From: Mariah Becker
To: EBSA MHPAEA Request for Comments
Subject: NCCMP Comments on MHPAEA Technical Release
Date: Tuesday, October 17, 2023 1:45:19 PM
Attachments: NCCMP Comments on MHPAEA Technical Release - Final.pdf

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Attached please find NCCMP's comments on the MHPAEA Technical Release. We look forward to further discussion on this topic.

Best regards,
Mariah

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NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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October 17, 2023

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

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

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

Submitted Electronically via: mhpaea.rfc.ebsa@dol.gov

RE: Technical Release 2023-01P Request for Comment on Proposed Relevant Data Requirements for Nonquantitative Treatment Limitations (NQTLs) Related to Network Composition

Dear Secretary Becerra, Secretary Yellen, and Acting Secretary Su:

The National Coordinating Committee for Multiemployer Plans ("NCCMP") appreciates the opportunity to submit these comments in response to the above-referenced Technical Release issued by the Department of Labor (DOL), on behalf of DOL, and the Departments of Health and Human Services (HHS) and the Treasury (collectively the "Departments") in connection with and referred to in the Department's Proposed Rule published in the Federal Register on August 3, 2023 (88 FR 51552).

Mental health (MH) and substance use disorder (SUD) benefits are critically important to multiemployer plan participants and their families. The NCCMP has provided a detailed comment letter regarding the MHPAEA Proposed Rules that were published contemporaneously with the Technical Release. A copy is attached. Among other things, the comment letter provides background on the NCCMP and underscores multiemployer plans' commitment to providing MH/SUD benefits as part of the robust, comprehensive benefit packages. However, the letter addresses concerns related to the requirements regarding network composition under the Proposed Rule.

The Proposed Rule would modify the 2013 regulations to identify and group a category of network composition NQTLs, which include:

- standards for provider and facility admission to participate in a network or for continued network participation; methods for determining reimbursement rates;
- credentialing standards; and
- procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan or coverage.

The NCCMP does not believe that network composition NQTLs should be addressed within the context of MHPAEA, because network composition and adequacy are the subject of U.S. market structure issues that neither plans nor insurers can control.

Health plans in today's market are not creating proprietary networks. Health plans have no control over the network provider and facility participation and are merely consumers of the available services. Network design is generally not directed by plans and is not used by plans as a method for limiting the scope or duration of MH/SUD care. The network composition approach under the MHPAEA Proposed Rule is using the plan sponsors as an intermediary for indirect regulation of third-party administrative activities.

While the NCCMP believes network access is an important issue, it is one that should be addressed through other legislative avenues, with separate rulemaking subject to notice and comment.

While our primary position is that Proposed Rules regarding network composition should not be finalized, to the extent the Departments nonetheless proceed, we have concerns with the data outcomes being proposed with respect to network composition. We firmly believe that out-of-network MH/SUD utilization cannot be a de facto indicator of an inadequate network. In terms of provider reimbursement, we believe higher payment metrics alone are not expected to drive adequate network participation. In terms of providers actively submitting claims, we believe realistic standards, such as a standard based on available and contracted network providers, would require development. While the safe harbor rules for network composition are appreciated by plans, it seems unlikely that plans could realistically rely upon them.

This letter is intended to supplement the detailed comment letter we have provided regarding the Proposed Rule, including regarding Network Composition standards. While we briefly reiterate our concerns in this letter, the time frame for submitting comments on the Technical Release, including the very limited extension provided, is inadequate for a full review and analysis of the details. We will work to further review the Technical Release and coordinate with third-party administrators regarding the Departments questions under the Technical Release in order to provide any additional information or feedback to any extent possible.

We appreciate the opportunity to provide input on the Technical Release and thank you for considering these comments. If you have any questions or would like to discuss these comments further, please contact Mariah Becker (202.756.4637 or mbecker@NCCMP.org).

Regards,

Michael D. Scott
Executive Director

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Submitted Electronically via: www.regulations.gov

RE: Requirements Related to the Mental Health Parity and Addiction Equity Act: Proposed Rule [CMS-9902-P]

Dear Acting Secretary Su, Secretary Becerra, and Secretary Yellen:

The National Coordinating Committee for Multiemployer Plans ("NCCMP") appreciates the opportunity to submit these comments in response to the above-referenced Proposed Rule issued by the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (collectively the "Departments") and published in the Federal Register on August 3, 2023 (88 FR 51552). We have overarching concerns with certain aspects of the Proposed Rule, as well as detailed comments.

Mental health (MH) and substance use disorder (SUD) benefits are critically important to multiemployer plan participants and their families, and the need to provide coverage for such benefits is similarly important to multiemployer plans and to the unions and employers that jointly sponsor them. Over the past decade, multiemployer plans have continued to offer and even expanded access to MH/SUD benefits as part of the robust, comprehensive benefit packages offered by these plans. The average actuarial value of multiemployer plans is 90 percent, therefore at or greater than the Platinum range of benefits offered in the Federal Marketplace. NCCMP and the multiemployer community remain strongly committed to providing much needed MH and SUD benefits. However, we are gravely concerned that this Proposed Rule would in fact harm our

participants' access to MH and SUD benefits, as plans find it impossible to satisfy the onerous and extreme requirements the Departments are introducing.

Overarching Concerns

1) In reviewing the Proposed Rule, it seems that the Departments misunderstand the voluntary nature of MH/SUD benefits and the potential implications of imposing massive, new compliance and administrative costs on the continued offering of these benefits, as well as the implications of increasing trustee liability without providing clear, attainable standards for compliance.

