11]

To Whom It May Concern:

The U.S. Chamber of Commerce ("Chamber") submits these comments in response to the new proposed rules which "[amend] the regulations that implemented the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and propose new regulations implementing the nonquantitative treatment limitation (NQTL) comparative analyses requirements under MHPAEA as amended by the Consolidated Appropriations Act of 2021 (CAA)."[1]

Employers are committed to improving the mental and behavioral health of their employees, the families of their employees and individuals in their communities particularly given the nationwide behavioral health crisis that has grown exponentially in recent years. Tackling this critical priority is further complicated by growing provider shortages which necessitate a wholistic multi-pronged approach to ensure that individuals and families are able to receive important treatments and services. While the

[1] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51,552-51,669. (August 3, 2023) (to be codified at 26 C.F.R. Part 54; 29 C.F.R. Part 2590; 45 C.F.R. Parts 146 and 147) [hereinafter referred to as the "Proposed Rules"] https://www.govinfo.gov/content/pkg/FR-2023-08-03/pdf/2023-15945.pdf

Chamber supports the goal of improving the lives, health and wellbeing of individuals with mental health and substance use disorder needs, these Proposed Rules are exceedingly problematic and will force employers and plans to redirect resources and attention away from this important goal.

I. COMMITMENT TO IMPROVING MENTAL AND BEHAVIORAL HEALTH

The business community is committed to improving the health and lives of employees and their families with robust high-value coverage. Employers, plan sponsors and insurers are working diligently within the legal and regulatory parameters to not only comply with parity requirements but to identify innovative ways to improve access and advance mental health.

Beyond simply doing the right thing, employers also have a vested interest in improving the overall health of their employees. Covering roughly 50 percent of the United States population, employer-sponsored insurance (ESI) provides benefits to nearly 155 million individuals. According to the U.S. Chamber of Commerce's Protecting Americans' Coverage Together (PACT) campaign, "a recent analysis[2] estimates that employer-sponsored coverage delivers $800 billion in personal value to American families and saves consumers $100 billion in health care costs each year." PACT also reports that, "employees value employer-sponsored coverage up to 84% more than the total cost of health coverage." Furthermore, a 2022 analysis[3] conducted by Avalere found that "companies that invest in their employees by providing high quality health coverage see a significant return on investment… for every dollar invested in ESI, these companies, on average, receive $1.47 back in financial benefits."

Following the COVID-19 pandemic and the "great resignation" that came in its wake, job seekers and current employees are demanding more from employers than ever before. To attract and retain talent, employers are responding to the stresses of the pandemic and its aftermath by offering more comprehensive benefits including mental health support. According to a report[4] published by McKinsey & Company, "about three in four large employers and two in four small/medium employers report that they offer at least one type of mental health support for employees."

While the COVID-19 pandemic precipitated an expansion of mental health benefits, these offerings have been growing for some time. Employers and policymakers addressed

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[2] Mulligan, Casey B. The Value of Employer-Sponsored Health Insurance. Report no. Working Paper 28590. National Bureau of Economic Research, 2021.

[3] Avalere Health. Return on Investment for Offering Employer-Sponsored Insurance, Protecting American's Coverage Together, 2022.

[4] Coe, Erica, Jenny Cordina, Kana Enomoto, Alex Mandel, and Jeris Stueland. National surveys reveal disconnect between employees and employers around mental health need. McKinsey & Company, 2021. Accessed October 11, 2023. https://www.mckinsey.com/industries/healthcare/our-insights/national-surveys-reveal-disconnect-between-employees-and-employers-around-mental-health-need.

behavioral health for many years prior to 2020, particularly when seeking to improve network adequacy across rural and urban populations. Telemedicine has played a vital role in expanding access. The Kaiser Family Foundation (KFF) published a 2022 Employer Health Benefits Survey[5] that found "among firms with 50 or more employees offering telemedicine benefits, 37% say that telemedicine is "very important" in providing access to mental health services for enrollees, and another 38% say that it is "important" to provide access to these services." Moreover, KFF found "forty percent say that telemedicine will be 'very important' in providing future access to care for enrollees in remote areas, and another 27% say that it will be 'important' to providing future access for remote enrollees."

II. PROVIDER SHORTAGES AND SUPPLY-SIDE CHALLENGES

Our nation's health system is multifaceted and complex. While a critical component, coverage and plan design alone cannot guarantee access to medical and behavioral health providers, services, and treatment. Parity can't and shouldn't be used as a vehicle to solve all of the problems that exist in behavioral health. Further, increased provider payments won't address problems arising from workforce shortages and will likely raise premiums. The entire mental and behavioral health landscape must be examined when evaluating how to increase the number of providers, expand the workforce, and improve access to services and treatment in the mental health and substance use disorder arenas. Beyond current behavioral health provider shortages, the sputtering talent pipeline of mental and behavioral health professionals must be tackled.

