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OFFICE OF THE ATTORNEY GENERAL

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Via Federal eRulemaking Portal

The Honorable Xavier Becerra
Secretary, U.S. Department of Health and Human Services
The Honorable Julie A. Su
Acting Secretary, U.S. Department of Labor
The Honorable Janet Yellen
Secretary, U.S. Department of the Treasury

RE: Requirements Related to the Mental Health Parity and Addiction Equity Act NPRM (Attention: 1210–AC11.)

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

The undersigned State Attorneys General of New York, California, Colorado, Delaware, the District of Columbia, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington ("the States") write in response to the proposed rules issued by the Department of Health and Human Services ("HHS"), the Department of Labor ("DOL"), and the Department of the Treasury (collectively, "the Departments"), which propose amendments to regulations implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") and new regulations implementing the nonquantitative treatment limitation ("NQTL") comparative analyses requirements under MHPAEA, as amended by the Consolidated Appropriations Act, 2021 ("CAA"). These comments are specifically tailored to the proposed regulations ("Proposed Rule") issued by HHS, which along with the States regulates health insurers, but are relevant to substantially similar regulations proposed by DOL and the Department of the Treasury.

The States commend the Departments' efforts to improve compliance with MHPAEA through the Proposed Rule and thereby improve access to behavioral health treatment. The States have a strong interest in these proposed rules, as all have enacted mental health and/or substance

use disorder ("MH/SUD") parity laws, some of which are modeled on or incorporate elements of MHPAEA,[1] and several States have partnered with the Departments to enforce MHPAEA.

Parity is an essential tool in addressing the mental illness and addiction crises affecting our nation. A 2021 survey by the Substance Abuse and Mental Health Services Administration found that 57.8 million adults aged 18 or older had a mental illness in the past year; of that population, 27.6 percent (or 15.5 million people) felt an unmet need for mental health services.[2] The most common reason for not receiving services was that they could not afford the cost of care (47.8 percent).[3] 16 percent of those who did not receive treatment indicated that the reason was that their health insurance does not pay enough for mental health services.[4]

Consumers, providers and advocates have conveyed that MHPAEA's significant protections are illusory due to health insurers' NQTLs, which are practices by which insurers can "manage away" even the most generous MH/SUD benefits. In particular, health insurers restrict MH/SUD benefits through medical necessity denials, low reimbursement rates, and high burdens for in-network providers, resulting in inadequate provider networks. It is troubling but not surprising that researchers have found little evidence that MHPAEA has led to expanded access to MH/SUD treatment. For example, a 2019 study found that MHPAEA had at most small effects on patterns of mental health services use and spending through 2013.[5] Therefore, proactive and rigorous enforcement of MHPAEA is paramount.

The Proposed Rule would be a huge step forward in MHPAEA compliance and enforcement. Most importantly, it would require health insurers to conduct and disclose to regulators comparative, data-driven analyses of the impact on access to treatment of NQTLs, including provider network admission standards, methods for determining reimbursement rates, and procedures for ensuring network adequacy. Importantly, insurers would be required to mitigate disparities between MH/SUD and medical/surgical benefits, which would make it easier for members of health insurance plans to find and afford treatment. These provisions of the Proposed Rule are faithful to the text and purpose of MHPAEA,[6] as amended by the CAA, and are consistent with prior guidance issued by the Departments.

For the reasons set forth below, the signatory States strongly support the additional protections offered by the Proposed Rule, and urge the Departments to move quickly to finalize them or to issue them as an interim final rule. The Departments' proposed regulations would

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[1] *See, e.g.*, N.Y. Ins. L. §§ 3216(i)(31), (i)(35); 3221(l)(5), (7); 4303(g), (l); Mass. Gen. Laws ch. 26 § 8K; ORS 743A.168 and Or Laws 2021, ch 629; RI Gen. Laws § 27-38.2-1(b)(i); 40 P.S. §§ 908-11 - 908-16.

[2] Substance Abuse and Mental Health Services Administration, Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (Dec. 2022), at 60, https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf.

[3] *Id.* at 61.

[4] *Id.* at A-33.

[5] Coleman Drake, et al. *The Effects of Federal Parity on Mental Health Services Use and Spending: Evidence From the Medical Expenditure Panel Survey*, 70 Psychiatric Servs. 287 (2019), https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201800313.

[6] Sen. Edward Kennedy introduced MHPAEA in the Senate, stating that "[a]ccess to mental health services is one of the most important and most neglected civil rights issues facing the Nation. For too long, persons living with mental disorders have suffered discriminatory treatment at all levels of society." 153 CONG. REC. S1864 (daily ed. Feb. 12, 2007), https://www.congress.gov/110/crec/2007/02/12/CREC-2007-02-12.pdf.

undoubtedly expand access to necessary MH/SUD treatment. Drawing on shared experiences among the States, we also address several points on which the Departments have requested comment, and offer recommendations to further strengthen the protections embodied in the Proposed Rule.

I. Health Insurers' Failure to Comply with MHPAEA Necessitates More Robust Enforcement and Regulatory Oversight

Since President George W. Bush signed MHPAEA fifteen years ago,[7] the promise of MH/SUD parity has not been fulfilled despite the Departments' steadfast enforcement and promulgation of regulations and dozens of guidance materials, including 15 sets of FAQs with 96 questions, eight enforcement fact sheets, six compliance assistance tools and templates, seven reports to Congress, six press releases, and seven consumer publications.[8] To promote compliance, Congress has amended MHPAEA several times, most significantly through the CAA, which requires health insurers to perform and document detailed comparative analyses of the design and application of NQTLs and make them available to the Departments, effective February 10, 2021.[9] In April 2021, the Departments issued a set of FAQs detailing how to comply with the CAA's comparative analysis requirements.[10] As described below, despite this unprecedented outreach, health insurers have fallen short of compliance.

