



October 17, 2023

Centers for Medicare and Medicaid
U.S. Department of Health and Human Services
Attention: CMS-9902-P

Employee Benefits Security Administration
U.S. Department of Labor
Attention: RIN 1210-AC11

Internal Revenue Service
U.S. Department of the Treasury
Attention: REG-1207270-21

Submitted via Regulations.gov

Re: Requirements Related to the Mental Health Parity and Addiction Equity Act (RIN 1210-AC11)

On behalf of the NYS Council for Community Behavioral Healthcare (NYS Council), thank you for the opportunity to comment on the Department of Health and Human Services, Employee Benefits Security Administration, and the Internal Revenue Service's (the "Departments") proposed rule, Requirements Related to the Mental Health Parity and Addiction Equity Act (hereinafter "2023 Proposed Rule").

The NYS Council is a statewide, non-profit, membership organization composed of 120 community-based organizations that provide recovery-focused mental health and/or substance abuse/chemical dependence and addiction treatment programs and services for New Yorkers in need. NYS Council members offer a broad array of behavioral health services designed to meet the unique needs of children and adolescents, individuals and families seeking our assistance. Our services are available in a variety of community settings including freestanding agencies, general hospitals, and county mental hygiene programs.

The NYS Council supports the 2023 Proposed Rule's overarching goal to increase access to mental health and substance use disorder (MH/SUD) treatment by addressing treatment limitations that place a greater burden on plan members' access to MH/SUD treatment than to medical/surgical treatment.

We vigorously support the provisions highlighted below and are especially supportive of the statement of the purpose of the regulations and law and the corresponding requirement that plans analyze the impact of a non-quantitative treatment limitation (NQTL) on access to MH/SUD services as part of the comparative analysis. We further support the data collection and reporting requirements of the rule,

particularly with respect to the comparative analyses of NQTLs and network composition, as such requirements are essential to ensure MHPAEA compliance given the longstanding history of practices to disparately limit access to MH/SUD services.

To fully realize the promise of the 2023 Proposed Rule's many extraordinarily strong provisions, however, the Departments must eliminate the proposed exceptions relating to "independent professional medical or clinical standards" and "fraud, waste, and abuse." To be clear, we absolutely support requirements for plans/issuers to follow independent professional medical / clinical standards (generally accepted standards of care) and believe it is critical to combat fraud, waste, and abuse to safeguard the health and well-being of consumers. However, as structured, the proposed exceptions threaten to swallow significant parts of the 2023 Proposed Rule, potentially making its promise of increased access to MH/SUD services by combatting discriminatory treatment limitations largely illusionary. Furthermore, we believe that these exceptions are not firmly based in MHPAEA's statutory text and that the underlying legitimate issues are most appropriately and effectively addressed within the existing (and proposed) NQTL rules.

Our full comments are as follows:

29 CFR § 2590.712, 45 CFR § 146.136, AND 26 CFR § 54.9812-1 – PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Purpose – (a)(1)

We strongly support the purpose of the 2023 Proposed Rule. If the problematic proposed exceptions to core requirements of the 2023 Proposed Rules are addressed, the Proposed Rule would significantly strengthen implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). When MHPAEA was enacted 15 years ago, the intent was to prohibit discriminatory treatment limitations that limit the "[scope or duration of treatment](#)." However, the current regulations have not always been sufficient to hold plans and issuers accountable for treatment limitations, including NQTLs, that place a greater burden on access to MH/SUD treatment as compared to comparable medical/surgical (M/S) benefits.