   Multiemployer plans are committed to ensuring that participants and their families have access to MH/SUD benefits. It would be remiss not to mention the extensive work that has been done by multiemployer plans to continue to find additional and innovative ways to get MH/SUD benefits to working Americans. Multiemployer plans have been seriously impacted by the national mental health crisis and particularly by the opioid epidemic. The severity of these issues and the importance of these benefits is something multiemployer plan sponsors take seriously and are willing to direct resources towards. In fact, many plans in the multiemployer community provide benefits to workers within the construction industry, who are at a disproportionate risk for death by suicide or drug overdose. This heightens the value of MH/SUD benefits as well as the risk if such benefits were eliminated. Plans want to continue offering MH/SUD benefits, but they seek a clear and efficient path to doing so without running the risk of noncompliance with applicable law.

   The interests of the Departments and plans are aligned to the extent that both share a goal of providing quality, clinically appropriate MH/SUD benefits to individuals who need those benefits. Parity may no longer be the proper construct for advancing this interest and may in fact disrupt tools, such as clinically based utilization management practices, which help consumers access optimal care. In a recent blog issued by the Department of Labor, Assistant Secretary Gomez notes that 15 years since the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA), work remains. This seems to further emphasize that a new approach may be needed. Plan sponsors agree that access to treatment for anxiety, depression, and post-traumatic stress disorders, as well as for other conditions such as eating and substance use disorders, should be available, much like benefits for heart disease, cancer, and diabetes. However, the comparative nature of the parity rules does not seem to work in the nonquantitative treatment limitation (NQTL) context. Much like we do not compare medical conditions to one another, comparing medical benefits to MH/SUD benefits does not seem to advance the intended goal. As discussed later in this letter, a uniform minimum suite of MH/SUD benefits, including the related operational requirements for those benefits, may be called for as a safe harbor to the confusing regulatory framework that has been laid out and as a meaningful way to advance the true intention of the law.

In addition, it is important that regulations reasonably align with the real-world health coverage market and administrative realities, so that plans can continue to provide meaningful MH/SUD benefits while operating within that relevant context. As proposed, the regulations will have an opposite effect of the Departments' intent to improve access to MH/SUD benefits. Plans will be forced to consider no longer providing these voluntary benefits due to the overwhelming administrative burden and cost, lack of clarity and significantly increased liabilities—especially with regard to the Named Fiduciary certification requirement.

2) The cost estimate in the Proposed Rule is shockingly low given the scope and requirements of the Proposed Rule; a cost estimate that is at odds with the new administrative requirements that are being proposed and the resources required to address these burdens. This added burden is daunting to multiemployer plans that operate from a finite set of resources, held in trust and required to be administered in the best interest of plan participants. In the multiemployer plan context, skyrocketing administrative and compliance costs will, if these voluntary benefits are continued to be provided at all, ultimately be paid for by reducing benefits, or by increasing participant contributions, which lowers the take-home pay of hard-working Americans. Lack of clear rules decreases compliance efficiency and increases potential noncompliance and litigation costs. Plans need workable, comprehensive rules and tools in order to be able to keep costs reasonable, so as to be able to provide these critical benefits.

3) The Proposed Rule seems to lack understanding of the tremendous amount of data and administrative analysis that is not held by plans, but rather is held and administered for them by outside entities with expertise in plan benefit administration, including insurers, third-party administrators, utilization review administrators, and network and claims administrators. The Proposed Rule places plans in the difficult position of being accountable for data the plan does not have and reliant upon third-party administrators for its production.

4) The NCCMP appreciates that network adequacy is a significant problem in the United States in terms of the provision of MH and SUD benefits, however, it does not appear to be an issue that can be appropriately addressed under MHPAEA, a rule that regulates NQTLs, not U.S. health care networks or the education and employment of mental health and substance use disorder professionals.

5) Along with an extensive group of stakeholders impacted by the regulations, the NCCMP respectfully submitted a request for the extension of the comment period beyond October 2, 2023. As you are aware, the Proposed Rule extends beyond addressing the statutory amendments to MHPAEA enacted through the Consolidated Appropriations Act, 2021 (CAA) and re-visits long-standing regulatory guidance under the MHPAEA 2013 final regulations. While we appreciate the modestly extended comment period, under the constraints of the October 17, 2023 deadline, we have focused efforts on initial commentary related to the proposed regulations. We also include some limited commentary related to the Technical

Release 2023-01P.[1] However, we welcome and in fact encourage the opportunity to provide additional feedback to the Departments with respect to the Technical Release and 2023 Comparative Analysis Report to Congress. We will gladly work with the Departments and with a full range of stakeholders impacted by these proposed rules, in order to find a workable and efficient path forward.

With the overarching concerns we have described at the forefront, we are providing, as follows, further comments with respect to our concerns related to timing, infrastructure/resources, and cost implications. We are also providing comments with respect to specific provisions of the Proposed Rule including concerns related to a named fiduciary certification, the expanded definition/list of NQTLs, the expanded NQTL three-part test (including the proposed application of the "substantially-all/predominant" test to NQTLs), the lack of clarity regarding proposed exceptions, the proposed data collection requirements (including concerns related to network composition NQTLs), the meaningful benefits rule and the expanded content and timing requirements related to documented comparative analysis.

Background on NCCMP and Multiemployer Plans

The NCCMP is the only national organization devoted exclusively to protecting the interests of multiemployer plans, as well as the unions and the job-creating employers of America that jointly sponsor them, and the more than 20 million active and retired American workers and their families who rely on multiemployer retirement and health and welfare plans. As such, the NCCMP is uniquely positioned to advocate on behalf of multiemployer plans, sponsoring employers and unions, participants and beneficiaries, and plan professionals to strengthen and preserve the multiemployer benefits system.