In their required reports to Congress during the past decade and a half, the Departments have repeatedly noted that health insurers' compliance with MHPAEA has ranged from inconsistent to nonexistent. The Departments' 2022 report to Congress states that "[d]espite the CAA's February 2021 deadline for plans to perform and document their comparative analyses, many plans and issuers stated that they were unprepared to respond to the Departments' requests and had not started preparing their comparative analyses by the February 2021 deadline."[11] The Departments' 2023 report to Congress states that "nearly all the initial comparative analyses [DOL] has reviewed have not contained the specific information required under [the CAA] that is necessary to assess compliance."[12] Many of the analyses that were submitted did not adequately address difference in access standards for MH/SUD providers as opposed to medical/surgical providers.[13] The Departments noted that in response to submitted comparative analyses, DOL issued 138 insufficiency letters for over 290 NQTLs and HHS issued 35

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[7] *Id*.
[8] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51559 (Aug. 3, 2023) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R pt. 2590, 45 C.F.R. pts. 146, 147).
[9] Consolidated Appropriations Act, 2021 § 203(a)(1), 42 U.S.C. § 300gg-26(a)(8)(A).
[10] Dep'ts of Labor, Health and Human Services, and the Treasury, FAQS about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 (April 2, 2021), https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf.
[11] Dep'ts of Labor, Health and Human Services, and the Treasury, 2022 MHPAEA Report to Congress, at 8, https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.
[12] Dep'ts of Labor, Health and Human Services, and the Treasury, MHPAEA Comparative Analysis Report to Congress (July 2023), at 94, https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis.pdf.
[13] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51562 (Aug. 3, 2023) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R pt. 2590, 45 C.F.R. pts. 146, 147).

insufficiency letters for 44 NQTLs.[14] Additionally, DOL issued 53 initial determination letters finding MHPAEA violations related to 76 NQTLs (56 of which were unique NQTLs) and 3 final determination letters finding that 3 plans violated MHPAEA, while HHS issued 15 initial determination letters finding MHPAEA violations related to 15 NQTLs and 5 final determination letters finding that 7 NQTLs on MH/SUD benefits violated MHPAEA.[15]

These egregious results confirm that despite longstanding obligations under MHPAEA, many health insurers have not designed or implemented their NQTLs to be compliant. Instead of meeting this requirement, health insurers often make blanket statements of compliance accompanied by conclusory, boilerplate recitations of the regulatory language and various processes, strategies, evidentiary standards, or other factors. For example, one health insurer maintains a compliance document on its website stating that its prior authorization practices comply with MHPAEA because the same three "factors and sources" are involved in determining whether to apply prior authorization, without any analysis whatsoever.[16] The Departments have previously stated that this is insufficient under CAA.[17] The Proposed Rule will remedy such deficiencies.

Health insurers have evaded MHPAEA requirements in variety of ways. In particular, they have failed to demonstrate that their NQTLs are compliant in operation, which has been required since the Interim Final Rule was issued in 2010.[18] For example, if the health insurer applies the NQTL of prior authorization to mental health or SUD treatment, it must be able to demonstrate that in operation the NQTL is applied in a comparable manner and no more stringently for MH/SUD treatment than for medical/surgical treatment. Prior guidance from the Departments as well as state disclosure requirements look to denial rates—a key metric—as a red flag for a potential violation of MHPAEA in operation.[19] Health insurers also fail to comply with

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[14] Dep'ts of Labor, Health and Human Services, and the Treasury, MHPAEA Comparative Analysis Report to Congress (July 2023), at 7-8, https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis.pdf.

[15] *Id.*

[16] *See* United Healthcare, Mental Health Parity and Addiction Equity Act Disclosure Prior Authorization Frequently Asked Questions (January 2022), https://www.uhc.com/content/dam/uhcdotcom/en/Legal/PDF/Prior-Authorization-FAQ.pdf.

[17] Dep'ts of Labor, Health and Human Services, and the Treasury, *FAQS about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 (April 2, 2021)*, at 3, https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf.

[18] Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5449 (Feb. 2, 2010) (codified at 45 C.F.R. pt. 146). The regulation currently states:

> A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

45 C.F.R. § 146.136(c)(4)(i).

[19] Department of Labor, Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) (Oct. 23, 2020), at 27, https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf; N.Y. Ins. L. § 343(b)(4).

MHPAEA's requirement that all treatment limitations be "no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits[.]"[20] For example, health insurers that impose so-called outlier management review for outpatient psychotherapy and counseling after a limited number of sessions within a certain time frame, such as twenty visits within six months (as discussed below regarding the United litigation), have contended that this is compliant with MHPAEA because they conduct outlier management for one or two medical/surgical benefits such as physical therapy or chiropractic. However, this does not show compliance because it does not address whether the NQTL is applied to substantially all medical and surgical benefits. The Proposed Rule will close these loopholes.

II. The States' Recent Efforts to Enforce Mental Health and Substance Use Parity Laws

States increasingly have enforced MH/SUD parity laws, including MHPAEA, finding serious instances of non-compliance. For example, in August 2021 New York jointly enforced MHPAEA with DOL against UnitedHealthcare ("United") through litigation in the Eastern District of New York.[21] The agencies' investigation found that United employed two illegal NQTLs in violation of MHPAEA. First, it reduced the allowed amount—which determines member reimbursement—for psychotherapy by 25 percent for all services provided by doctorate-level psychologists and by 35 percent for masters-level therapists, without applying such reductions to medical/surgical treatments except in narrow circumstances. Second, it required utilization review of psychotherapy after 20 sessions but did not apply a comparable program to medical/surgical services. The litigation resulted in settlements that required United to pay $14.3 million to consumers and remove the illegal NQTLs.

Rhode Island's Health Insurance Commissioner conducted market examinations of insurance providers regarding compliance with state and federal mental health parity laws between 2018 and 2020. Based on those reports, several insurance companies were found to be not fully compliant with state and federal mental health parity laws. Ultimately, the lack of compliance led to over $7 million from insurers being placed in a fund that supports behavioral health and substance abuse prevention and early intervention programs. The findings included:

- Neighborhood Health Plan of Rhode Island did not fully comply with Rhode Island General Laws § 27-38.2-1(a), the State's statute on coverage for mental health and substance use disorders. The insurer applied its utilization review to a much broader scope of behavioral health services, and in a more stringent manner, than was the case with medical/surgical services.[22] As a result, Neighborhood Health Plan of Rhode

[20] 42 U.S.C. § 300gg-26(a)(3)(A)(ii).
[21] Press Release, Att'y Gen. Letitia James, Attorney General James and U.S. Department of Labor Deliver $14 Million to Consumers Who Were Denied Mental Health Care Coverage (Aug. 12, 2021), https://ag.ny.gov/press-release/2021/attorney-general-james-and-us-department-labor-deliver-14-million-consumers-who.
[22] Rhode Island Office of the Health Insurance Commissioner, *Examination Report of Neighborhood Health Plan of Rhode Island, in accordance with R.I G.L. § 27-13.1-5(b),* Page 23-24, *(*Feb 14, 2020) https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/2020/March/NHP-MCE_V12.2_03042020_WEBSITE.pdf.