We have seen how plans and issuers have, at times, engaged in post-hoc rationalizations for why treatment limitations that place a greater burden on access to MH/SUD care are nonetheless compliant with the existing rules. While some state and federal regulators are increasingly holding plans and issuers accountable, the current regulations have not adequately placed the emphasis on the disparate burden that treatment limitations frequently place on plan members' access to MH/SUD treatment as compared to M/S treatment. **Instead, too often, plans and issuers (as well as many regulators) have lost sight of a fundamental, obvious question of MHPAEA: the degree to which a "treatment limitation," in fact, restricts access to MH or SUD treatment. We strongly support the Departments anchoring the purpose of MHPAEA, including its implementing regulations, to this fundamental question of whether plans/issuers' treatment limitations disparately limit access to MH/SUD treatment.**

Meaning of Terms – (a)(2)

We support the new and revised definitions in (a)(2) of the 2023 Proposed Rule. These changes significantly improve clarity and will increase access to care. The proposed changes to definitions of "mental health benefits" and "substance use disorder benefits" would ensure that the placement of

benefits is consistent with “generally recognized independent standards,” which are tied to the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the mental, behavioral, and neurodevelopmental disorders chapter of the International Classifications of Disease (ICD). The 2023 Proposed Rule would also ensure that any state laws that define MH/SUDs in a manner that conflicts with “generally recognized independent standards” does not reduce plan members’ protections under MHPAEA. **This has particularly been an issue where autism spectrum disorder (ASD) benefits have been defined as M/S benefits, even though this is contrary to generally recognized independent standards as reflected by the DSM and ICD. Where this has occurred, individuals with ASD have been denied MHPAEA protections.**

We also strongly support the Departments’ proposed definitions for key terms relating to NQTLs – “evidentiary standards,” “factors,” “processes,” and “strategies.” The lack of definitions for these terms, which are foundational to MHPAEA’s NQTL requirements, has hindered efforts to hold health plans accountable on discriminatory NQTLs due to frequent disagreements about their meaning.

Meaningful Benefits of Treatment of a Mental Health Condition or Substance Use Disorder – (c)(2)(ii)(A)

We support the provision requiring that if any MH or SUD benefits are provided in any classification of care, both MH and SUD benefits must be provided in all classifications of care and the scope of covered MH and SUD benefits in each classification must be “meaningful.” Though plans/issuers are already required to provide MH/SUD benefits in all classifications if they provide services in any classification, there has been a **lack of clarity on the breadth of MH and SUD services that must be covered**. This is a very important addition. *However, the lack of definition of the term “meaningful” would likely result in significant future disagreement about whether covered benefits are, in fact, “meaningful.”*

To address this issue, we request that the Departments not only define “meaningful” but also identify “scope of covered services” as an NQTL in the non-exhaustive NQTL list. Every plan/issuer limits the scope of covered services, and any limitation on covered services meets MHPAEA’s statutory definition of “treatment limitation” and the current regulations definition of NQTL (“nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage”). Given this, every plan/issuer should already be conducting NQTL analyses for “scope of covered services,” yet we are aware of none that do so. If the Departments identified “scope of covered services” as an NQTL, they would remove any ambiguity that a plan/issue must identify, for any excluded service, the “factor” and “evidentiary standard” that the plan/issuer used for M/S exclusions within the classification of care and determine whether the MH/SUD exclusion met the NQTL comparability and stringency test. A “scope of covered services” NQTL would also be subject to the 2023 Proposed Rule’s requirements relating to outcomes data and actions to address access disparities.

Examples Relating to Prohibited Exclusions of Autism and Eating Disorder Coverage – (c)(2)(ii)(C)

We strongly support the addition of new examples in the 2023 Proposed Rule, which would make clear that **exclusions of key services for autism spectrum disorder (Applied Behavioral Analysis, or ABA) and eating disorders (nutritional counseling) violate MHPAEA**. While the Departments have already been taking enforcement action against plans/issuers’ discriminatory exclusions of ABA therapy and nutritional counseling, these examples will remove any remaining ambiguity that these exclusions are inconsistent with MHPAEA’s requirements.

Substantially All / Predominant Test for NQTLs – (c)(4)(i)

We strongly support applying the substantially all / predominant test to NQTLs. The statutory language of MHPAEA is unambiguous in its requirement that treatment limitations applicable to MH/SUD benefits must be “no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits...” This test already applies to financial requirements and quantitative treatment limitations, and it should apply to NQTLs as well, which are also a “treatment limitation” under MHPAEA. Thus, we agree with the 2023 Proposed Rule’s requirement that, if an NQTL is not applied to “substantially all” (i.e., two-thirds under the longstanding regulations) M/S benefits within a classification of care, plans/issuers may not apply the NQTL to MH/SUD benefits within that classification. If a plan/issuer does apply an NQTL to “substantially all” M/S benefits within a classification of care, a plan/issuer must then show that the NQTL applied to MH/SUD benefits within that classification is no more restrictive than the predominant variation applied to M/S benefits within the classification.