The NCCMP is a non-partisan, nonprofit, tax-exempt social welfare organization established under Internal Revenue Code ("IRC") Section 501(c)(4), with members, plans and contributing employers in every major segment of the multiemployer universe. These industries include the airline, agriculture, building and construction, bakery and confectionery, entertainment, health care, hospitality, longshore, manufacturing, mining, office employee, retail food, service, steel, and trucking/transportation industries.

Multiemployer health and welfare trust funds are administered by boards of trustees comprised of an equal number of union and management trustees as required under Section 302(c)(5) of the Taft-Hartley Act. The funds are designed to hold contributions negotiated through the collective bargaining process as part of a wage-benefits package and made by employers on behalf of employees for covered employment performed under a collective bargaining agreement. This is the only purpose of the trust – they are non-profit entities designed solely to provide health and

[1] https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/23-01

welfare benefits to workers and their families. The board of trustees is the plan sponsor under ERISA and is typically the named fiduciary in the trust funds' governing trust agreements.

Employers contribute to multiemployer funds based on work performed by collectively bargained employees in covered employment. Contributing employers do not directly provide health coverage; that coverage is provided through the multiemployer fund. Most employers that contribute to multiemployer plans are small employers. Fundamentally, multiemployer funds may only use their resources for the benefit of the participants and to improve care while seeking to defray administrative costs.

Detailed Comments

I. Timing, Infrastructure, and Costs

Timing—The applicability date should be re-visited and, to any extent the proposed requirements are finalized, a reasonable, informed applicability date should be provided.

The Departments are suggesting that if finalized, the proposed requirements would be applicable for plan years beginning on or after January 1, 2025. As discussed in further detail throughout this comment letter, fundamental questions about the workability of core aspects of the Proposed Rule exist; fundamental technical questions would require clarification before any implementation could begin, and once clarified, significant administrative infrastructure and staffing resources will need to be built to help meet the proposed compliance obligations. The applicability date will need to be extended to allow for compliance implementation. Because a significant portion of the initial implementation burden will be borne by insurers, third-party administrators and their consulting and resource affiliates, we encourage the Departments to engage these entities regarding realistic implementation timing implications if the compliance framework is finalized comparably to how it has been proposed. If finalized as proposed, it would seem that, at a minimum, a two-year implementation period would be necessary, followed by an enforcement grace period while implementation questions are resolved. Unless and until the Departments provide a clear, uniform approach for what constitutes a "compliant" NQTL comparative analysis, administrators are unlikely to consistently cooperate with plans in a satisfactory manner. If most administrators in the market are taking the position that they are unable to meet the Departments standards, this signals fundamental problems and the unrealistic nature of the Department's current approach.

As discussed below, the network composition rules raise severely problematic issues. We suggest that these rules be removed from the MHPAEA NQTL framework. If they are not removed, we believe that additional stakeholder input and coordination with the Departments is necessary and that this section of the Proposed Rule should be handled separately and subject to a subsequent, later applicability date.

Infrastructure*—*The administrative aspects of compliance with the Proposed Rule, if finalized, will be a massive, expensive undertaking. If finalized, the rule must reflect an understanding of and allow time for resources and administrative systems to be adapted.

In terms of the resources, staffing, and administrative tools needed to meet the requirements the of the Proposed Rule, we continue to hear resounding concern from multiemployer plan sponsors that plans do not have the resources or available personnel to perform the required duties in-house, and must rely on qualified third-parties. In the Proposed Rule, the Departments ask, "Do self-insured plans maintain systems capable (i.e., for performing the two-thirds test)?" They do not. This Proposed Rule overlooks the different roles and levels of control that are a part of today's benefits market. The information and data requested by the Departments is predominantly outside of the control of plan sponsors.

Specific issues related to the technical aspects of the "substantially-all/predominant" testing and data collection are discussed later in this comment letter. However, we note here that if finalized as proposed, the rule poses a number of problems regarding access to information. The information that is being required for both the testing and the mandatory data collection elements is generally housed within a plan's third-party administrators' systems. Further. the plan's administrative practice may comprise multiple third-party service providers. Required information may be in different systems within and across different third-party administrators, and in some instances is not likely in any system designed to issue reports. In some instances, information may not be available to the plan at all or will only be available with complete dependence on the plan's third-party administrators. In addition, in-house plan administrative resources are not available to support these efforts. The requirements the Departments propose will require hiring additional internal staff and/or further outsourcing to other organizations who can support these efforts. The Proposed Rule, if finalized, would demand very expensive system changes across the industry to allow for information sharing among plans and a range of plan third-party administrators. Systems are not set up to generate all of the necessary information quickly and on a client-specific basis. Third-party administrators presently struggle to provide plan-specific information and data, citing limited internal resources and bandwidth.

Cost*—*The cost estimates in the Proposed Rule are extremely underestimated. The Departments should seek detailed stakeholder input regarding the infrastructure changes required by this proposed rule to help better assess economic impact, as well as to inform a rulemaking that can propose more efficient compliance methods and therefore, more responsibly implicate the use of limited plan resources.

The cost estimates are severely underestimated. As noted, the Proposed Rule requires new data collection, extensive reporting, and information sharing across systems and organizations that are currently not designed for this. We wonder whether the Departments have given any consideration to how they might assist in reducing costs by contributing to front-end support of the

implementation. For instance, training and tools will be needed across the industry to stand up the compliance framework that the Departments seem to envision.

II. Evaluation and Certification by a Named Fiduciary—A rule that does not recognize the ability of a plan to rely on its outside administrative experts in any meaningful way and a framework requiring plan certification of compliance for items out of the plan's control is unworkable and not consistent with ERISA's framework. The liability being imposed on trustees, who are largely unpaid, is without precedent and is one which is potentially uninsurable in the market.