Island had to contribute $333,000 over three years to a fund that supports behavioral health and substance abuse prevention and early intervention programs.[23]

- Blue Cross Blue Shield of Rhode Island applied its utilization review to a much broader scope of behavioral health services than its medical/surgical services and thus may have been non-compliant with Rhode Island General Laws §27-38.2-1.[24] The Insurer was also found to be noncompliant with Rhode Island General Laws § 27-9.1, the Unfair Claims Settlement Practices Act.[25] Blue Cross Blue Shield, in lieu of a penalty, agreed to give $5 million over five years to the same behavioral health prevention and intervention fund as Neighborhood Health Plan.[26]
- Tufts Health Plan's utilization review and care management programs caused State regulators to be concerned that the insurer applied those programs to a broader scope of behavioral health services compared to medical/surgical services. Specifically, after eight outpatient behavioral health visits, prior authorization was required for additional visits, which was not the policy for many medical/surgical visits.[27] Tufts Health plan agreed to contribute $150,000 to the same fund as BCBS and Neighborhood health, in lieu of a fine for its non-compliant practices.[28]
- United Healthcare violated Rhode Island General Law §27-38.2.-1 and 42 U.SC § 300gg-26 by having coverage exclusions that exclusively applied to behavioral health services and applying its utilization review to a wider scope in a more stringent manner to behavioral health services compared to the scope of review for medical surgical services.[29] United Healthcare's violations "had the potential to impede patient care" and/ or were "coercive."[30] Thus, the company was ordered to pay a $350,000 penalty to the State and a $2.85 million contribution to the same fund as the other insurers.[31]

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[23] Rhode Island Office of the Health Insurance Commissioner, *OHIC Releases Two Market Conduct Exams for Behavioral Health Coverage*, (March 5, 2022) at https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/2020/March/Tufts-NHPRI-MCE-Press-Release.pdf.

[24] Rhode Island Office of the Health Insurance Commissioner, *Examination Report of Blue Cross Blue Shield of Rhode Island, in accordance with R.I G.L. § 27-13.1-5(b),* page 19, (Aug. 1, 2018), https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/Regulation-and-Enforcement/Examination-Report---BCBSRI.pdf.

[25] *Id*. at 12.

[26] Rhode Island Office of the Health Insurance Commissioner, *OHIC Release First of Four Mark Conduct Exams for Behavioral Health Parity* (September 17, 2018), https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/OHICpressreleaseBCBSRIexamreport09.17.2018.pdf.

[27] Rhode Island Office of the Health Insurance *Examination Report of Tufts Health Plan of Rhode Island, in accordance with R.I G.L. § 27-13.1-5(b),* page 21, (Feb. 12, 2020), https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/2020/March/THP_FINAL-MCE-Report-03042020_website.pdf.

[28] Rhode Island Office of the Health Insurance Commissioner, *OHIC Releases Two Market Conduct Exams for Behavioral Health Coverage,* (March 5, 2022) at https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/2020/March/Tufts-NHPRI-MCE-Press-Release.pdf.

[29] Rhode Island Office of the Health Insurance Commissioner, *Examination Report United Healthcare of Rhode Island, in accordance with R.I G.L. § 27-13.1-5(b),* Page 28-29 (March 11, 2020)

[30] Rhode Island Office of the Health Insurance Commissioner, *United Healthcare agrees to pay state $350K, contribute $2.85 to mental health fund*, (March 30, 2020), https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/2020/March/United/United-Healthcare-agrees-to-pay-state-%24350k%2C-contribute-%242.85-million-to-mental-health-fund-.pdf.

[31] *Id*.

Additionally, in February 2020, the Massachusetts Office of the Attorney General announced settlements with three Massachusetts health plans concerning allegations that each violated MHPAEA in various ways, including by using methods to determine provider reimbursement rates that resulted in lower payments for outpatient behavioral health services than for comparable medical/surgical services.[32] Each agreed to change (or during the investigation had already changed) the way they establish their minimum reimbursement rates for in-network behavioral health outpatient services at all provider levels – including psychiatrists, psychologists, and social workers – generally resulting in higher reimbursement rates for such services.

III. Recommendations to Strengthen the Three-Pronged Test for MHPAEA Compliance for NQTLs

The States welcome the Departments' proposal to reframe current regulations into a three-prong test that is consistent with MHPAEA as amended by the CAA. It is important to note that these modifications do not create brand new obligations but rather clarify existing regulations. Set forth below are brief summaries of each prong of the test and recommendations.

a. The "Predominant/Substantially All" Test for NQTL Compliance Should Provide Additional Examples

The first prong of the NQTL test under the Proposed Rule would prohibit application of an NQTL to MH/SUD benefits in any benefit classification[33] that is more restrictive than the predominant variation of the NQTL applied to substantially all (two-thirds) medical/surgical benefits in a classification (such as inpatient, in-network benefits), as written and in operation.[34] This is a logical extension of current regulations, which specify that the same "predominant/substantially all" test applies to financial requirements (*e.g.*, co-pays and coinsurance) and quantitative treatment limitations (*e.g.*, day and visit limits). Moreover, application of this test to NQTLs is consistent with the plain language of MHPAEA, which states that the "predominant/substantially all" requirement applies to all treatment limitations. The proposed change eliminates the ability of health insurers to evade compliance by contending, as some do at present, that application of an NQTL (*e.g.*, prior authorization or concurrent review) to a single medical/surgical benefit in a classification by itself justifies application of that NQTL to all MH/SUD benefits in a classification.

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[32] Press Release, Att'y Gen. Maura Healey, *AG Healey Announces Groundbreaking Agreements that Expand Access to Behavioral Health Services for More Than One Million Residents* (Feb, 27, 2020), https://www.mass.gov/news/ag-healey-announces-groundbreaking-agreements-that-expand-access-to-behavioral-health-services-for-more-than-one-million-residents.

[33] The current regulations set forth six benefit classifications, which are unchanged by the Proposed Rule:

(1) Inpatient, in-network.
(2) Inpatient, out-of-network.
(3) Outpatient, in-network.
(4) Outpatient, out-of-network.
(5) Emergency care.
(6) Prescription drugs.

45 C.F.R. § 146.136(c)(2)(ii)(A).

[34] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51658 [Proposed 45 C.F.R. § 146.136(c)(4)(i)] (Aug. 3, 2023) (to be codified at 45 C.F.R. pts. 146, 147).

The Departments' proposed approach to define the "predominant" level of an NQTL as "the most common or most frequent variation" based on plan payments for various levels (45 C.F.R. § 146.136(c)(4)(i)(C) and (D))[35] aligns with the test currently used for financial requirements and quantitative treatment limitations and is therefore logical and workable. The brief inpatient mental health concurrent review example presented in the definition of "predominant"[36] is instructive and addresses an unfortunately common problem, as such reviews and the denials they generate are often barriers to MH/SUD treatment.[37] It would be helpful if the example could explain how plan payments for medical/surgical benefits for each variation of an NQTL (in the example, concurrent review 1 day, 3 days, or 7 days after admission) are to be calculated, as is currently done in 45 C.F.R. § 146.136(c)(3)(iv) for financial requirements and quantitative treatment limitations. Similarly, for proposed illustrative Example 1 (45 C.F.R. § 146.136(c)(4)(viii)(A)),[38] which analyzes prior authorization requirements in operation, it would be helpful to explain how plan payments were used to determine that prior authorization approvals for 7 days were the most common variation.