A. Increased Demand for Services

The National Institute on Mental Health estimates[6] that as of 2021 approximately 57.8 million Americans aged 18 and up (22.8 percent of adults overall) are currently living with some degree of mental illness. Further, as an individual's mental health changes over time and when accounting for behavioral health challenges over the course of a lifetime, not just on an episodic period, the number of Americans impacted rises to as much as 50 percent.[7]

When accounting for substance use disorders (SUDs) as part of the diagnosable population suffering from a behavioral health condition, the numbers rise even further.

[5] 2022 Employer Health Benefits Survey: Section 13: Employer Practices, Telehealth, Provider Networks and Coverage for Mental Health Services. Kaiser Family Foundation, 2022. Accessed October 11, 2023. https://www.kff.org/report-section/ehbs-2022-section-13-employer-practices-telehealth-provider-networks-and-coverage-for-mental-health-services/.

[6] National Institute of Mental Health. "Mental Illness." Last modified March 2023. Accessed October 10, 2023. https://www.nimh.nih.gov/health/statistics/mental-illness.

[7] Counts, Nathaniel. Understanding the U.S. Behavioral Health Workforce Shortage. The Commonwealth Fund, 2023. Accessed October 10, 2023. https://www.commonwealthfund.org/publications/explainer/2023/may/understanding-us-behavioral-health-workforce-shortage.

The Senate Finance Committee's Mental Health Report released in 2022[8] expressed just how prevalent substance abuse disorder exists amongst Americans aged 12 or older, estimating approximately 40 million Americans to be impacted. Looking in more granular detail the report outlined: *In 2020, an estimated 2.7 million people were living with opioid use disorder (OUD), but only 11% received medication for OUD in the past year. About 8% of hospitalized adults with OUD died within 1 year of discharge – mortality rates that are similar to patients admitted with acute heart attacks. SUD may co-occur with behavioral health conditions and nearly 10 million adults have both SMI and SUD.*

Most alarming is the impact this will have on youth who will soon be transitioning into early adulthood, and in turn, the workforce. Research has shown[9] that "behavioral health conditions often begin at a young age: 50% of adults with a behavioral health condition had symptoms by age 14, and 75% experienced symptoms by age 24." Facing dual challenges of the opioid epidemic and the COVID-19 pandemic has had an unprecedented impact. The Senate Finance Committee report:

- In 2020, more than 24% of young adults reported a substance use disorder in the past year. The opioid overdose mortality rate for children and adolescents under the age of 20 has tripled in the past two decades, with prescription opioids accounting for about one-third of overdose-related fatalities among 15- to 19-year-olds in 2016.

- As of June 2021, more than 140,000 children in the country lost a parent or grandparent caregiver to COVID-19. Two-thirds of these children were racial and ethnic minorities. Depressive and anxiety symptoms have doubled during the pandemic, with 25% of youth experiencing depressive symptoms and 20% experiencing symptoms of anxiety.

B. Insufficient Supply of Providers

Given the scale of this issue, it is evident that public and private sector actions are needed to address the systemic shortcomings we observe today. According to an April 2023 study[10] conducted by the National Council of Mental Wellbeing "the vast majority (83%) of the nation's behavioral health workforce believes that without public policy changes, provider organizations won't be able to meet the demand for mental health or

[8] United States Senate Committee on Finance. Mental Health Care in the United States: The Case for Federal Action. 2022. Accessed October 12, 2023. https://www.finance.senate.gov/imo/media/doc/SFC%20Mental%20Health%20Report%20March%202022.pdf.

[9] Ibid.

[10] National Council for Mental Wellbeing. New Study: Behavioral Health Workforce Shortage Will Negatively Impact Society. 2023. Accessed October 9, 2023. https://www.thenationalcouncil.org/news/help-wanted/#:~:text=WASHINGTON%2C%20DC%20(April%2025%2C,meet%20the%20demand%20for%20mental

substance use treatment and care." The survey also pointed to the potential exodus of behavioral health workers due to burnout.

Workforce shortages are particularly acute in psychiatry; approximately 55% of continental U.S. counties have no psychiatrists, and 77% of counties report a severe shortage. Approximately 70% of practicing psychiatrists are 50 years or older and are approaching retirement.[11] Without an influx of psychiatry students, the demand for psychiatrists will outstrip supply by 25% in 2025.

While it existed before the pandemic, burnout has been exacerbated by COVID and further compounded by provider shortages. In May 2023, the Commonwealth Fund[12] reported that "160 million Americans live in areas with mental health professional shortages, with over 8,000 more professionals needed to ensure an adequate supply." Likewise, the National Institute for Health Care Management published a June 2023 overview, *The Behavioral Health Care Workforce*[13], and found that "49 percent of the U.S. population lives in a mental health workforce shortage area… with two-thirds of shortage areas are in rural or partially rural parts of the country."

