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Advancing Health in America

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Lisa M. Gomez
Assistant Secretary for Employee Benefits
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW, Room N-5653
Washington, DC 20210

Attention: 1210-AC11

Dear Assistant Secretary Gomez:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide comment on the proposed rule regarding Requirements Related to the Mental Health Parity and Addiction Equity Act (MHPAEA) issued by the Department of the Treasury, Department of Labor, and the Department of Health and Human Services ("the departments").

The AHA applauds the Administration for proposing these clear and specific provisions to improve oversight and enforcement of MHPAEA. While the law has stood in place since 2008, its enforcement has been challenged by the difficulty in defining and identifying instances of noncompliance in coverage of mental health and substance use disorder (SUD) services as well as the efforts of some health plan issuers to avoid covering this vital and lifesaving care. We appreciate the efforts of the joint departments over the past few years to establish distinct guidelines for what health plan issuers may and may not do in terms of designing and administering benefits and believe that the provisions proposed in this rule will further close coverage loopholes and help ensure that patients can access the care they need.

We agree with the departments that the next wave of enforcement of MHPAEA must focus on network adequacy, which is the inclusion of sufficient numbers and types of behavioral health providers to meet the needs of beneficiaries enrolled in the plan in a reasonable amount of time. While many health plan issuers construct narrow networks

of clinicians to negotiate lower prices, there is also a significant shortage of behavioral health clinicians in the nation. As of March 31, 2023, the Health Resources and Services Administration (HRSA) designated more than 6,635 health professional shortage areas for mental health, with more than one-third of Americans living in these areas.[1] Although HRSA projects shortages of health professionals in other disciplines as well, those of behavioral health are especially dire — likely due to high turnover rates placing enormous demands on the workforce. Research indicates that the behavioral health workforce in particular experiences high levels of work-related stress and full caseloads coupled with low payments relative to comparable professionals.[2] No doubt these insufficient reimbursements are in part driven by unfavorable contracting strategies that offer unfairly low rates and routine payment denials by some plans. The provisions proposed in this rule are likely to help address some of the underlying causes of behavioral health professional shortages, but **we also urge the Administration to work with Congress to invest in the behavioral health workforce in tandem with provisions related to network adequacy in this rule.**

Design and Application of Non-quantitative Treatment Limitations (NQTLs)

Insurance issuers continue to flout the requirements of MHPAEA by pointing to the difficulty of identifying uneven application of NQTLs between behavioral health and medical/surgical benefits. These barriers to coverage are not obvious instances of non-compliance; for example, a plan would clearly violate the parity law if it offered behavioral health services but only covered them at 50% cost-sharing as a policy while covering other medical and surgical benefits at 80% cost-sharing. NQTLs, on the other hand, involve restraints on coverage based on qualitative characteristics of the services — like requiring demonstrable improvement in the treated diagnosis as a condition of continued coverage, which is more difficult to discern for many behavioral health disorders than for physical ailments — or administrative barriers that are more stringent or applied more frequently to behavioral health services — like requiring blanket precertification of all outpatient behavioral health services but for only select medical or surgical procedures.

Historically, these parameters have been challenging to identify without comprehensive plan information (that is, a direct comparison between how a behavioral health service is covered and how a comparable medical/surgical service is covered). Providers and patients are often unaware that behavioral health benefits are held to different qualitative standards than those for medical and surgical services because these NQTLs are not enumerated in benefits information.

To shine a light on these practices, the Consolidated Appropriations Act of 2021 amended MHPAEA to require plans and issuers to provide comparative analyses of

[1] Health Resources and Services Administration, Health Workforce Shortage Areas, https://data.hrsa.gov/topics/health-workforce/shortage-areas
[2] Kelly, R.J., Hearld, L.R. Burnout and Leadership Style in Behavioral Health Care: a Literature Review. J Behav Health Serv Res 47, 581–600 (2020). https://doi.org/10.1007/s11414-019-09679-z

their NQTLs upon request. In its 2022 report to Congress on the first year of enforcement of this provision, the joint departments found that not a single plan provided sufficient information in their comparative analyses. In its 2023 report to Congress released contemporaneously with this proposed rule, the departments found that many comparative analyses remained deficient, even after multiple insufficiency letters; they also issued numerous initial and final determinations of non-compliance with MHPAEA.