The Proposed Rule contemplates that a Named Fiduciary will collect and evaluate the required data and comparative analysis and will certify that the plan complies with MHPAEA. Before we discuss the other issues addressed throughout this letter, we wanted to flag this evaluation and certification requirement as one that underpins all of the requirements and presents fundamental problems for plans.

As you review our comment letter you will see repeated discussion about plans' reliance on third-party administrators to generate claims information, other data, and operational descriptions, often across many business enterprises. These outside experts have been hired by the plan to manage plan functions that the plan does not have in-house expertise or resources to address. The idea that the same plan would then be asked to evaluate the very information they hired an outside expert to manage and develop seems to contravene logic. Further, this is an unprecedented requirement that has never been imposed on a health plan. In fact, the Proposed Rule seems to be fundamentally changing fiduciary duties. The requirement that the named fiduciary certify legal compliance is outside their area of expertise. Plans rely on counsel to opine on the plans' compliance with legal requirements, however, legal counsel also lacks the expertise to assess the MHPAEA clinical and operational information generated by plan administrators.

Clarity is needed regarding how a plan sponsor can fairly meet its duty to monitor compliance without having to wholly re-evaluate the work of outside experts. As proposed, this rule seems to conflict with the ERISA premise that plans should hire outside experts when they lack specific expertise and seems to underscore a plan's liability risk where they now have an inability to rely on hired experts in a meaningful way.

Further, a framework requiring named fiduciaries to certify compliance for items entirely or substantially out of the plan's control seems unworkable. Here plans are seeking relief. Can the Departments provide a process whereby plans can safely rely on insurers and third-party administrators for parity compliance without re-evaluating their decisions? Can certain organizations be approved or accredited so that plans can rely on use of such organizations for compliance? Can alternative avenues to compliance be provided, such as a minimum MH/SUD

benefit that can serve as a safe harbor and an alternative to compliance with MHPAEA's additional requirements entirely?

This named fiduciary certification raises practical questions as well. For instance, to whom does "named fiduciary" specifically refer? Who may appropriately sign on behalf of the plan? How do plans account for changes in staff? Would this be an annual or bi-annual activity given anticipated updates from administrators on a recurring basis?

In addition, fiduciaries rely on insurers to provide insurance against liability for actions taken in their official capacity. At a minimum, the penalties that may arise under Code Section 4980D and ERISA Section 104(b) for not providing documents in a timely fashion to participants, and liability that may arise against plan trustees for non-compliance related to the NQTLs under ERISA Section 404(a)(1)(D) are deeply concerning to the trustees as well as to fiduciary liability insurers. Today, it is unclear as to the full intent of the rule and how frequently and how severely the Department or participants will apply the above penalties or bring claims for breaches of fiduciary duty against trustees. However, if there is a frequency or severity of claims brought against multiemployer plans related to this rule, insurance carriers may be forced to exclude coverage for these fines and penalties, reduce coverage or not write fiduciary insurance for benefit plans at all. The fiduciary insurance market has already seen increased severity with excessive fee litigation and has taken this very approach over the past few years. This should be of enormous concern to the Departments, as fiduciary liability insurance is central to the ability of plans to operate.

III. Definition of NQTLs—Health plans in today's market are not creating proprietary networks and do not control the network and therefore, network adequacy. Network composition NQTLs should not be addressed within the context of MHPAEA, because network composition and adequacy are the subject of U.S. market structure issues that neither plans nor insurers can control.

Generally

Plans need a clear and certain path to compliance. The Proposed Rule includes an expanded and detailed non-exhaustive list of NQTLs, as compared to the list under the 2013 regulations. The Departments underscore that plans are not only responsible for meeting compliance with respect to these NQTLs, but also with respect to any other unlisted NQTL the plan might apply. While we appreciate the Departments' interest in supporting MH/SUD benefits, one has to wonder whether analyzing all of the listed NQTLs in the manner the Departments propose is either meaningful or efficient. Further, the open-ended nature of the list again leaves plans navigating an uncertain and volatile compliance landscape which also raises further questions about the required certification by the named fiduciary discussed in the previous section. All of this will result in a massive increase in expense and legal liability and will certainly increase litigation.

Given the overall burden and complexity of the requirements imposed by the Proposed Rule, a question we are hearing often is whether the Departments can provide a uniform set of MH/SUD benefits and administrative terms that if followed by plans can serve as a safe harbor?

Network Composition NQTLs

Of note, under the Proposed Rule the 2013 regulations are modified to identify and group a category of network composition NQTLs, which include: standards for provider and facility admission to participate in a network or for continued network participation; methods for determining reimbursement rates; credentialing standards; and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan. Network composition NQTLs should not be addressed within the context of MHPAEA, as network composition and adequacy are the subject of U.S. market structure issues that neither plans nor insurers can control.

Network adequacy for providing MH/SUD benefits is a significant U.S. problem. The problem starts with too few providers overall, which is a higher education, cost and reward problem for the nation to solve. It is compounded by the fact that many mental health clinicians are cash pay practices and that psychiatrists are almost twice as likely to be solo practitioners than other types of physicians, thus lacking the support of a larger medical group.

Health plans in today's market are not creating proprietary networks. Health Plans have no control over the network and therefore network adequacy NQTLs should be removed - especially considering the liability from non-compliance and the Named Fiduciary having to certify compliance. Insurers and third-party administrators are better positioned to address network access concerns. These issues should be addressed through other legislative avenues, with separate rulemaking subject to notice and comment.