In a survey of practicing behavioral health providers and organizations, the behavioral health system is issuing its own cry for help and the findings are stunning:[14]

- The impacts of workforce shortages have caused them to consider other employment options (48%).
- Around nine in ten behavioral health workers are concerned about the ability for those not currently receiving care to gain access to care (90%) and the ability to provide care in the event of another health crisis in the future (87%).
- A third of the workforce reported spending most of their time on administrative tasks, with 68% of those who provide care to patients saying the amount of time spent on administrative tasks takes away from time they could be directly supporting clients.

C. Addressing the Shortfall

Addressing workforce shortages and the disparity in the demand for services and the supply of providers is critical if access is to be improved. Opportunities through telehealth to provide care for portions of the population where shortages exist must be leveraged. Such "[p]olicies that could increase the provision of telepsychiatry include:

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[11] Kuntz, Leah. Psychiatric Care in the US: Are We Facing a Crisis? April 2022. Accessed October 13, 2023https://www.psychiatrictimes.com/view/psychiatric-care-in-the-us-are-we-facing-a-crisis

[12] Counts, Nathaniel. Understanding the U.S. Behavioral Health Workforce Shortage. The Commonwealth Fund, 2023. Accessed October 10, 2023. https://www.commonwealthfund.org/publications/explainer/2023/may/understanding-us-behavioral-health-workforce-shortage.

[13] National Institute for Health Care Management (NIHCM). "The Behavioral Health Care Workforce." NIHCM.org. Last modified June 2023. Accessed October 11, 2023. https://nihcm.org/publications/the-behavioral-health-care-workforce-shortages-solutions.

[14] National Council for Mental Wellbeing (NCMW).

passing license reciprocity laws, or expanding membership of the interstate licensing compact, to more easily allow out-of-state psychiatrists to provide telepsychiatry; amending state Medicaid plans to reimburse for telepsychiatry; and increasing medical residents' exposure to telemedicine during training."[15]

The implementation and expansion of telehealth services has a massive impact on the ability of individuals to access care in urban and rural settings. While the need for greater mental health care access remains a commonality between both geographical regions, the needs of each vary greatly and telehealth serves as the bridge to obtaining a greater level of care. The Senate Finance Committee's Mental Health Report released in 2022 recognized the importance of access to tele-mental services for underserved populations and elaborated[16]:

> Despite challenges with access to broadband internet, smart phones and computers, telehealth utilization has grown in rural and urban areas. From 2010 to 2017, telehealth visits for mental health increased by 425% among rural Medicare beneficiaries.17 Between 2016 and 2019, treatment for SUD via telehealth increased from 13.5% to 17.4%, with a greater adoption being associated with rural locations.18 Under the PHE, Medicare telehealth utilization increased sharply at the start of the COVID-19 pandemic in both urban and rural areas, and despite declining somewhat in the latter half of 2020, utilization has remained substantially higher than 2019 levels.

Seeking solutions such as these will help broaden access to mental health services. We urge the Departments to identify and encourage tangible solutions that the public and private sector can build on jointly. Unfortunately, as currently written, the Proposed Rules will only make the provision of mental health benefits across the country more difficult.

III. HISTORICAL LEGAL AND REGULATORY CONTEXT: EVOLUTION OF NQTL PARITY

The Chamber and its members strongly support efforts to improve access to mental health services as well as ongoing efforts to advance compliance with both MHPAEA and the CAA. However, these Proposed Rules go far beyond implementing the statutory requirements under MHPAEA, as amended by the CAA, and instead upend the regulatory and compliance framework which has evolved consistently over the past 15 years.

As our nation's commitment to improving access to mental health benefits has grown, the types of plans (from group health plans to plans in the individual market) and ways of assessing parity have as well. Following new statutory provisions and regulations to

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[15] The University of Michigan's School of Public Health Behavioral Health Workforce Research Center issued a 2018 report detailing

[16] United States Senate Committee on Finance. Mental Health Care in the United States: The Case for Federal Action. 2022. Accessed October 12, 2023. https://www.finance.senate.gov/imo/media/doc/SFC%20Mental%20Health%20Report%20March%202022.pdf

implement these legal changes, parity in the provision of mental health benefits (MH benefits) has expanded to include parity in the provision of substance use disorder benefits (SUD benefits) when compared with medical/surgical benefits (MS benefits).

The original Mental Health Parity Act of 1996 (MHP Act) focused on ensuring parity in the application of aggregate lifetime and annual dollar limits to MH benefits compared to MS benefits. In 2008, MHPAEA (and later the Affordable Care Act in 2010 and the CAA in 2021) expanded the types of health plans and benefits legally required to comply with parity rules.