“Independent Professional Medical or Clinical Standards” Exception to NQTL Requirements – (c)(4)(i)(E), (c)(4)(ii)(B), (c)(4)(iv)(D), and (c)(4)(v)(A)

We support the Departments’ desire to incentivize plans/issuers to follow “independent professional medical or clinical standards (consistent with generally accepted standards of care)” when imposing NQTLs. All plans/issuers should be following these standards and adherence to clinical standards is often identified as a factor or evidentiary standard in NQTL analysis.

However, we urge the Departments to remove the exception, which we believe is flawed and may be exploited by plans/issuers to limit access to needed MH/SUD services. While we appreciate the Departments’ statement in the preamble that this exception (along with the “fraud, waste, and abuse” exception) is meant to be “narrow,” the experience of individuals and families under the existing regulations indicates that some plans/issuers may seek to exploit both exceptions.

We remind the Departments that they included a “clinically appropriate standards of care” exception to MHPAEA’s NQTL requirements in their previous interim final regulations. Yet, in the final regulations, the Departments removed this exception. The Departments [wrote](#):

[C]ommenters raised concerns that this exception could be subject to abuse and recommended the Departments set clear standards for what constitutes a “recognized clinically appropriate standard of care.” For example, commenters suggested a recognized clinically appropriate standard of care must reflect input from multiple stakeholders and experts; be accepted by multiple nationally recognized provider, consumer, or accrediting organizations; be based on independent scientific evidence; and not be developed solely by a plan or issuer. Additionally, since publication of the interim final regulations, some plans and issuers 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. These plans and issuers generally argue 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 medical/surgical benefits under the exception in the interim final regulations. [emphasis added]

We urge the Departments not to repeat this mistake again. In 2013, the Departments correctly determined that, rather than an exception, clinical appropriateness was most properly placed squarely within the framework of the regulations' NQTL requirements. Furthermore, we believe that such an exception lacks a firm basis in MHPAEA's statutory text, which requires that treatment limitations applicable to MH/SUD benefits be no more restrictive than the predominant treatment limitations applied to substantially all M/S benefits and includes no exceptions to this standard. We also note that the Consolidated Appropriations Act, 2021's (CAA, 2021) amendments to MHPAEA put into statute MHPAEA's NQTL regulatory framework without any exceptions to the NQTL framework.

Additionally, we believe the "independent professional medical or clinical standards" exception is likely unworkable. For example, if a plan/issuer claimed that independent professional medical or clinical standards justified the imposition of prior authorization or retrospective review under the "design and application" test ((c)(4)(ii)), how would the substantially all / predominant test ((c)(4)(i)) be applied to the prior authorization or retrospective review NQTL? Also, how would outcome data collection and analysis requirements ((c)(4)(iv)) assess an NQTL's impact on access if a plan/issuer could just claim that some undetermined part of the decreased access was due to following purported "independent professional medical or clinical standards"?

Even if we believed that an "independent professional medical or clinical standards" exception were theoretically appropriate or workable, we have deep concerns that this term's current ambiguity and lack of definition will allow the exception to negate the proposed strengthened NQTL requirements in paragraphs (c)(4)(i)(E), (c)(4)(ii)(B), and (c)(4)(iv)(D). If the Departments permit this to occur, the Departments' fundamental objective in putting forward the 2023 Proposed Rule will be severely undermined, and individuals will still be subjected to discriminatory treatment limitations that restrict access to care. In fact, we fear that the exception could even result in the 2023 Proposed Rule weakening the existing regulations.