It would also be helpful if the Departments could provide an example of the application of the "predominant/substantially all" test to network composition NQTLs such as methods for determining reimbursement rates,[39] since empirical evidence suggests that low rates for MH/SUD providers may contribute to consumers' difficulty finding such providers who participate in health insurance networks.[40] The example could examine whether a health insurer practice that pays in-network medical/surgical providers a certain percentage above a benchmark

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[35] *Id*. [Proposed 45 C.F.R. § 146.136(c)(4)(i)(C), (D)].
[36] *Id*. [Proposed 45 C.F.R. § 146.136(c)(4)(i)(C)].
[37] *See New York State Attorney General Public Hearing on Access to Mental Health Care in New York* (June 22, 2022) (testimony of Dr. Tony Carino), at 22:9-14, https://ag.ny.gov/sites/default/files/2022-12/hearing_pdftran.pdf ("[O]ftentimes patients need more than the 4 to 12 days of inpatient care, especially with homelessness and physical health complexity. And so, the insurance disincentive beyond a few days really pushes inpatient teams to discharge soon."); Attorney General of the State of New York, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15, at 10, *In the Matter of ValueOptions, Inc.*, Assurance No. 14-176, https://ag.ny.gov/sites/default/files/settlements-agreements/ValueOptionsAOD-FullyExecuted.pdf ("The utilization review that ValueOptions conducts for behavioral health claims is often intensive and frequent, and providers and members must spend a great deal of time justifying each day or visit. For example, a 14-year old MVP member with an eating disorder was receiving partial hospitalization treatment for her illness, until ValueOptions denied additional days of treatment. As a result, the member had to interrupt treatment while an appeal was lodged on her behalf, exacerbating the symptoms of her illness, and causing her and her family extreme emotional stress. Additionally, although it is not possible to complete substance abuse rehabilitation treatment in one day, in some cases, ValueOptions authorizes one day of inpatient substance abuse rehabilitation treatment at a time.")
[38] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51658 [Proposed 45 C.F.R. § 146.136(c)(4)(viii)(A)] (Aug. 3, 2023) (to be codified at 45 C.F.R. pts. 146, 147).
[39] *Id*. at 51562 [Proposed 45 C.F.R. § 146.136(c)(4)(iii)(D)]. Network composition NQTLs include but are not limited to "standards for provider and facility admission to participate in a network or for continued network participation, including 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[.]"
[40] Steve Melek et al., Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement (Milliman, Nov. 19, 2019), at 22, https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf.

fee schedule, or allows them to negotiate their rates, complies with the test if it pays in-network MH/SUD providers only the benchmark rate and does not allow them to negotiate their rates.[41]

The States also support codifying that a health insurer must provide "meaningful benefits" for treatment of a MH/SUD condition in each benefit classification as compared to benefits for medical/surgical conditions in the same classification.[42] Proposed Example 6[43] reflects an unfortunate scenario that too many consumers have encountered: a health insurer covers diagnosis and treatment of eating disorders, a mental health condition, but excludes coverage for nutritional counseling even though it is one of the primary treatments for the condition, whereas the plan covers the primary treatments for medical/surgical conditions.[44] The States appreciate that the Departments have explained that this violates MHPAEA. But it would be helpful to define "primary treatments" based on independent medical and clinical guidelines. The same sources could be used to determine "meaningful benefits."

b. The "Design and Application" Test Should Define "Discriminatory" Broadly and Provide Additional Examples

The second prong of the NQTL test under the Proposed Rule would prohibit application of an NQTL to MH/SUD benefits in any classification unless, as written and in operation, the "processes, strategies, evidentiary standards, and other factors" used in designing and applying the NQTL for MH/SUD benefits are comparable and applied no more stringently than those used in designing and applying the NQTL to medical/surgical benefits.[45] This test incorporates the current requirements under paragraph (c)(4)(i) and the CAA's requirement that health insurers document comparative analyses of the design and application of NQTLs.[46] Example 4 is clear and realistic, explaining that a plan violates the second prong if it reimburses non-physician providers of MH/SUD services by reducing their reimbursement rate from the rate paid to physician providers by the same percentage for every CPT code but does not apply the same reductions to non-physician providers of medical/surgical services.[47]

The second prong would also prohibit use of discriminatory factors and evidentiary standards in designing and applying NQTLs, defining discriminatory as "biased and not objective, in a manner that results in less favorable treatment of [MH/SUD] benefits, based on all the relevant facts and circumstances[.]" This important additional requirement, which is consistent with the text and anti-discriminatory purpose of MHPAEA as well as Affordable Care Act Section 1557's nondiscrimination requirements,[48] should be interpreted broadly given

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[41] *See* Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51661 [Proposed 45 C.F.R. § 146.136(c)(4)(viii)(D) (Example 4)] (Aug. 3, 2023) (to be codified at 45 C.F.R. pts. 146, 147).
[42] *Id.* at 51654-55 [Proposed 45 C.F.R. § 146.136(c)(2)(ii)(A)].
[43] *Id.* at 51655 [Proposed 45 C.F.R. § 146.136(c)(2)(ii)(C)(6)].
[44] *Id.*
[45] *Id.* at 51658-59 [Proposed 45 C.F.R. § 146.136(c)(4)(ii)].
[46] 42 U.S.C. § 300gg-26(a)(8)(A).
[47] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51661 [Proposed 45 C.F.R. § 146.136(c)(4)(viii)(D) (Example 4)] (Aug. 3, 2023) (to be codified at 45 C.F.R. pts. 146, 147). This example contains facts similar to those alleged in the complaint in *New York v. United Health Group Inc., et al.*, Case 1:21-cv-04533 (E.D.N.Y. Aug. 11, 2011), https://ag.ny.gov/sites/default/files/11.pdf.
[48] 42 U.S.C. § 18116.