As part of this consistent evolution, MHPAEA included in statute a "mathematical" rule to evaluate parity in the application of financial requirements ("deductibles, copayments, coinsurance, and out-of-pocket expenses"[17]) and treatment limits ("frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment[18]") to MH/SUD benefits as compared to MS benefits. MHPAEA's implementing regulations (both the Interim Final Rules published in 2010 and the Final Rules published in 2013) further specified that this "**general parity requirement… ** prohibits plans from imposing **a financial requirement or a quantitative treatment limitation** on mental health and substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical surgical benefits in the same classification."[19, 20]

> "For this purpose, the regulations incorporated the two-thirds ''substantially all'' **numerical** standard from the regulations implementing MHPA 1996 and **quantified** ''predominant'' to mean that more than one-half of medical/surgical benefits in the classification are subject to the financial requirement or **quantitative** treatment

[17] Section 512 (a) (1) "(3)(B)(i)" Page 117 https://www.govinfo.gov/content/pkg/PLAW-110publ343/pdf/PLAW-110publ343.pdf

[18] Section 512 (a)(1) "(3)(B)(iii) Page 117.

[19] Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. at 5,412-5,413. (February 2, 2010) (to be codified at 26 C.F.R. Part 54; 29 C.F.R. Part 2590; and 45 C.F.R. Part 1460 [hereinafter referred to as the "Interim Final Rules published in 2010"]
"The general parity requirement…of these regulations prohibits a plan (or health insurance coverage) from applying any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same classification. For this purpose, the general parity requirement of MHPAEA applies separately for each type of financial requirement or treatment limitation (that is, for example, copayments are compared to copayments, and deductibles to deductibles)."

[20] 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. 68,240-68,296 (November 13, 2013) (to be codified at 26 C.F.R. Part 54; 29 C.F.R. Part 2590; 45 C.F.R. Parts 146 and 147)[hereinafter referred to as the "Final Rules published in 2013"] https://www.govinfo.gov/content/pkg/FR-2013-11-13/pdf/2013-27086.pdf

limitation in the relevant classification. Using these **numerical** standards, the Departments established a **mathematical test** by which plans and issuers could **determine what level of a financial requirement or quantitative treatment limitation**, if any, is the most restrictive level that could be imposed on mental health or substance use disorder benefits within a classification. (This **mathematical test** is referred to in this preamble as the **quantitative parity analysis**.)"[21] [emphasis added]

Although not delineated in the statute, MHPAEA's Interim Final Rules published in 2010 and Final Rules published in 2013 established nonquantitative treatment limitations (NQTLs) and set forth a different and wholly separate mechanism to assess parity with respect to NQTLs. This differentiation of the numeric standards for quantifiable treatment limits (the statute's substantially all/predominant math test) from the separate standard for nonquantifiable limits which are limits that cannot be expressed numerically is significant. While creating and imposing a parity rule on NQTLs in regulations which were omitted in statute constitutes regulatory overreach, the codification of the Final Rules published in 2013 in the Consolidated Appropriations Act of 2020 has cemented these rules into statute. The nonquantitative NQTL parity assessment has been consistently framed by regulators for nearly a decade in guidance, FAQs, and compliance materials and notably was not modified by Congress when the CAA 2020 provisions were enacted into law. As originally and (until these Proposed Rules) consistently delineated:

"A plan may not impose an NQTL with respect to MH/SUD benefits in any classification unless… factors used in applying the NQTL to MH/SUD benefits in the classification are **comparable to,** and are applied **no more stringently than,** …the factors used in applying the limitation to MS benefits in the same classification."[22] [Emphasis added]

In fact, MHPAEA's implementing regulations qualified two different treatment terms (quantitative treatments limits and nonquantitative treatment limits) and repeatedly differentiated the applicable tests based on whether the treatment limitations are quantitative or nonquantitative:

"Section 1. B. Clarification- Parity Requirements"[23]

This section which details the parity requirements contains the regulatory provisions regarding quantitative treatment rules under MHPAEA limits and the mathematical test for "**quantitative parity analysis."**[24]

"Section 1. C. Nonquantitative Treatment Limitations"[25]

[21] Final Rules published in 2013, at 68,241.
[22] Ibid.
[23] Final Rules published in 2013, at 68242.
[24] Final Rules published in 2013, at 68,243.
[25] Final Rules published in 2013, at 68,244.

This section includes a discussion on the creation of different parity standards for NQTLs.

"Section 1. C. 2. Parity Standards for NQTLs Versus Quantitative Treatment Limitations"[26]

> "These final regulations continue to provide **different parity standards with respect to quantitative treatment limitations and NQTLs**, because although both kinds of limitations operate to limit the scope or duration of mental health and substance use disorder benefits, they **apply to such benefits differently."**[27]

The two underlying statutes sited in the Proposed Rules have retained a consistent approach to and standard for assessing mental health parity as it relates to NQTLs which is decisively different than the parity standards for quantitative treatment limitations. This is clear by the repeated phrases that differentiate the analyses, rules, and tests such as "different parity standards with respect to quantitative treatment limits and NQTLs," "Quantitative treatment limitation rules," and "Quantitative parity analysis."

In 2021, the CAA codified the NQTL requirements set forth in the Final Rules published in 2013 implementing MHPAEA and specified a 5-step approach for plans to document their NQTL comparative analysis that plans meet the "comparable and no more stringent requirement."