IV. Comments Relating to the Three-Part Test for Imposing NQTLs on MH/SUD Services—Network composition should not be addressed as an NQTL and cannot be appropriately addressed under MHPAEA. The data components and possibility of de facto findings of noncompliance based on data raise significant concerns and are unworkable, particularly given that plans cannot be liable for network limitations they do not control

The burden related to NQTL compliance under the Proposed Rule has more than tripled. In addition to the expanded documentation requirements, which were anticipated in light of the CAA amendments to MHPAEA, the changes and additions to the 2013 final rules for NQTL compliance seem beyond the scope of anything that was intended by Congress when it codified the then existing 2013 final regulatory standards. Nonetheless, if the proposed three-part test provided clear standards and certainty for MHPAEA compliance, it may be embraced by plans and third-party administrators who are only seeking reasonable and clear standards consistent with the statutory

requirements for compliance. Unfortunately, the Proposed Rule presents more new questions and challenges, and remedies little.

Data Collection and Evaluation Generally (including material differences)

Under the Proposed Rule the Departments would require plan sponsors to collect certain prescribed data for the purpose of determining the impact of an NQTL on access to MH/SUD benefits relative to access to medical/surgical (M/S) benefits. The Departments generally indicate that material differences in data will be a strong indicator of noncompliance. However, with respect to network access data, material differences will mean a violation of MHPAEA. As already discussed throughout this letter, there are concerns regarding the administrative burden and timely access to reliable data. We have a series of additional concerns related to the proposed data requirements as outlined below.

With respect to NQTL data generally, there are legitimate reasons for NQTL metrics to vary that would not be a demonstration of disparity in design or administration of plan policy. These include items like market dynamics, low credibility of mental health data, and physical treatment services that are not analogous to the mental health services within the same benefit classifications.

With respect to material differences, neither parameters for assessing data nor a definition of "material" for purposes of data evaluation are provided under the Proposed Rule. The proposed data collection also includes *any other data relevant to the nonquantitative treatment limitation required by state law or private accreditation standards*. It is unclear how the Departments intend for this to be applied and what the expectations are related to this requirement for plans and particularly for multiemployer plans. These are further examples of the clarity absent from this Proposed Rule but needed by plans.

Network Composition Data

In the Proposed Rule, the Departments seemingly implicit assumption is that the United States market for MH/SUD professionals is significantly larger than the one that actually exists, that insurers could have larger networks if they would just pay adequately, and that plans or insurers will be able to produce MH/SUD professionals in the quantities needed to alleviate the serious shortages in the U.S. market.

Cash pay practices are a rational market response to the fact that psychiatrists and psychologists can fill more than 100% of their available time without needing an insurance company to provide clients for presumably lower compensation. Parity rules would not be expected to shift this market reality in part because network participation is not about monetary considerations alone. There are also the burdens of in-network qualification, billing and compliance burdens, and the lack of standardized technology which come along with working with one or more insurance companies.

As already noted, we reject the idea that network composition standards should be addressed as NQTLs or under MHPAEA. Network design is generally not directed by plans and is not used by plans as a method for limiting the scope or duration of MH/SUD care. Regulating network composition under parity is patently inappropriate given the hugely different sizes of the MH/SUD and M/S provider networks available in the United States and the lack of plan control over this provider availability.

Just to provide context, DOL's Bureau of Labor Statistics own data[2] shows that at most there are 674,000 people that could provide MH related services to insurers and plans, as compared with 12.2 million people for medical related services. The fact that around 20% of MH/SUD providers accept insurance[3] versus more than 90% for M/S providers, further widens the disparity. This data should provide the Departments with a clear understanding of why the availability of MH/SUD services is not the same as the availability of M/S services and highlights that it is not a plan-driven problem, but rather a market reality. GAO issued a report in March 2022 that highlighted longstanding workforce "shortages of qualified behavioral health professionals, including shortages of mental health professionals". GAO referenced a 2015 report (GAO-15-449) that noted the Substance Abuse and Mental Health Services Administration "found that more than three quarters of counties in the U.S. had a serious shortage of mental health professionals in 2013" and that "these workforce shortages are expected to continue." GAO further note that "as of September 30, 2022, HRSA (Health Resources and Services Administration) designated more than 5,700 mental health provider shortage areas, with more than one-third of Americans (119 million people) living in these shortage areas."

While the GAO report notes several factors impacting access challenges, they find that "low reimbursement rates affect provider willingness to join networks" while noting that interviewed stakeholders explained "that mental health providers can often make more money and still have patients by converting to a self-pay or cash-only practice." Ultimately, the network composition approach fails to take into account market realities beyond the scope of MHPAEA.

There are further concerns with the data approach proposed by the Departments. Firstly, low in-network utilization cannot be a de facto indicator of an inadequate network. In some plans out-of-network utilization is simply not due to a lack of in-network provider access, but rather is due to consumer preferences. With respect to out-of-network utilization, in the past we have seen the Departments focus on ensuring plans do not have added stringency for access to out-of-network

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[2] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment and Wage Statistics, May 2022 data, accessed on August 23, 2023 at https://www.bls.gov/oes/current/oes_stru.htm, for occupation codes included in 19-3030, 21-1010, 29-0000, 31-1130, 31-2000, and 31-9090.

[3] Center for Primary Care, Harvard Medical School, Harvard Medical School Primary Care Review, *Here's Why Mental Healthcare is So Unaffordable & How COVID-19 Might Help Change This*, December 15, 2020. Accessed August 26, 2023 at https://info.primarycare.hms.harvard.edu/review/mental-health-unaffordable#:~:text=Despite%20over%2090%25%20of%20general,suitable%2C%20in%2Dnetwork%20referrals.

MH/SUD benefits. As the Departments know, individuals often seek care at out-of-network facilities and/or with out-of-network providers based on their personal preferences and individual circumstances. Historically, the Departments have encouraged this access. This historical policy clearly does not fit with a presumption that higher out-of-network use is a de facto indication of noncompliance. In fact, out-of-network use may be a sign of robust benefits and flexible access policies. In addition, some plan populations trend towards higher out-of-network utilization even in cases where in-network benefits are generous and reflect industry standards of in-network benefit offerings.