Therefore, we urge the Departments to remove this exception **and instead** strengthen NQTL requirements relating to medical necessity/appropriateness. We urge the Departments to put in place the following requirements:

- **Evaluate divergence from "independent professional medical or clinical standards."** The Departments should require plans/issuers to analyze how any MH or SUD criteria/guidelines that plans use diverge from "independent professional medical or clinical standards." Such an analysis would also be done for M/S benefits within the classification of care and would be subject to the NQTL comparability and stringency test. Given the Departments have previously found that plans/issuers have simply issued conclusory or generalized statements of compliance, it would be critically important for the Departments to analyze criteria/guidelines that plans use to ensure the accuracy of plans' conclusions. Further, the Departments should utilize groundbreaking work done by the New York State Office of Mental Health (NYS OMH), which evaluated mental health plans' medical necessity criteria against "Guiding Principles" that represent generally accepted standards of care. In its reviews of 69 health plans' criteria, NYS OMH found that every plans' criteria was deficient. If plans exclusively utilize specified nonprofit clinical specialty association criteria/guidelines, the Department could permit plans/issuers not to conduct such an evaluation for these specified nonprofit criteria/guidelines.
- **Require specific data reporting for the medical necessity/appropriateness.** The special rule should require specific data collection and analysis requirements relating to medical

necessity/appropriateness. Such data should include the number of authorizations issued for participants/beneficiaries by each of the levels (and sub-levels) of care described in The American Society of Addiction Medicine (ASAM) Criteria and the age-specific Level of Care Utilization System (LOCUS) family of criteria developed by the American Association of Community Psychiatrists and the Academy of Child and Adolescent Psychiatry, as well as the average length of stay / treatment units and denial rates by each of these levels of care.

- **Prohibit plans/issuers from withholding their criteria/guidelines for MHPAEA review.**

We have heard disturbing reports that plans/issuers do not make the criteria/guidelines they use available for MHPAEA compliance reviews. Where NQTLs rely on such criteria/guidelines that are not made available to regulators, it would be impossible to determine the NQTL's MHPAEA compliance. The Departments noted in their [2023 MHPAEA Report to Congress](#) that plans/issuers did not provide external guidelines they claimed to use as evidentiary standards. The Departments should explicitly require that plans/issuers make available any criteria/guidelines they use to federal and any applicable State authorities, without any exceptions for criteria/guidelines that are "proprietary" or have "commercial value."

If the Departments impose such requirements, it will be essential that they tightly define "independent professional medical or clinical standards" and tie these standards to criteria/guidelines from the relevant nonprofit clinical specialty associations. Key nonprofit criteria include the ASAM Criteria and the age-specific LOCUS family of criteria.

Tying this definition to nonprofit clinical specialty association guidelines and criteria is essential because they are:

- **Fully transparent and accessible.** Consumers, providers, and other stakeholders can readily access the criteria being used to determine whether specific MH/SUD services are, in fact, appropriate to meet individual patient needs.
- **Developed through a consensus process that protects against conflicts of interest.** The authors and reviewers of nonprofit criteria are publicly identified. Credentials and expertise can be evaluated by the public.
- **Externally validated.** Nonprofit clinical criteria are subject to rigorous peer review, validation studies in real-world clinical settings, and are reviewed in professional and scholarly journals.

In fact, as early as 1997, [research published in the American Journal of Psychiatry](#), the official, peer-reviewed journal of the American Psychiatric Association, sounded warning bells, concluding that: "Our findings underscore the necessity of determining the validity of all criteria used to assess the appropriateness of medical care. Wide acceptance of an instrument is clearly not sufficient to justify its use . . . The need for validation studies is particularly great when proprietary criteria are not available for public scrutiny."

To address this critical issue, an increasing number of states are adopting a strong definition of "generally accepted standards of care" for MH/SUDs. Strong definitions have been enacted in [Illinois](#), [California](#), [Georgia](#), and [New Mexico](#). We support the following version of these definitions for "independent professional medical or clinical standards," which we view as synonymous with "generally accepted standards of care":

“Independent professional medical or clinical standards” mean standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, social work, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of [MH/SUD] care are peer-reviewed scientific studies and medical literature, recommendations of federal government agencies, drug labeling approved by the United States Food and Drug Administration, and recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines.