MHPAEA's remedial nature. It could also use additional clarification through examples. Although it is well established that preamble language operates as guidance and provides the agency's interpretation and explanation of the regulatory requirements, for clarity the States recommend that the example provided in the preamble be incorporated into the enforceable regulatory text. It states:

> [U]nder these proposed rules, a plan or issuer would not be permitted to calculate reimbursement rates based on historical data on total plan spending for each specialty that is divided between mental health and substance use disorder providers and medical/surgical providers, when the total spending by the plan was based on a time period when the plan or coverage was not subject to MHPAEA or was in violation of MHPAEA, if the data results in less favorable treatment of mental health and substance use disorder benefits.[49]

To the extent that the Departments' reports to Congress have identified widespread MHPAEA violations, the burden should be on the health insurer to show that it was compliant with MHPAEA during the period from which it seeks to use historical data. Additional illustrative examples of discriminatory conduct would also be helpful.

c. The Departments Should Define Key Terms in the "Outcomes Data" Test and Narrow the Exceptions

The third prong of the NQTL test under the Proposed Rule would require health insurers to collect and evaluate relevant outcomes data to assess the impact of each NQTL on access to MH/SUD benefits as compared to medical/surgical benefits, including but not limited to percentage of claim denials, and network composition standards such as utilization rates, provider reimbursement rates, time and distance standards, and whether providers are accepting new patients.[50] If the relevant data show material differences in access to MH/SUD benefits as compared to medical/surgical benefits, the differences would be considered strong indicators that the health insurer violates prongs one and two, and the health insurer would need to take reasonable action to address the material differences to ensure compliance.[51] The proposed special rule for NQTLs related to network composition (*e.g.*, network admission standards, reimbursement rates, and network adequacy procedures) states that a health insurer fails to

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[49] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51573 (Aug. 3, 2023).

[50] *Id.* at 51659 [Proposed 45 C.F.R. § 146.136(c)(4)(iv)]. The States support recharacterizing the existing illustrative NQTL of "Standards for provider admission to participate in a network, including reimbursement rates" as "Standards related to network composition, including but not limited to, standards for provider and facility admission to participate in a network or for continued network participation, including 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." *See also id.* at 51659 [Proposed 45 C.F.R. § 146.136(c)(4)(iii)(D)]. The revised NQTL encompasses interrelated NQTLs that limit the scope or duration of benefits and thus fall within MHPAEA's definition of "treatment limitation"). *See also* 42 U.S.C. § 300gg-26(a)(3)(B)(iii).

[51] Because the data outcomes prong is a required element of the first two prongs, it might be helpful to include in them a cross-reference to it.

satisfy the first two prongs of the NQTL test if its data show material differences in access to in-network MH/SUD benefits as compared to in-network medical/surgical benefits.[52]

Firmly rooted in the MHPAEA statute, regulations, and previously issued guidance, the third prong is a watershed in the evolution of MH/SUD health parity enforcement and may finally bring the dream of parity to fruition. For example, the statute as enacted in 2008 prohibited more restrictive treatment limitations for MH/SUD benefits than for medical/surgical benefits. As noted above, the CAA requires health insurers to document comparative analyses of the application of NQTLs in operation.[53] MHPAEA regulations have required NQTLs to be no more restrictive "in operation" since the promulgation of the Interim Final Rule in 2010.[54] And the 2020 MHPAEA Self-Compliance Tool notes that substantially disparate results in various metrics, including denial rates and average provider reimbursement rates against external benchmarks, are red flags that an NQTL may violate MHPAEA.[55] The 2020 Self-Compliance Tool also notes that to comply with MHPAEA, health insurers may need to take steps to address disparities, including to address provider shortages, ensure an adequate network of mental health and substance use disorder providers, and ensure reasonable patient wait times to avoid noncompliance with MHPAEA's parity requirements.[56] As the Departments correctly note, requiring data to be provided to demonstrate compliance with MHPAEA is not a new concept, and several states already require submission of such data.[57] The proposed special rule for NQTLs related to network composition[58] is consistent with these existing authorities and advances MHPAEA's remedial purpose of increasing access to MH/SUD treatment.

Collection of data regarding access to mental health and substance use disorder treatment, as required under the proposed third prong, is well within the ability of health insurers and would help identify gaps and compliance red flags. The Departments conclude that because compliance would result in de minimis costs to health insurers, the benefits of increased access to medically necessary mental health care and mental health outcomes justify the costs.[59] In the States' experience, health insurers routinely collect data on metrics relevant to MHPAEA compliance as part of their normal business operations, including in- and out-of-network utilization rates, claim submission rates (by provider, both in- and out-of-network), claim denial rates, reimbursement

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[52] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51659 [Proposed 45 C.F.R. § 146.136(c)(4)(iv)(C)] (Aug. 3, 2023) (to be codified at 45 C.F.R. pts. 146, 147).
[53] Consolidated Appropriations Act, 2021 § 203(a)(1), 42 U.S.C. § 300gg-26(a)(8)(A)(iii).
[54] Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5449 (Feb. 2, 2010) (codified at 45 C.F.R. pt. 146).
[55] In 2019, the Departments stated in guidance that substantially disparate results are a red flag. Dep'ts of Labor, Health and Human Services, and the Treasury, FAQS about Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act, Part 39 (September 5, 2019), at 10, https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf
[56] Dep'ts of Labor, Health and Human Services, and the Treasury, Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) (Oct. 23, 2020), at 20, https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf.
[57] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51592 (Aug. 3, 2023). *See, e.g.,* N.Y. Ins. L. § 343(b); Mass. Gen. Laws ch. 26 § 8M(a)(viii).
[58] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51659 [Proposed 45 C.F.R. § 146.136(c)(4)(iv)(C)] (Aug. 3, 2023) (to be codified at 45 C.F.R. pts. 146, 147).
[59] The Departments estimate that costs to plans from collecting and analyzing data and documenting NQTL comparative analyses would be between 0.01 percent and 0.04 percent of health insurance premiums. *Id*. at 51602.

rates (both in- and out-of-network), time and distance standards, and whether providers are accepting new patients. A growing body of academic literature has examined relevant metrics, suggesting serious inadequacies in MHPAEA compliance. For example, numerous independent, peer-reviewed studies have shown that health insurers' networks of MH/SUD providers are in fact ghost networks due to rampant inaccuracies in provider directories.[60] Likewise, Massachusetts' examination of the behavioral health provider directories of six health plans led to allegations that each was materially inaccurate in a variety of ways, including in some instances listing providers in group practices at multiple office locations where they did not actually provide health care services, thus significantly overstating provider availability.[61]

Therefore, NQTLs related to network composition should be measured not by names on a list but by the percentage of in-network providers actually treating members as reflected in health insurers' claims data, a metric that has also been studied by researchers.[62] Studies have also examined out-of-network utilization (showing that members must go out of network far more often for MH/SUD treatment than for medical/surgical treatment), reimbursement rates (showing significantly lower rates for MH/SUD providers than for medical/surgical providers),[63] and time and distance standards in operation.[64] Consequently, the Departments should require health insurers to collect and evaluate each of the metrics described in the Technical Release issued by the Departments contemporaneously with the Proposed Rule, in which the Departments identify four types of data they would require to be collected regarding network composition NQTLs: (1) out-of-network utilization; (2) percentage of in-network providers actively submitting claims; (3) time and distance standards; and (4) reimbursement rates.[65] Because studies and enforcement actions[66] show that many mental health providers are incorrectly listed in health plan directories as "accepting new patients," the States recommend that insurers also be required to collect and

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[60] *See, e.g.,* Nicole L. Tenner et al., *Secret Shopper Analysis Shows Getting Psychiatry Appointment in New York City is Well Kept Secret*, 59 Cmty. Mental Health J. 290 (2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9287131/.