In terms of the percentage of in-network providers actively submitting claims, in the current market we expect that all plans will fail MHPAEA if a data point for compliance compares in-network M/S and MH/SUD providers accepting claims. Plan designs generally encourage in-network utilization with lower co-insurance and/or co-pays. Even so, personal preferences often drive the out-of-network choice. Further, if the Departments retained this data measure, we understand that there are different ways to measure this. At a minimum, an alternative and uniform approach should be promulgated by the Federal Departments. However, again, network administrators, not plan sponsors contract with network providers and are best suited to monitoring this, therefore it does not seem that this should be regulated under MHPAEA.

In terms of provider reimbursement, higher payment metrics alone are not expected to drive adequate network participation. A standard comparative does not work and neglects to reflect market realities, how pricing is set, and how provider specialties and payment vary.

While the safe harbor rules for network composition are appreciated by plans, it seems unlikely that they can realistically be relied upon. Most networks will show disparity between M/S and MH/SUD at a data level and every plan through its network administrator will be tasked with explaining the market realities and how the plan/network administrator works to accommodate these realities. This would be a redundant and unhelpful use of resources because it would not expand networks or change available benefits. Network access is outside of the plan's domain because plans hire, rather than build, these networks. Issues regarding network access should be regulated directly through a thoughtful rulemaking process aimed at addressing network access in a comprehensive way through the regulation of insurers and network administrators as well as through efforts directed towards expanding the number of MH/SUD providers, rather than through indirect regulation under MHPAEA.

"Substantially-all/ Predominant Testing"—***Overall the "substantially-all/predominant test" is excessively burdensome and inefficient. Applying this testing to NQTLs is contradictory to the long-standing approach to NQTL regulation. The Departments can reach their objectives through other regulatory measures without the necessity of this testing.***

With respect to the "substantially-all test," plans would be required to determine the portion of plan payments for M/S benefits expected to be subject to the NQTL based on the dollar amount of all plan payments for M/S benefits in the classification expected to be paid under the plan for the plan year. The Departments note that for the method for determining the dollar amount expected to be paid under the plan to be considered reasonable, the plan would be required to consider plan-level claims data unless a qualified actuary makes a finding that the plan does not have sufficient data at the plan level for a reasonable projection of future claims.

If an NQTL does not apply to at least two-thirds of all M/S benefits in a classification, then that NQTL would not be permitted to be applied to MH/SUD benefits in that classification. The Departments explain that whether the NQTL applies to at least two-thirds of all M/S benefits would be determined without regard to whether the NQTL was triggered based on a particular factor or evidentiary standard, but instead, based on plan payments for M/S benefits subject to an NQTL as a portion of the dollar amount of all plan payments for M/S benefits in the classification expected to be paid under the plan.

Self-insured plans would also be required to determine the "predominant" variation of the NQTL that is applied to "substantially-all" M/S benefits subject to the NQTL in the classification. Again, departing from the traditional use of the "substantially-all/ predominant" testing as applied with respect to financial requirements and quantitative treatment limitations (QTLs), the Departments propose that the term "predominant" would, for this purpose, mean the most common or most frequent variation of an NQTL within a benefit classification. The most common or frequent variation would be the variation that applies to the highest portion of all M/S benefits within a classification that are subject to the NQTL based on expected plan payments. For example, plans would be required to determine the portion of the benefit subject to different variations of the NQTL, if any, based on the dollar amount of all plan payments expected to be paid under the plan.

Historically, the Departments have acknowledged the significant differences between QTLs and NQTLs, NQTLs being non-numerical and subjective in nature. The Departments proposal to apply the "substantially-all/predominant" test to NQTLs is a reversal of the long-standing approach under which this testing did not apply to NQTLs. It is unclear why the Departments have proposed this testing. The application of the substantially-all/predominant test to benefit management is inconsistent with how benefit design and operation have historically been crafted to, in part, take into account clinical considerations related to benefits delivery.

The proposed testing would be difficult, and in many cases impossible, particularly testing for "predominant" levels of NQTLs. It seems that in many instances, based on estimates consistent with common plan designs rather than plan level data, the Departments could determine when the two-thirds test will most commonly support ongoing application of an NQTL, such as for inpatient prior authorization, and could determine when the presumption would be that the NQTL will most likely become impermissible, such as with respect to outpatient fail-first policies. Plans could test if they wanted to support an NQTL that would generally be presumed noncompliant. However, generally subjecting plans to this two-thirds testing exercise seems unnecessary. Then, as even admitted by the Departments throughout the preamble discussion in the Proposed Rule, it is unclear how one would define the predominant level of many NQTLs in a way that has practical meaning and how one would attach paid dollars to do the tests. As noted earlier in this comment letter, systems are not even built to support this.

Additional Technical Comments Regarding Challenges Related to the Proposed Testing— ***The proposed testing lacks the clarity necessary to be actionable by plans and administrators and would require extensive re-development by the Departments. The guiding principle of the rule should be the promotion of access to MH/SUD benefits consistent with clinically appropriate treatment and utilization guidelines. Therefore, the Departments should re-visit the Proposed Rule and its exceptions and consider how to better articulate a clear path to compliance for plans that want to retain offering clinically indicated MH/SUD benefits.***

While we do not see meaningful value in or support for the proposed testing, if advanced, the Departments would need to invest substantial time and resources to cultivate a better understanding of benefit design and administration and develop a detailed and specific testing methodology that could be adopted across the entire industry. Specifically, when we begin to think of the challenges or impossibility of this testing, a leading consideration is that different organizations do not assign benefits to classifications in the same manner. This Proposed Rule would seem to require that the Departments dictate a set list of core benefits and how the Departments would like them assigned for purposes of testing in order to promote the consistency needed to support the subsequent information sharing across plans and administrators necessary to comply with the rules. The Departments have traditionally touted the flexibility plans can retain in the assignment of benefits. While flexibility is often appreciated within the regulatory context, a point exists, such as is the case for NQTL analysis, where any potential benefit from flexibility is offset by the time and financial burdens created by confusion and inconsistency.