From the enactment of MHPAEA in 2008 through the enactment of CAA in 2021, the Departments have reiterated two different and distinct parity standards with respect to quantitative treatment limitations and nonquantitative treatment limitations. However, these Proposed Rules ignore the NQTL parity rules, comparative analysis requirements and standards codified recently by Congress and years of guidance under the auspice of "amending" the regulations and the existing NQTL standard.[28] Regulatorily creating a completely different standard, complex testing and convoluted analysis regime for NQTL parity determinations, these Proposed Rules not only upend a framework that has been iterated on over the past 15 years but do so without (and in fact in conflict with) a direct legal basis in statute.

The Departments provide no justification for their surprising new conclusion that the entirety of their previous guidance was wrong. Indeed, the entire premise for creating

[26] Final Rules published in 2013, at 68,245.

[27] Ibid.

[28] Since the MHPAEA statute was passed, the Tri-Departments have issued Interim Final Rules published in 2010, Final Rules published in 2013, fourteen (14) FAQs, a Self-Compliance Tool that has been updated at least three (3) times, seven (7) reports to Congress, two (2) published studies on compliance, a "Warning Signs" document, and nine (9) enforcement fact sheets, not to mention a variety of webinars and other publications on parity compliance. For 15 years, this guidance has been consistent: the "predominant" and "substantially all" quantitative testing requirements apply to quantitative limits and financial requirements; the "processes, strategies, evidentiary standards, and other factors" test applies to NQTLs.

extensive new and confusing requirements for applying quantitative testing to NQTLs is based on the brief and unsupported assertion that it is "more consistent" with the text of the statute than the previous 15 years of guidance and enforcement.[29]

IV. PROBLEMATIC NEW REQUIREMENTS & RECOMMENDATIONS FOR REVISIONS

While we share the Departments' important commitment to improve access to MH/SUD benefits and services, the Chamber is deeply concerned with many of the dramatic and unimplementable new requirements included in the Proposed Rules. There are five particularly concerning proposed regulatory elements which the Chamber urges the Departments to reconsider and offers recommendations for revisions in the Final Rules.

A. New 3-Part Test for NQTL Parity: Problematic Part 1 and Problematic Part 3
B. New "Meaningful Benefit" Requirement
C. New Fiduciary Certification Mandate
D. Unilateral Power to Prohibit Plan Operations
E. Problematic Applicability Date

The discussion of these five categorical elements includes additional detail regarding the components of these categories. For the most problematic proposed changes, the Chamber shares:

- Our understanding of the dramatic proposed changes ("Overview"),
- Our alarm regarding the significant complications associated with the most concerning proposed changes ("Concerns"), and
- Our feedback to better advance the goals of improving access to mental and behavioral health services ("Recommendations").

A. New 3-Part Test for NQTL Parity: Problematic Part 1 & Problematic Part 3

Overview

As detailed above in the Section III. Historical Legal and Regulatory Context, these new Proposed Rules for NQTL parity upend the guidance and regulations from multiple administrations which consistently implemented a distinctly different NQTL process-oriented rule over the past 15 years which was codified by Congress in the CAA. The long-standing NQTL process-oriented parity rule states an NQTL could not be applied to MH/SUD benefits in a classification unless the NQTL was applied "comparably to" and "no more stringently in writing or operation" to MS benefits in that same classification.

Now, the Proposed Rules dramatically put forth a new convoluted and unprecedented 3-part test before plans can impose an NQTL on MH/SUD benefits under which they must:

[29] Proposed Rules, at 51,565.

(1) Apply for the first time the substantially all/predominant (math) test to assess the application of NQTLs to MH/SUD benefits;
(2) Conduct the design & application requirement as previously applied, along with a new non-discrimination requirement; and
(3) Collect and analyze outcomes data to evaluate the impact on access for which any material difference creates a presumption of non-compliance and in some instances a determination of non-compliance.

In the Proposed Rules, the Departments propose a schema to quantify the nonquantifiable. "Non-quantitative" treatment limitations are just that – not quantifiable. Previously, the Departments recognized that and as a result, focused on ensuring the nonquantifiable treatment limits are developed in a way that does not burden mental health benefits—e.g., that the standards applied to mental health benefits are no more burdensome than those applied to medical surgical benefits. However, in these Proposed Rules, the Departments seem to abandon this understanding and instead, have tried to quantify the nonquantifiable. The results are standards that can neither be understood nor met.

CONCERNS
The Chamber has significant concerns with Part 1 and Part 3 of this expansive new test as detailed below.

RECOMMENDATIONS
We urge the Departments to rescind the expanded regulatory requirements detailed in the first and third steps of the new 3-part test which go beyond the statutory direction and the current regulatory framework. Instead, the Departments should focus efforts on the existing parity requirements which Congress recently reaffirmed and provide clear, workable guidance to implement the NQTL requirements and comparative analysis obligations enacted the CAA.