Finally, we note that the Departments’ example framing in the preamble of “independent professional medical or clinical standards” – that these standards “must be independent, peer-reviewed, or unaffiliated with plans and issuers” – is too weak. Such a framing could allow for nontransparent, proprietary criteria created by for-profit companies to establish “the independent professional medical or clinical standards,” because it would likely be argued that such criteria are developed “independently” (even if they financial self-interest exists), “peer-reviewed” (even if the reviewers are unidentified and must not disclose conflicts of interest), and “unaffiliated with plans and issuers” (even though such companies’ financial interests may be aligned with plans/issuers to have criteria used to limit access to needed treatment). We believe any such requirements must be much stronger as outlined above. Use of “independent professional medical or clinical standards” should require that the full detail of the standards be publicly available, including the process utilized to develop the standards, identifying individuals responsible for developing the standards, and the specific peer-reviewed literature or other information relied upon to justify the standards. Professional medical clinical standards are by their nature an ongoing and evolving consensus across the professional community. No position on professional standards can be legitimate unless it is available in full detail to be considered, criticized, discussed, and judged by the entire professional community.

“Fraud, Waste, and Abuse” Exception to NQTL Requirements – (c)(4)(i)(E), (c)(4)(ii)(B), and (c)(4)(v)(B)

There is no place for fraud, waste, and abuse in MH/SUD services, just as there is no place for fraud, waste, and abuse in M/S services. We strongly support efforts to ensure that individuals needing MH/SUD care receive the most clinically appropriate care, which is why it is so important for both providers and payers to follow generally accepted standards of care. Unfortunately, we know that many health plans have sought to exploit claims of “fraud, waste, and abuse” to deny or otherwise limit access to medically necessary care. **The largest sources of waste and abuse are not related to behavioral health.**¹ As reported by the DOJ, the most substantial cases have been related to durable medical equipment (DME), compounding pharmacies, pain clinics, hospices, and diagnostic laboratories. Additionally, upcoding for expensive medical services accounts for 2 percent of all provider fraud cases but has a high financial impact.² Therefore, **we do not support the Departments’ attempts to create a “fraud, waste, and abuse” exception to the NQTL requirements in paragraphs (c)(4)(i)(E) and (c)(4)(ii)(B).** While we support plans/issuers’ legitimate efforts to combat, prevent and detect fraud, waste, and abuse, the Departments’ proposed exception (like the independent professional medical or clinical standards exception) has the potential to negate the proposed stronger NQTL requirements.

To combat fraud, waste, and abuse, plans/issuers should incorporate “fraud, waste, and abuse” as a factor for numerous NQTLs. Importantly, these NQTLs are then subject to MHPAEA’s comparability and

stringency tests for MH/SUD and M/S. This is the appropriate way to ensure the plans are not inappropriately limiting MH/SUD treatment under the guise of efforts to combat “fraud, waste, and abuse.” Locating “fraud, waste, and abuse” within the existing and proposed NQTL requirements also has the advantage of being well-grounded in MHPAEA’s statutory text. In contrast, there is no “fraud, waste, and abuse” exception in MHPAEA’s statutory text that would allow plans/issuers to avoid MHPAEA’s NQTL requirements, which the CAA, 2021 incorporated into the MHPAEA statute.

As we described above for the “independent professional medical or clinical standards” exception, we also believe this exception is broadly unworkable. For instance, it is unclear how plans/issuers that use “fraud, waste, and abuse” as a factor in designing and applying an NQTL would perform the substantially all / predominant test. We do not believe the Departments have made clear the answer.