Plans and issuers have had ample time to build the internal structures necessary to analyze their benefits to ensure compliance with MHPAEA. While plans once were able to claim the definition of compliance with NQTLs was too nebulous to understand or apply to their benefit designs, the provisions regarding precisely what must be included in a comparative analysis as proposed in this rule will provide clarity about the appropriate application of these coverage limits.

One criterion to determine compliance with MHPAEA is that the NQTL is no more restrictive when it is applied to mental health and SUD benefits than it is when applied to medical/surgical benefits. The proposed rule provides an explanation of how to determine compliance with these requirements; in essence, plans and issuers would be required to follow similar steps to those used when analyzing parity with respect to quantitative (or financial) treatment limitations. **We support this approach and appreciate the clear example provided in the rule that demonstrates each of the steps in the analysis.**

Another criterion of determining compliance with the law is that the plan or issuer must satisfy a requirement related to how the NQTL is designed and used. As proposed, this would include a prohibition on plans relying upon any factor or evidentiary standard that discriminates against mental health or SUD benefits as compared to medical/surgical benefits. Specifically, the departments cite the example of plans using their own historical data from a time when the coverage was not subject to the parity law; that is, a plan would not be permitted to calculate reimbursement rates for behavioral health services based on spending on those services in 2007, before MHPAEA was passed. **We support this proposal and value the departments' acknowledgment that many plans have relied upon factors that are discriminatory against behavioral health benefits and have benefited from historical inequities in rate structures that MHPAEA sought to prohibit.**

Network Composition

Parity does not only entail covering behavioral health services in the same way as medical and surgical benefits financially; plans also must ensure parity in terms of available services to ensure that consumers have access to needed care without unreasonable delay. This means that plans are obligated to deliver the benefits promised by providing access to enough in-network providers and services included under the terms of the contract. Plans and issuers have been able to meet network adequacy requirements on paper while failing to provide their beneficiaries meaningful

access to care. For example, plans may establish standards for provider and facility admission to participate in a network or to continue to participate in a network that result in unfavorable reimbursement rates; in addition, they may use restrictive credentialing procedures that result in an inadequate number of certain categories of providers and facilities to provide services under the plan.

One pervasive method employed by some plans involves the growing disparity between in-network reimbursement rates for mental health and SUD providers and those for medical/surgical providers, as well as a significant disparity between how often beneficiaries are forced to utilize out-of-network mental health and SUD providers and facilities as compared to medical/surgical providers and facilities. Therefore, the departments propose that a plan would be considered noncompliant if relevant outcomes data (such as beneficiary utilization) shows material differences in access to in-network mental health or SUD benefits as compared to in-network medical/surgical benefits in a classification as a result of the design or application of one or more NQTLs related to network composition standards. In other words, the rule proposes to treat network composition as an NQTL for the purposes of the regulation as opposed to merely an *outcome* of other NQTLs. **We support this approach and have encouraged Congress and the Administration in the past to use quantitative information on beneficiary utilization to determine appropriate network composition standards.**

We acknowledge that developing a robust, highly specialized network of providers is a daunting task considering the severe shortages of behavioral health providers across the country; however, these shortages and gaps in coverage will persist without further action. Further, in the rule, the departments note that if despite taking appropriate action the relevant data continues to reveal material differences in access — that is, the plan is unable to improve network composition because of provider shortages, as opposed to plan business or operational decisions — then the plans would not be cited for noncompliance as long as they are able to document the actions they have taken to attempt to address the differences in access. **We agree with this approach and appreciate that the departments will allow for good-faith efforts to meet network adequacy standards in the face of ongoing provider shortages.**