1. Problematic Part 1: New Application of Substantially All/Predominant Test to Measure NQTLs' Parity

OVERVIEW
Part 1 of the unexpected significantly expanded 3-part test for NQTLs would, for the first time, apply the mathematical rule specifically created in statute for assessing "quantitative treatment limit parity" to NQTLs. Beyond the policy shift that upends the longstanding compliance framework, there is no underlying statutory provision or court decision to dictate such a change. In fact, Congress chose not to incorporate any such rule or test when recently codifying the NQTL comparative analysis requirement and the process oriented "comparably to" "no

more stringent" assessment.[30] Instead, the existing NQTL assessment is the applicable parity test required by the recently enacted CAA, which specifically preserves the process-based test, recognizing that NQTLs are nonquantitative by definition.

Under the Proposed Rules, the Departments have created a new schema whereby any NQTL applied to MH/SUD benefits must be no more restrictive, as written or in operation, than the predominant NQTL that is applied to substantially all the M/S benefits in the same classification. This new application for assessing NQTLs by the substantially all/predominant test would require plans to:

i. Determine the share of plan payments for M/S benefits covered by an NQTL in a class;
ii. Assess whether the NQTL applies to substantially all the M/S benefits in that class;
iii. Determine the predominant variation of the NQTL applied to M/S benefits in that class; and
iv. Assess whether the NQTL, as applied to the MH/SUD benefits in that class, is more restrictive than the predominant variation of the NQTL that is applied to substantially all the M/S benefits.

CONCERNS

The Departments should not proceed with the Proposed Rules dramatic new application of a mathematical test to NQTLs. This mathematical test was created, reaffirmed in statute, and implemented through multiple regulatory materials specifically for measuring **quantitative** treatment limits. We are concerned with the Departments' failure to abide by Congressional intent and the issuance of disparate proposed regulations which ignore the applicable provisions from several reaffirming statutes.

Our concerns also relate to the practical and operational effects this new NQTL test could produce: the prohibition of common medical management techniques which are crucial to advance Americans' health outcomes and curtail waste. Prohibiting such medical management tools would have particularly negative impacts on patients. In addition to restricting the ability of health plans to control costs to the *patient's* benefit, common utilization management approaches ensure patients do not receive harmful care. Medical management tools generally are not applied to restrict *access* to care, rather these tools are used to verify care is medically appropriate and provided under the terms of the plan.

[30] The CAA, which codified the Tri-Agencies NQTL analysis "process-based" test, does not mandate application of this substantially all/predominant test to NQTLs in its requirement for the Tri-Agencies to issue NQTL-related guidance. *See, e.g.,* IRC §§ 9812(a)(6), (7), (8); ERISA §§ 712)(6), (7), (8); PHSA §§ 2726(6), (7), (8).

Lastly, we are concerned this requirement could have unintended and detrimental consequences contrary to the goals of the Departments and plans. To satisfy these significant steps required by the new application of the math test to prove parity in the application of NQTLs while maintaining reasonable medical management on some MH/SUD services, plans may be forced to subject *more* M/S services to NQTLs. This may prove to be necessary for plans to both satisfy the parity standard and ensure their beneficiaries and participants continue to receive appropriate and medically necessary MH/SUD services. Further, plans' struggle to comply with this requirement could even result in coverage becoming more expensive following premium increases, specifically due to the lack of medical management, and the increased costs of the parity analysis.

Recommendations

To avoid these consequences, the Departments should rescind the proposal to apply the substantially all predominant test to NQTLs and instead provide clear and workable guidance for plans to satisfy NQTL compliance as provided for under the CAA.

2. Problematic Part 3: Assessing Outcomes Data & Material Difference Standard

Overview

Part 3 of the unexpected significantly expanded 3-part test for NQTLs would require a plan to collect and evaluate relevant data in a manner reasonably designed to assess the impact of the NQTL on access to MH/SUD disorder benefits relative to M/S benefits. Data collected and the consequence of triggering the material difference standard differ depending on the type of NQTL assessed. Relevant outcomes data for NQTLs generally include the number and percentage of claims denials and any other data relevant to the NQTL. And for NQTLs generally, to the extent that the relevant data show material differences in access to MH/SUD benefits as compared to M/S benefits, the differences will be considered a strong indicator that the plan violates parity in its use of the general NQTL.

However, relevant outcomes data for NQTLs specifically related to network composition standards include but are not limited to in-network and out-of-network utilizations rates, network adequacy metrics and provider reimbursement rates. Further, to the extent that the relevant data for an NQTL related to network composition standards, show a material difference in access to in-network MH/SUD benefits as compared to in-network M/S benefits, this material difference would constitute a per se (non-rebuttable) determination of noncompliance.