[61] Press Release, Att'y Gen. Maura Healey, *AG Healey Announces Groundbreaking Agreements that Expand Access to Behavioral Health Services for More Than One Million Residents* (Feb. 27, 2020), at https://www.mass.gov/news/ag-healey-announces-groundbreaking-agreements-that-expand-access-to-behavioral-health-services-for-more-than-one-million-residents.

[62] *See, e.g.,* Jane M. Zhu et al., *Phantom Networks: Discrepancies Between Reported And Realized Mental Health Care Access In Oregon Medicaid*, 41 Health Aff. 1013 (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9876384/.

[63] *See, e.g.,* Tami L. Mark et al., *Differential Reimbursement of Psychiatric Services by Psychiatrists and Other Medical Providers*, 69 Psychiatry Serv. 281 (2018) , https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700271.

[64] *See, e.g.,* Benzion Blech et al., *Availability of Network Psychiatrists Among the Largest Health Insurance Carriers in Washington, D.C.*, 68 Psychiatr Serv. 962 (2017), https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201600454.

[65] U.S. Dep't of Labor, Technical Release 2023-01P (July 25, 2023), Request For Comment On Proposed Relevant Data Requirements For Nonquantitative Treatment Limitations (NQTLs) Related To Network Composition And Enforcement Safe Harbor For Group Health Plans And Health Insurance Issuers Subject To The Mental Health Parity And Addiction Equity Act July 25, 2023, https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/guidance/technical-releases/23-01.pdf.

[66] *See, e.g.*, Shireen Cama, et al., *Availability of Outpatient Mental Health Care by Pediatricians and Child Psychiatrists in Five U.S. Cities*, 47 Int J Health Serv. 621 (2017), https://pubmed.ncbi.nlm.nih.gov/28474997/; Press Release, Att'y Gen. Maura Healey, *AG Healey Announces Groundbreaking Agreements that Expand Access to Behavioral Health Services for More Than One Million Residents* (Feb, 27, 2020), https://www.mass.gov/news/ag-healey-announces-groundbreaking-agreements-that-expand-access-to-behavioral-health-services-for-more-than-one-million-residents.

evaluate data concerning provider availability. Collecting such information would allow a more in-depth understanding of actual provider availability and patient access, as opposed to relying on names on a list as a measure of network adequacy.

Several key terms used in prong three could benefit from clarification. First, "material differences" should be defined to mean differences showing that a substantial number of members cannot access MH/SUD benefits. Numerous independent surveys have shown that health plans' members cannot access in-network providers and thus must pay out of pocket for out-of-network treatment.[67] Additionally, "reasonable action" in response to a "material difference" in access should be defined to mean actions, including but not limited to internal reforms and modification or elimination of the NQTL, that resolve the material difference. The preamble provides several helpful examples regarding network composition NQTLs, including special efforts to contract with MH/SUD providers (presumably by actively recruiting from a broad range), authorizing greater compensation to providers, and ensuring that network directories are accurate and reliable.[68] Additional examples could include removing prior authorization or concurrent review requirements.

Any exceptions to the third prong should be narrow. The preamble raises the possibility of an exception for health insurers that demonstrate that they are unable to address material differences due to provider shortages.[69] This potential exception is concerning, as it is the States' experience that health insurers frequently raise "workforce shortage" as a catchall excuse for having inadequate MH/SUD networks, pointing to statements in publications (some issued by the Departments) but without making any effort to describe specifically how the insurers have attempted to remedy the problem. General citations to "workforce shortage" should be rejected as inadequate. To even be considered for an exception, a health insurer must provide specific documentation regarding all efforts it has undertaken to address the shortage. For example, the insurer must show specific efforts to recruit MH/SUD providers into their network, including a detailed outreach and advertising plan for a reasonable period of time (including contacting providers who have left the network), contract flexibility options, and potential reimbursement rate enhancements. The insurer must also conduct comparative analyses of these recruitment techniques as compared to medical/surgical providers. If a health insurer has been able to remedy a shortage of providers for a particular medical/surgical specialty using certain techniques, it must show that it attempted to use comparable techniques for MH/SUD providers. Additionally, the health insurer should be required to conduct a network breadth study, comparing the percentage of MH/SUD providers in their coverage area who are in-network to the percentage of area medical/surgical providers who are in-network.[70] Disparities in breadth rate indicate that the problem might be the health insurer's NQTLs rather than a workforce shortage.

Finally, the Departments should delay evaluation of any possible safe harbor provisions until after the Proposed Rule becomes effective and compliance is demonstrated over a

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[67] *See, e.g.,* Kelly A. Kyanko et al., *Out-of-network provider use more likely in mental health than general health care among privately insured*, 51 Med Care 699 (2013), https://pubmed.ncbi.nlm.nih.gov/23774509/.
[68] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51577 (Aug. 3, 2023).
[69] *Id.* at 51578.
[70] *See, e.g.,* Jane M. Zhu et al., *Networks In ACA Marketplaces are Narrower for Mental Health Care than for Primary Care*, 36 Health Aff 1624 (2017), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0325.

substantial period of time. The repeated and persistent nature of health insurers' non-compliance with MHPAEA, the lack of meaningful NQTL comparative analyses submitted to the Departments to date, and the documented problems consumers have in accessing their MH/SUD benefits make it premature to even consider the possibility of an enforcement safe harbor related to network composition NQTLs, as contemplated by the Departments.[71] Additionally, the States' experience has been that health insurers often tighten benefits to improve their financial condition and plan benefits may change year-to-year. Thus, there would likely be a significant time lag between a new or modified NQTL and data reflecting the impact of the change. Consequently, there is a significant danger that any data-related safe harbor related to network composition would be based on obsolete data, which would dilute MHPAEA's protections.

IV. The New, Overly Broad Exceptions Should Be Eliminated or Substantially Narrowed

The States are very concerned that the Proposed Rule contains two entirely new exceptions that would likely be used by health insurers to circumvent the regulations, thus undermining the language and purpose of MHPAEA. Accordingly, to avoid creating major loopholes, these exceptions should be eliminated or substantially narrowed.

a. The "Medical Standards" Exception Lacks a Statutory Basis, is Unnecessary, Would Likely Be Abused by Health Insurers, and Would Conflict with Existing Regulations.

The exception for "independent professional medical or clinical standards" would allow a health insurer to evade the first (predominant/substantially all) and third (outcomes data) prongs of the NQTL test in their entirety so long as it makes some kind of showing that it designed and applied an NQTL "that impartially applies" such standards without deviating from them in any way. This vague standard is likely to be abused by health insurers and would be a substantial step backwards for MHPAEA compliance.