Next, it should not be assumed that all plan sponsors have all operations performed within the same entity or that the various systems that apply and track NQTLs could be easily mapped to the associated claims data. It is not uncommon to carve out certain administrative practices, including claims processing or clinical review functions, to third parties (often a mix of third parties). Gathering the information and data necessary for this testing is anticipated to create substantial administrative confusion and burden.

Additionally, if finalized, the Proposed Rule would necessitate a prescribed methodology for mapping claims data to the different benefit classifications used in measurement/assessment, a prescribed method to determine if plan experience is credible, and a prescribed set of alternative approaches, which may include a federal calculator. Greater specificity would be needed in defining what level of detail is intended by "benefit".

In general, the differences between physical treatment and treatment for MH/SUD make it challenging to verify that a plan's policies are in parity and that those policies are being followed in practice. The Departments do not seem to appreciate that the universe of M/S treatment is much broader, administered by a broader range of specialties, and that it is not necessary or meaningful to compare this full set of M/S benefits and services to MH/SUD services (within each benefit classification). The Departments could potentially work to define a narrower subset of M/S and MH/SUD benefits where limited comparatives could provide some meaningful insights into comparability. This again would be best supported through stakeholder collaboration and require careful work by the Departments to develop a methodology that would ensure consistency and limit uncertainty. Such efforts should be undertaken from a studied point of view and should only be implemented where a comparative would have a chance of benefiting parity in a meaningful way. Given the administrative burden and conceptual shortcomings of the proposed approach, in re-visiting the proposal, if the "substantially-all predominant test" is not entirely abandoned, the Departments should consider estimation methods and safe harbors (after further stakeholder input).

Finally, while we appreciate that the Departments provided exceptions for use of independent professional medical or clinical standards, or standards related to fraud, waste, and abuse, it is completely unclear how the Departments anticipate these exceptions can be appropriately relied upon by plans. Most, if not all, NQTLs are derived from clinical guidance and evidentiary standards and the role of clinical guidance should not be usurped in an effort by plans to make select metrics look similar. If there is an exemption for NQTLs set on this basis of clinical evidence, the application needs to be very clear. Furthermore, the most commonly applied NQTL is medical necessity, and it is presently impossible for plans to know what standard they can rely upon for purposes of applying medical necessity to MH/SUD and/or how those activities mesh with the intent anticipated by the exception for care delivered pursuant to current medical and clinical standards.

The Departments should consider a wholistic approach to how they can re-visit their work on this proposed regulation. Advancing coverage for clinically appropriate, quality MH/SUD benefits should be the priority and ultimately, may be most appropriately framed as a guiding principle (or safe harbor) rather than as a vague exception. Disrupting the ability of plans to manage MH/SUD benefits consistent with industry treatment and utilization guidelines can actually negatively impact patients and is counter to the intent of the statute.

Design and Application Requirement (including nondiscrimination standard)—***The expanded inclusion of "design," the subjective nature of the standards, and the uncertain ability of plans to rely on the operational analysis conducted by plan administrators make the "design and application" and nondiscrimination standards unworkable.***

Plans would not be permitted to impose an NQTL with respect to MH/SUD 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 *designing and applying* the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently, than those used in *designing and applying* the NQTL with respect to M/S benefits in the classification.

While this is substantially similar to the 2013 regulatory requirement, it expands the rule to specifically include "designing". This is contradictory to the Departments' shift in their application of the "substantially-all/predominant testing" and review of data outcomes to the NQTLs. In one regard, the Departments seem to be relying on bright-line testing measures to evaluate an NQTL, while here the Departments broaden and retain a subjective measure that will also be reviewed to evaluate compliance.

Again, the extensive burdens implicated in compliance with this law continue to escalate, making the risk and burden of subjective standards more and more untenable. Plans need a clear and certain path to compliance, which includes how they are expected to meet this standard as written and in operation. Plans under audit that have provided descriptions of operations through documented comparative analyses have been subject to numerous follow-up requests for additional, supplemental information. The Departments have found initial operational summaries insufficient, even when those summaries are quite robust. Plans are uncertain of what is expected and are cooperating with the Departments through a series of requests, hoping to satisfy a standard so vaguely crafted that there is no chance of compliance certainty. Regulation through audit is not reasonable. Further, plans generally rely on their administrators with respect to the design and application of NQTLs, and therefore are relying on the operational analysis and conclusions of those administrators with respect to compliance. The subjective nature of existing guidance and the fact that this Proposed Rule contravenes the normal standards through which a plan may have some reasonable reliance on its administrator make the application of these requirements problematic.

With respect to the nondiscrimination standard, plans would be prohibited from relying upon any factor or evidentiary standard if the information, evidence, sources, or standards on which the factor or evidentiary standard is based discriminates against MH/SUD benefits as compared to M/S benefits. Information would be considered to discriminate against MH/SUD benefits if it is biased or not objective, in a manner that results in less favorable treatment of MH/SUD benefits, based on all the relevant facts and circumstances. This is again a facts and circumstances

determination that is subjective in nature and evades a plan's ability to have certainty of compliance.