Prohibition on Discriminatory Factors and Evidentiary Standards – (c)(4)(ii)(B)

We strongly support this provision, which prohibits a plan/issuer from relying on any factor or evidentiary standard if it discriminates against MH/SUD benefits. This self-evident provision is necessary to ensure that plans/issuers, in designing and applying any NQTL, do not simply attempt to launder their discriminatory intent by relying on a factor or evidentiary standard that itself is discriminatory. This can occur when plans/issuers rely on and perpetuate historic data or discriminatory structures as the basis for how they have designed and applied an NQTL or apply metrics that have not been subject to MHPAEA. For example, plans commonly justify discriminatory reimbursement rates by citing the Medicare Fee Schedule. Of course, Medicare is not subject to MHPAEA and has long undervalued MH/SUD services. The Centers for Medicare & Medicaid Services (CMS) have recognized this [undervaluation](#) in recently proposed updates to the reimbursement rate for psychotherapy in the Medicare Physician Fee Schedule (PFS), but they acknowledge that they still need to develop systemic solutions to longstanding process limitations. In the meantime, MH and SUD clinicians account for [almost half](#) of the total providers who opt out of Medicare, with [low reimbursement rates](#) cited as a key factor affecting provider willingness to accept insurance and join networks. Given how frequently the Medicare Fee Schedule is used to justify discriminatory MH/SUD reimbursement, we urge the Departments to specify that utilizing the Medicare PFS to justify reimbursement rates will fall within the proposed prohibition of (c)(4)(ii)(B).

Non-Exhaustive List of NQTLs – (c)(4)(iii)

We support the revisions to the list of NQTLs, including relating to “network composition,” and the clarification that this list is “non-exhaustive.” As referenced above, we urge the Departments to add “**scope of covered services**” as an identified NQTL.

Required Use of Outcomes Data & Actions to Address Material Differences in Access – (c)(4)(iv)(A-B)

We strongly support this provision to require a plan/issuer to collect and evaluate relevant data to assess the impact of the NQTL on MH/SUD and M/S benefits and to tie the “type, form, and manner of collection and evaluation” of data to guidance that can be periodically updated. The collection of data using standardized definitions and methodologies is critical to assessing an NQTL’s impact on access to MH/SUD and M/S care. A core failing of the existing MHPAEA regulations is that an NQTL’s impact on access to MH/SUD as compared to M/S treatment is rarely appropriately measured and analyzed. Instead, plans/issuers rely on process-related justifications and arguments to inappropriately justify disparate access to treatment.

We urge the Departments to clarify that outcome data must be separately reported for MH and SUD services to conform to the statutory standard. Experience has also demonstrated that a plan/issuer’s

performance for one set of benefits (either MH or SUD) does not necessarily reflect performance for the other set of benefits.

We also strongly support the requirement that plans/issuers must take “reasonable action” to address differences in access shown by this data. However, we are concerned that the proposed action would only be necessary when such differences are “material,” a term that is not defined. We note that MHPAEA’s statutory “no more restrictive” standard is stronger and does not require a “material difference.” Consistent with the statute’s “no more restrictive” standard, we urge the Departments to require plans to take action whenever the data shows *any* difference in access. If the Departments do not alter the “material differences” standard, we believe the Departments must narrowly define the meaning of this term, with a low threshold. Without a definition, plans/issuers will be left to determine whether the differences in access shown by the data are “meaningful.” Such a situation will make it extraordinarily difficult for the Departments or any applicable State authority to hold plans accountable.

Special Rule for NQTLs Related to Network Composition – (c)(4)(iv)(C)

We strongly support the new proposed rules relating to “network composition,” which would address many of the access issues encountered by individuals seeking MH/SUD care. The special rule relating to network composition NQTLs is particularly powerful because a plan/issuer would fail to meet the requirements of (c)(4)(i) and (c)(4)(ii) “if the relevant data show material differences in access to in-network mental health and substance use disorder benefits as compared to in-network medical/surgical benefits in a classification.” This strong requirement should be maintained.