Not only does the proposed "medical standards" exception lack any basis in the MHPAEA text or regulations, but the Departments previously rejected a substantially similar version. The 2010 MHPAEA Interim Final Rule allowed a complete exemption from compliance with the NQTL regulations where "recognized clinically appropriate standards of care may permit a difference" between MH/SUD benefits and medical/surgical benefits.[72] The Departments repealed this troublesome exception when the Final Rule was issued in 2013, in part because some health insurers "may have attempted to invoke the exception to justify applying an NQTL to all mental health or substance use disorder benefits in a classification, while only applying the NQTL to a limited number of medical/surgical benefits in the same classification," based on the insurers' spurious contention that "fundamental differences in treatment of mental health and substance use disorders and medical/surgical conditions, justify applying stricter NQTLs to mental health or substance use disorder benefits than to

[71] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51578 (Aug. 3, 2023).
[72] Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5449 (Feb. 2, 2010) (codified at 45 C.F.R. pt. 146).

medical/surgical benefits under the exception[.]"[73] Ten years of health insurers' non-compliance with MHPAEA do not warrant restoring this exception. Additionally, because regulations already identify "[m]edical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative"[74] as an NQTL, adding a "medical standards" exception would create conflict and confusion.

The Departments understandably aver that they do not wish to create loopholes, and propose that the exception be narrowly tailored.[75] However, the Departments' suggestion that the "medical standards" exception be limited to "generally recognized independent professional medical or clinical standards [that are] independent, peer-reviewed, or unaffiliated with [health insurers],"[76] while helpful, does not address the question of how this exception is to be applied without undermining the regulatory requirements. Although illustrative Example 3 explains that a health insurer's purported reliance on this exception fails where it deviates from "medical standards" by imposing an additional peer-to-peer review requirement, not enough details are provided about the source or scope of the purported standards.[77] Illustrative Example 5 is more problematic, as it states in conclusory fashion that a hypothetical health insurer "impartially applies independent professional medical or clinical standards…in a manner that qualifies for the exception[]" without specifically explaining how the application is impartial.[78] The example then offers a recitation of the regulatory requirements, which the Departments have stated is insufficient to show compliance, and concludes that notwithstanding disparate denial rates the health insurer complies with MHPAEA.[79] The States are concerned that health insurers will rely on this insufficiently developed example as a shortcut to broadly invoke the clinical standards exception and therefore recommend that the Departments replace illustrative Example 5 with a more detailed and realistic example.

Although the "medical standards" exception would apply to the second prong (design and application) of the NQTL test, such standards would not be considered to discriminate against MH/SUD benefits. It is difficult to understand how an NQTL that satisfies the predominant/substantially all test and has been determined to be objective and unbiased could still be deemed to be discriminatory. Put simply, the "medical standards" exception is unworkable.

For the above stated reasons, the States urge the Departments to remove the "medical standards" exception. If it is not removed, the States respectfully request that the requirements for invoking the exception be made much stricter. For example, the regulatory language should state that a health insurer attempting to invoke the exception must prove by clear and convincing

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[73] Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68240, 68245 (Nov. 13, 2013) (codified at 45 C.F.R. pts. 146, 147).
[74] 45 C.F.R. § 146.136(c)(4)(ii)(A).
[75] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51578 (Aug. 3, 2023) (to be codified at 45 C.F.R. pts. 146, 147).
[76] *Id.*
[77] *Id.* at 51660-61 [Proposed 45 C.F.R. § 146.136(c)(4)(viii)(C) (Example 3)].
[78] *Id.* at 51661-62 [Proposed 45 C.F.R. § 146.136(c)(4)(viii)(E) (Example 5)].
[79] *Id*.

evidence that the purported "independent professional medical or clinical standard" justifies the exception. Furthermore, the regulation should state that standards developed by health insurers or their affiliates would not be eligible for the exception and that the health insurer must provide documentary evidence that the standard: (i) reflects input from multiple stakeholders and experts not affiliated with the health insurer; (ii) has been accepted by a national recognized provider, consumer, or accrediting organization not affiliated with the health insurer; and (iii) is based on independent scientific evidence.

b. The "Fraud, Waste, and Abuse" Exception Lacks a Statutory Basis, is Unnecessary, and Would Likely be Abused by Health Insurers.

The exception for "standards to detect or prevent and prove fraud, waste, and abuse" would allow a health insurer to evade the first and second prongs of the NQTL test so long as it makes some kind of showing that an NQTL is "reasonably designed to detect or prevent and prove fraud, waste, and abuse, based on indicia of fraud, waste, and abuse that have been reliably established through objective and unbiased data, and [is] narrowly designed to minimize the negative impact on access to appropriate mental health and substance use disorder benefits."[80] The "fraud, waste and abuse" exception lacks any basis in the MHPAEA text or regulations, has never before been proposed by the Departments, and none of the examples address its application. Further, the exception is wholly unnecessary, because if a health insurer implements a valid, reasonable anti-fraud program that limits the scope or duration of benefits for treatment, such program would fall under the definition of an NQTL and thus already be subject to MHPAEA regulations.[81]

The States, like the Departments, have a strong interest in combatting fraud, waste and abuse in health care. But it is telling that the Departments propose not to apply the "fraud, waste, and abuse" exception to the third prong of the NQTL test (outcomes data) because the tools "are more likely than independent professional medical or clinical standards to result in NQTLs that ***improperly restrict access*** to mental health or substance use disorder benefits and the impact of those NQTLs on access to mental health and substance use disorder benefits should be assessed" (emphasis added).[82] In essence, the Departments appear to be concerned that "fraud, waste and abuse" NQTLs may themselves be subject to "fraud, waste, and abuse."[83] This vague exception is likely to be abused by health insurers and would be a substantial step backwards for MHPAEA compliance. For example, in New York, a health insurer operates a program in which it applies claims utilization algorithms to psychotherapy treatment, attempting to justify the practice as a purported antifraud program.[84] For psychotherapy providers whose patients exceed a certain

[80] *Id*. at 51658 [Proposed 45 C.F.R. § 146.136(c)(4)(i)(E)].
[81] *See* 45 C.F.R. § 146.136(a).
[82] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51577 (Aug. 3, 2023) (to be codified at 45 C.F.R. pts. 146, 147).
[83] Such concerns apply equally to health insurers that might purport to rely on a "medical standard" exception, in particular where the health insurers have a structural conflict of interest. *See Wit v. United Behavioral Health*, 2023 WL 5356640, *12 (9th Cir. Aug. 22, 2023) (in case concerning appropriateness of health insurer's home-grown medical necessity criteria, affirming district court's factual findings that insurer had a structural conflict of interest and a financial conflict because it was incentivized to keep benefit expenses down).
[84] Prior to the enactment of MHPAEA, the health insurer required providers to submit detailed treatment plans before authorizing treatment. The current requirements for some providers are much more onerous.

quantity or frequency of treatment, the insurer withholds reimbursement and requires providers to submit detailed medical records for every treatment session. The insurer continues its voluminous record demands and pays claims only after 80% of the submitted medical records satisfy standards devised by the insurer, as determined by the insurer's staff.[85] Put simply, this is an abusive and wasteful utilization review program masquerading as an antifraud program.