V. Meaningful Benefits Rule—The "meaningful benefits rule" is overly expansive, unclear and contrary to long-standing principles of parity. Any desired benefit mandates should be accomplished through legislative initiatives.

The Departments are adding to the NQTL requirements by requiring plans and issuers to compare the *treatments* of conditions or disorders in each classification in which M/S and MH/SUD benefits are provided instead of the *coverage* for M/S benefits as compared to *coverage* for MH/SUD benefits more generally. This significantly broadens the scope and complexity of analyzing MHPAEA NQTL compliance. Further, as explained in other sections of this letter, this is not the position of the 2013 regulations, which the CAA amendments codified.

Specifically, M/S has a broader range of conditions and treatments, and an analysis of this type makes little sense. The Departments have not defined "meaningful benefit," so again, without further detail, the application of this rule remains subjective, again lacking clarity and certainty in terms of a path to compliance. Further, as discussed with respect to substantially-all/predominant testing, greater specificity would be needed in defining what level of detail is intended by "benefit" in this context, which could be interpreted as finely as each individual procedure code (a seemingly unreasonable and tremendously burdensome option).

In some regards the "meaningful benefits" standard appears to be aimed at addressing benefit exclusions that the Departments have identified in the enforcement context, such as exclusions for applied behavioral analysis therapy and nutrition counseling for eating disorders. However, it is unclear what treatments the Departments will consider to be "meaningful benefits" in the future, and plans have no way to determine when a "meaningful benefit" is lacking. Perhaps it would be more appropriate that Congress pass express MH/SUD benefit mandates in instances where the view is that a benefit is so meaningful it must be covered. The "meaningful benefit" approach that would compare specific M/S and MH/SUD treatments is a reversal of the long-standing rule that allowed plans flexibility in benefit design as long as MH/SUD benefits are covered in all classifications in which M/S benefits are provided.

VI. Documented Comparative Analysis—The Departments should re-focus the rulemaking with an eye towards how to better increase efficiencies, reduce undue burden and scope documentation objectives in an approachable and usable manner. Plans continue to seek exemplary analysis with detailed instructions and seek safe harbors for areas where data shows there is no negative impact on MH/SUD benefits. Timeframes for providing information and notices under these requirements are overly restrictive and should be revised.

The Departments provided additional, detailed requirements related to the documented comparative analysis requirement. Again, as noted throughout this letter, plans extensively rely upon third-party administrators for the operational details included in the comparative analysis. Issues related to reliance on information outside a plan's scope of control are a theme throughout this letter and are relevant again with respect to the documented comparative analysis. The comparative analysis also raises concerns related to burden, time and cost. Further, there is tremendous redundancy in these reporting requirements. Plans seek any area where these analyses can be simplified and streamlined.

It is our hope that the Departments will consider the comments and revise the approach of this proposed rulemaking, including revising the comparative analysis content requirements consistent with those changes throughout. While the intent of the documented comparative analysis may be to help mitigate noncompliant NQTLs, it creates administrative burden with little relative impact. It also raises a range of questions related to potentially unreasonable applicability to unique plan designs, such as supplemental networks and non-restrictive member assistance programs, which may not always be an "excepted benefit". The Departments should re-focus the rulemaking with an eye towards how to better increase efficiencies, to reduce undue burden and to scope documentation objectives in an approachable and usable manner. As we have requested in the leadup to this Proposed Rule, plans continue to seek exemplary analysis with detailed instructions and safe harbors in reporting for areas where data shows there is no negative impact on MH/SUD benefits.

The Departments propose 10 days for plans to respond to a request for an initial documented comparative analysis, 10 days to respond if supplemental information is requested, 45 days for submission of a corrective action plan in response to an initial finding of noncompliance and 7 days for publication of a participant notice in instances of a final determination of noncompliance. These timeframes, particularly the 10 days for supplemental information and 7 for publication of a participant notice, are unrealistically short. Something as simple as the absence of a key staff person could create problems meeting a 7- or 10-day timeframe for an initial response. In terms of supplemental requests, these often involve multiple benefit administrators and the production of complicated information or data explanations, therefore, 10 days is almost always an overly restrictive and unrealistic timeframe for plans to work with administrators to develop a complete and accurate response.

Given the public nature and significant potential consequences related to final determinations of noncompliance, with respect to such determinations, the Departments should determine an appeals process administered jointly by the Departments of Labor, HHS, and Treasury and available in instances when plans do not agree with the final determination.

Conclusion

Mental health and substance use disorder benefits are extremely important to multiemployer health plans, to the participants and their families, and to the unions and employers that jointly sponsor these plans. However, the Departments need to be mindful that these benefits are voluntary in nature. Expensive and unrealistic/impossible regulatory requirements that also attach significant legal liability, both for the plans and the trustees, will drive many plans to cease these critical benefits.

As we have previously commented, the only funding that a multiemployer trust has comes from contributions negotiated through the collective bargaining process as part of a wage-benefits package and made by employers on behalf of employees for covered employment performed under a collective bargaining agreement. Any cost increase is borne by the hard-working participants through benefit reductions or increased contributions, which lowers the take-home pay of the participants. There is no corporate deep pocket to tap to pay for administrative and compliance costs of the plans.

The widely known history of lengthy and expensive EBSA investigations of health plans does not provide the regulated community with confidence that, as proposed, this rulemaking will provide a clear path to compliance. As noted, regulation through enforcement is not reasonable. This Proposed Rule is expected to significantly increase costs, liability, and complexity of plan operations for plans that voluntarily offer MH/SUD benefits.

We appreciate the opportunity to provide input on the Proposed Rule and thank you for considering these comments. If you have any questions or would like to discuss these comments further, please contact Mariah Becker (202.756.4637 or mbecker@NCCMP.org).

Regards,

Michael D. Scott
Executive Director