Concerns

This is another significant and drastic change with no statutory language dictating its parameters or directing its imposition. In fact, the focus on outcomes data as determinative contradicts repeated acknowledgements over the years that "[d]isparate results alone do not mean that the NQTLs in use do not comply." [31, 32, 33]

The types of outcomes data the Proposed Rules would rely on in assessing parity would not appropriately reflect efforts, actions, and compliance by the plan. There are many different components driving various outcomes data from a plan – patient compliance, provider choice, the accuracy and complexity of a diagnosis, comorbidities, and efficacy of the treatment, not to mention workforce, geographic variations in populations and providers, and unprecedented supply/demand discrepancies during periods of unexpected and unpredicted nationwide crisis.

Further, in imposing this type of data test, the Departments are creating and imposing a completely new network adequacy requirement on self-insured group health plans which is not based in statute and is unprecedented.

Presumption of noncompliance and per se noncompliance are unfairly prejudicial for material differences in data that are not indicative or reflective of a plan's parity. It would be an arbitrary and capricious exercise of the Departments' enforcement powers to require corrective action in the absence of noncompliance. Finally, the Departments' proposal is a one-way ratchet. While material differences may cause a plan or issuer to fail, demonstrating no material differences (however defined) does not demonstrate success. The Departments should not propose standards under which health plans and issuers can only fail.

RECOMMENDATIONS

The Chamber urges the Departments to rescind the requirement to assess outcomes data as well as the proposal to have such data assessed against a material difference standard.

B. NEW "MEANINGFUL BENEFIT" REQUIREMENT

OVERVIEW

Under the Final Rules published in 2013 and guidance since that regulation was finalized, the parity requirement delineated if a plan is **providing a MH/SUD benefit** in a classification, the plan **must provide that MH/SUD benefit in all classifications** that the

[31] Final Rules published in 2013, at 68,245.

[32] Final Rules published in2013, at 68,246. "Again, disparate results alone do not mean that the NQTLs in use fail to comply with these requirements."

[33] Interim Final Rules published in 2010, at 5,416 "The mere fact of disparate results does not mean that the treatment limitations do not comply with parity."

MS benefits are provided. This is parity in providing MH/SUD benefits in the same classification as MS benefits which the statute requires.

The Proposed Rules, if finalized, would create through regulation an entirely new benefit coverage requirement: If plans are covering a MH/SUD condition in a benefit classification, the plan must provide "meaningful benefits" for that condition in all classification as compared to MS benefits. This is a significant revision and is not contemplated or required by the legal provisions of MHP Act, MHPAEA, CURES Act, CAA or any implementing rules or guidance to date.

Current Framework	Proposed Rules' Framework
If providing a MH/SUD benefit in a class, (i.e., nutrition counseling benefit in a hospital in-network class)	If covering a MH/SUD condition in a class (i.e., anorexia in a hospital in-network class)
Must provide that MH/SUD benefit in every class as MS benefits. (i.e., nutrition counseling benefit for out-patient in-network benefit)	Must provide "meaningful benefits" for that condition in every class as MS benefits. (i.e., "meaningful benefits" for anorexia in outpatient in-network class)

CONCERNS

MHPAEA does not include a benefit mandate, and Congress did not mandate coverage for all MH/SUD treatments in all classifications when enacting MHPAEA. Further, repeated regulatory materials reiterated the fact the law does not mandate the coverage of mental health or substance use disorder benefits – meaningful or otherwise.

> The statute does not mandate coverage for either mental health or substance use disorder benefits.[34]
>
> The Departments 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.[35]
>
> These final regulations continue to provide that nothing in these regulations requires a plan or issuer to provide any mental health benefits or substance use disorder benefits. Moreover, the provision of benefits for one or more mental health conditions or substance use disorders does not require the provision of benefits for any other condition or disorder.[36]

[34] Interim Final Rules published in 2010, at 5,420.
[35] Final Rules published in 2013, at 68,246.
[36] Final Rules published in 2013, at 68,251.

> To the extent the State law mandates that an issuer provide some coverage for any mental health condition or substance use disorder, benefits for that condition or disorder must be provided in parity with medical/surgical benefits under MHPAEA.[37]

The Chamber is extremely concerned the new proposed requirement to provide regulatorily injected and to date undefined "meaningful benefits" could be interpreted as to require coverage of every possible recommended treatment for a MH/SUD condition.

Recommendations

The Chamber urges the Departments to revise the Proposed Rules to reflect the various applicable statutory provisions and legal requirements Congress created and enacted, as well as the consistently interpreted regulatory framework implementing parity requirements. The law prohibits the application of financial limitations and treatment limitations imposed on MH/SUD benefits which are offered in a class are applied in parity to MS benefits in that class. It does not contemplate requiring particular benefits when a condition is covered by a plan.

C. New Fiduciary Certification Mandate

Overview

For health plans subject to the Employee Retirement Income Security Act ("ERISA"), the comparative analysis would be required to include a certification by one or more named fiduciaries who have reviewed the analysis, stating whether the fiduciary/fiduciaries found the comparative analysis to be in compliance with the content requirements of these Proposed Rules. The Department assert "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 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 plan.[38]

Concerns

The Chamber is concerned this new requirement will add further unnecessary costs and do little to nothing to strengthen compliance, advance parity, or improve access to benefits. Given the incredible complexity of the comparative analysis, which a third-party administrator (TPA) or service provider will conduct, we are concerned a plan fiduciary is not capable of assessing and certifying the comparative analysis.