Impact Analyses

The departments propose that a plan or issuer would be required to collect, evaluate and consider the impact of relevant data on access to mental health and SUD benefits relative to access to medical/surgical benefits and subsequently take reasonable action as necessary to address any material differences in access. **The AHA supports this proposal;** it aligns with the November 2021 report from the Office of the Assistant Secretary for Planning and Evaluation (ASPE)'s Office of Behavioral Health, Disability and Aging Policy, which suggested using data on enrollee characteristics — such as information gleaned from claims on utilization and diagnostic patterns as well as qualitative information similar to that found on hospital community health needs assessments — to determine, generally, how, when, where and with whom enrollees

seek care. In the rule, the departments cite examples of relevant data including data related to NQTLs as required by state law or private accreditation standards as sources of information to determine access to care.

We suggest that, in addition to retrospectively evaluating whether aspects of care episodes were covered, this process could also identify general gaps in access to inform more adequate network and benefit design. For example, the aforementioned ASPE report suggested a comparison of utilization of covered behavioral health services with emergency department visits for behavioral health crises, use of crisis services and jail volumes as indicators of insufficient access to routine behavioral health care.

In addition to collecting and analyzing relevant data related to access and network composition (including in- and out-of-network utilization rates, time and distance to available appointments, and provider reimbursement rates), the departments also propose to require plans to document any action that has been or is being taken by the plan to mitigate any material differences in access to services between mental health/SUD and medical/surgical care. The disparity in access would only be considered a "strong indicator" that the plan or issuer is violating the law and would not alone result in a finding of noncompliance. **We believe that this is a reasonable approach to identifying likely instances of noncompliance while allowing for instances where disparities in access are due to factors beyond the plan or issuer's control, such as workforce shortages.**

The departments solicit comments on other relevant data points that could be used in an impact analysis to determine material differences in access to care, such as the number and percentage of relevant claims denials. We encourage the departments to also consider the following relevant data:

- Variation in authorization request submission processes (including means — verbal, electronic, fax — as well as criteria, necessary documentation and involvement of third-party vendors);
- Application of prior authorization for services for which the clinical standards of care are well established;
- Variation in and plan modification of clinical guidelines used to determine medical necessity;
- Unreasonable requests for documentation;
- Turnaround time for approval of a request for prior authorization of a behavioral health service compared to a medical/surgical service including those submitted for expedited review;
- Time to appeal response and resolution for denied claims for behavioral health services compared to medical/surgical services;
- Variation in the appeal overturn rate between behavioral health denials and medical/surgical denials;

- Inappropriate delays in decisions, such as returning requests multiple times claiming insufficient information or not responding outside of traditional office hours; and
- Volume and nature of patient grievances against plans related to behavioral health services.

For too long, benefit management techniques have created dangerous delays in care delivery; due to the nature of behavioral health care — that is, it is more time-based with less clear or quantitative ways to improve efficiency or definitively measure outcomes — these processes take a disproportionate toll on these services. We look forward to working with the Administration to help identify practices that restrict access to mental health and SUD care and continue improving access to these services as Congress intended under MHPAEA.

Parity Opt-out for Self-funded Non-federal Governmental Plans

Under the Health Insurance Portability and Accountability Act of 1996, sponsors of self-funded, non-federal governmental health plans may elect to exempt those plans from parity in the application of certain limits to mental health and SUD benefits (including requirements of MHPAEA). However, the Consolidated Appropriations Act of 2023 eliminated this opt-out. In this proposed rule, the Department of Health and Human Services proposes to amend regulations to implement this change as of the date of enactment of the Consolidated Appropriations Act. **The AHA supports this proposal and the efforts to continue to close loopholes that have impeded progress towards broader compliance with MHPAEA.**

Again, we thank you for your consideration of our comments. Please contact me if you have questions, or feel free to have a member of your team contact Caitlin Gillooley, AHA's director of policy, at cgillooley@aha.org or (202) 626-2267.

Sincerely,

/s/

Stacey Hughes
Executive Vice President