Although the "fraud, waste and abuse" exception would not apply to the second prong (design and application) of the NQTL test, "fraud, waste and abuse" NQTLs would not be considered to discriminate against MH/SUD benefits.[86] It is difficult to understand how an NQTL that under the Proposed Rule does violate the predominant/substantially all test and is considered to be objective and unbiased (*i.e.*, not discriminatory)[87] could still violate the design and application test. Like the "medical standards" exception, the "fraud, waste and abuse" exception is unworkable.

For the above stated reasons, the States urge the Departments to remove the "fraud, waste, and abuse" exception. If it is not removed, the States respectfully request that the requirements for invoking the exception be made much stricter. For example, the regulatory language should state that a health insurer attempting to invoke the exception must prove by clear and convincing evidence that the purported "fraud, waste and abuse " NQTL is: (i) reasonably designed to detect or prevent and prove fraud, waste, and abuse; (ii) based on indicia of fraud, waste, and abuse that have been reliably established through objective and unbiased data; and (iii) narrowly designed to minimize the negative impact on access to appropriate mental health and substance use disorder benefits. Furthermore, the regulation should state that the "fraud, waste, and abuse" NQTL must be based on an independently designed and validated program with an empirically proven methodology, and that the NQTL be time limited.

V. The Departments Should Issue Guidance Containing an Example of a Compliant Comparative Analysis.

The States commend the Departments for issuing proposed regulations that would establish a clear six-step process for NQTL comparative analyses that is faithful to the text of CAA, reflects prior guidance,[88] and affirms that all NQTLs must be analyzed.[89] The Proposed Rule contains a high-level example of a comparative analysis for the NQTL of calculation of reimbursement rates for out-of-network providers, explaining that if the two factors used to determine how the NQTL applies to MH/SUD providers are (1) the geographic location of providers and (2) the licensing and accreditation of providers, the comparative analysis must

[85] The insurer's staff sometimes reject records as deficient for trivial reasons such as putting a session time in the wrong place.
[86] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51578 (Aug. 3, 2023) (to be codified at 45 C.F.R. pts. 146, 147).
[87] Id. at 51658 [Proposed 45 C.F.R. § 146.136(c)(4)(ii)(B)(2)].
[88] *See* Dep'ts of Labor, Health and Human Services, and the Treasury, FAQS about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 (April 2, 2021), https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf.
[89] Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51665-68 [Proposed 45 C.F.R. § 146.137] (Aug. 3, 2023) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R pt. 2590, 45 C.F.R. pts. 146, 147).

explain in detail how each factor is used to determine the out-of-network reimbursement rates for both MH/SUD and medical/surgical providers, describe how the two factors relate to each other, and address how the health insurer establishes any deviations or variations from these factors.[90] A more detailed example walking through the six steps contained in the proposed regulation would promote compliance.

VI. The Already-Effective CAA Amendments to MHPAEA and the Ongoing Mental Health and Addiction Crises Warrant Quickly Making the Proposed Rule Effective.

Although the States are appreciative of the Departments' considerable efforts in promulgating the Proposed Rule, as noted above, the CAA required guidance and regulations regarding comparative analyses to be finalized by June 27, 2022 (18 months after the date of enactment).[91] The comparative analyses relate to the three-prong test outlined in § 146.136(c)(i), (ii), and (iv), as well as proposed § 146.137. The States are troubled that the Departments propose that the Proposed Rule, if finalized, would not apply to group health plans until 2025 or to individual health plans until 2026.[92] Although the Departments correctly note that current regulations would continue to apply and that the comparative analysis requirements added to MHPAEA by the CAA, 2021 are self-implementing and took effect on February 10, 2021, delaying applicability of the Proposed Rule until up to five years after enactment of the CAA would also delay access to vital MH/SUD benefits. The Departments explain that new requirements may take time for health insurers to implement, but as described above, the requirements are not new but rather have already been spelled out in the statutory and regulatory text, as well as in guidance.

The States respectfully request that the Departments advance the Proposed Rule's effective dates to 2024 or, in the alternative, issue them as an interim final rule, as they did for their first set of MHPAEA regulations in 2010. This approach was upheld under the "good cause" exception to the notice and comment requirements of the Administrative Procedures Act based on the Departments' statutory authority to issue interim final rules and that the original version of MHPAEA had already become effective for many health plans.[93] The same rationales apply just as much if not more here, as the CAA amendments to MHPAEA have been effective for more than two and a half years. The ongoing mental health and addiction crises provide additional good cause for issuing an interim final rule.

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[90] *Id.* at 51591.
[91] Consolidated Appropriations Act, 2021 § 203(a)(1), 42 U.S.C. § 300gg-26(a)(8)(A).
[92] The Departments propose that the Proposed Rule would apply to group health insurance plans on the first day of the first plan year beginning on or after January 1, 2025, and to individual plans for policy years beginning on or after January 1, 2026. Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552, 51596 (Aug. 3, 2023) (to be codified at 45 C.F.R. pts. 146, 147).
[93] *Coalition for Parity, Inc. v. Sebelius*, 709 F. Supp.2d 10, 20 (D.D.C. 2010).

CONCLUSION

The Departments are crucial partners in the ongoing effort to ensure access to necessary MH/SUD treatment. For the foregoing reasons, the signatory States strongly support the increased protections offered by the Proposed Rule, which will close loopholes and implement the NQTL comparative analysis requirements of the 2021 CAA. Further, in order to strengthen these protections, we urge the Departments to implement the above improvements. The Departments' swift action in implementing these essential protections is a critical step in ensuring compliance with MHPAEA and improving the lives of millions.

Sincerely,

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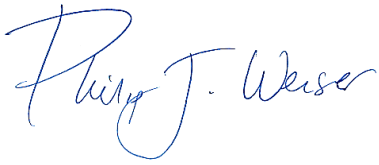
New York State Attorney General

ROB BONTA
California Attorney General

KWAME RAOUL
Illinois Attorney General



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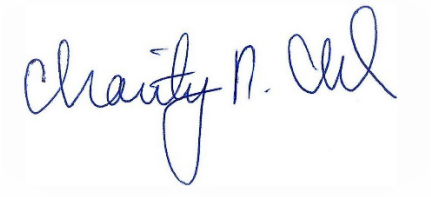

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