Generally, the TPA and/or the owner of the provider network will be charged with, responsible for and relied on to (1) develop plan designs and (2) develop and impose

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[37] Final Rules published in 2013, at 68,252.
[38] Proposed Rules, at 51,593.

NQTLs on both MH/SUD and M/S benefits. As a result, it will be the TPA/service provider for a self-insured plan that conducts and produces the NQTL analyses for the plan. In most cases, the designated plan fiduciary does not have the requisite knowledge and experience to fully understand, dissect the findings, and ultimately conclude whether or not the TPA's/service provider's NQTL analysis for the plan is indeed compliant with the proposed content elements.

Therefore, in order to comply with this proposed certification requirement, the plan's fiduciary would likely need to find, hire and pay an independent expert to review the TPA's/service provider's NQTL analysis which is an inefficient use of resources and assets. Instead, employers and surely the Departments too would prefer for funds to be directed at ways to improve access to MH/SUD benefits rather than unnecessarily adding to the cost of plan administration.

Recommendations

The Chamber urges the Departments to rescind this requirement which will do nothing to advance the goals of parity and instead siphon resources away from investments in coverage.

D. Unilateral Power to Prohibit Plan Operations

Overview

The Departments propose to add language specifying that, if a plan receives a final determination from the relevant Secretary that it is not in compliance with the requirements of Proposed Rules with respect to an NQTL, the NQTL would violate the Proposed Rules and the relevant Secretary may direct the plan or issuer not to impose the NQTL, unless and until the plan demonstrates compliance with the requirements of MHPAEA or takes appropriate action to remedy the violation.

The requirement states a plan may not impose an NQTL in the first place unless it meets all of the applicable substantive requirements for NQTLs under these Proposed Rules. However, this proposed provision grants recourse for the Departments following a final determination of noncompliance with the NQTL comparative analysis documentation requirements.

Concerns

First, it is highly unusual for a Secretary to be given the authority to prohibit a company from using legal medical management tools simply because the comparative analysis document is not sufficient. Congress did not grant the Departments the power to demand immediate cessation of an NQTL without intervention of a court of law. Further, by proposing that any of the Secretaries may order immediate cessation of an NQTL, the Departments have proposed to violate the statutory division of authority that provides the HHS with oversight of issuers, the DOL for self-funded plans, and the IRS for self-funded

plans and church plans. Finally, the Chamber is concerned about the lack of a formal appeals process for plans deemed non-compliant.

RECOMMENDATIONS
The Chamber recommends that the Department adopt an appeals process modeled on the process for appeals of civil monetary penalties for Medicare Advantage Organizations. Plans and issuers should have recourse to explain or defend their own analysis; especially when there will be such ambiguity created by this proposed rule.

E. PROBLEMATIC APPLICABILITY DATE

OVERVIEW
"[T]his section applies to group health plans and health insurance issuers offering group health insurance coverage on the first day of the first plan year beginning on or after January 1, 2025."[39]

CONCERNS
Given the time required to review and respond to comments submitted on this Proposed Rules, it is likely that the Departments will publish the Final Rule in 2024. A 1/1/2025 application date does not permit plans sufficient time to update their systems to comply with the major expansions of MHPAEA and CAA requirements included in the Proposed Rules.

RECOMMENDATIONS
The Chamber recommends the Departments extend the applicability date for all plans to 1/1/2026. Further, given the magnitude of the changes proposed by the Departments and the extensive amount of new documentation and analyses the proposals would require, at a minimum, we urge the Departments to announce a one year good faith enforcement safe harbor following a 1/1/2026 applicability date during which the Departments will work with, and not penalize, stakeholders acting in good faith to redesign benefits, reprogram systems, reanalyze outcomes to comply with the new requirements. Full application of the changes should be effective for plans that begin on or after 1/1/2027.

V. CONCLUSION

Our concerns relate to provisions that are wholly unrelated to implementing the NQTL standards and processes as codified by the CAA. The CAA amended MHPAEA to create specific new documentation standards for NQTLs. In adopting these provisions, Congress codified the NQTL standards and the process for demonstrating NQTL parity compliance from MHPAEA's Final Rules. The CAA does not include the application of substantially all/predominant test to NQTLs, the new outcomes data assessment requirement and the meaningful benefits mandate, or the fiduciary certification. Clear guidance implementing

[39] Proposed Rules, at 51,633.

the existing NQTL rules will allow plans and issuers to more readily demonstrate compliance. However, the Proposed Rules include many new requirements that are not provided for in statute and constitute a dramatic change. The Chamber requests all new requirements unrelated to CAA implementation be rescinded and urges the Departments to remain focused on improving compliance with the NQTL requirement codified in the CAA.

Sincerely,

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U.S. Chamber of Commerce