Effect of Final Determination of Noncompliance – (c)(4)(vii)

We strongly support the provision that gives the Secretaries the ability to direct that a plan/issuer not impose an NQTL after a final determination of noncompliance and urge the Departments to change the “may” to a “shall” to indicate that the plan will not be permitted to apply a non-compliant NQTL. This standard is consistent with (c)(4), which makes clear that a plan that fails to meet any of the NQTL standards cannot impose the limitation and the current (h), which bars the sale of any plan that does not comply with the NQTL standards. We strongly urge the Departments to clarify that, if a plan/issuer cannot demonstrate that an NQTL is compliant, it should not be allowed to be imposed. Otherwise, the Departments are allowing plan members to be subject to noncompliant treatment limitations. The result will inevitably be individuals who are wrongly denied access to needed MH/SUD services, placing the health, well-being, and potentially lives of these individuals at risk. Furthermore, we urge the Departments to add provisions that, if a plan/issuer does not comply, the Departments will work with the Internal Revenue Service to assess penalties allowed by MHPAEA.

Furthermore, this power should clearly be available, not just to Secretaries of the relevant federal regulator, but to any applicable State authority as well, as set out in the HHS proposed section 146.137(e)(1). State insurance departments have played a leading role enforcing MHPAEA, particularly given the federal Departments’ inadequate resources that allow them to review only a small fraction of overall plans/issuers. They should clearly have authority to make such a determination under the 2023 Proposed Rule.

For too long, there have been no meaningful consequences when plans/issuers have violated MHPAEA. Through widespread inaction, insignificant to no penalties for failure to conduct a complete NQTL

analysis and clear violations or anemic consequences, state and federal regulators have prioritized plans/issuers' interests and profits over the ability of individuals to receive needed MH/SUD care. It is now finally time to put teeth into the rules and prohibit plans/issuers from imposing treatment limitations that are not in compliance with MHPAEA. Stopping the non-compliant NQTLs is a critical step in incentivizing plans to evaluate NQTLs more carefully as they design and apply plan benefits and during the comparative analysis.

29 CFR § 2590.712-1, 45 CFR § 146.137, AND 26 CFR § 54.9812-2 – NONQUANTITATIVE TREATMENT LIMITATION COMPARATIVE ANALYSIS REQUIREMENTS

We strongly support the addition of new requirements relating to plans/issuers' NQTL comparative analyses that they are required to conduct under amendments to MHPAEA enacted as part of the CAA, 2021. These detailed requirements are necessary to ensure there is clarity on what plans/issuers' analyses must contain and hold plans accountable for following these requirements.

We also appreciate language relating to providing participants/beneficiaries with information summarizing changes the plan/issuer "has made as part of its corrective action plan following the initial determination of noncompliance, including an explanation of any opportunity for a participant or beneficiary to have a claim for benefits reprocessed." Yet, this language appears to place the burden on the participant/ beneficiary to identify that they may have been impacted by a noncompliant NQTL and pursue remedies (presumably through some unidentified pathway). Instead, we strongly recommend that the Departments squarely place the burden on the plan/issue to identify affected participants/beneficiaries, reprocess any claims, etc. and thereby notify those who they determine have been impacted by the non-compliant NQTL. We commend the agencies for appropriately shifting the burden away from consumers throughout this proposed rule, and we urge a consistent approach here.

The framing of the notice as an "opportunity" for a participant/beneficiary to have a claim for benefits reprocessed must be revised to be clear that the plan is responsible for notifying the individual and reprocessing the claim. The Plan is in a much better position than the individual to know which claims and which beneficiaries have been impacted. We request that the Departments incorporate into the 2023 Proposed Rule an affirmative obligation for plans/issuers, as part of a corrective action plan, to identify affected participants/beneficiaries, reprocess any claims, and take any other necessary steps to rectify the harms caused.

45 CFR § 146.180 – TREATMENT OF NON-FEDERAL GOVERNMENT PLANS

We support the language implementing the elimination of self-funded non-federal government plans' ability to opt out of MHPAEA. Hundreds of thousands of public employees and their family members have for too long been denied critical protections as [their public-sector employer affirmatively opted-in to discriminating against individuals needing MH/SUD services](#).

We urge the Department of Health and Human Services to prioritize robust MHPAEA compliance reviews of these plans as soon as their opt out is no longer valid. This is particularly important given that many of these public sector plans opted out of MHPAEA specifically because they wished to continue discriminatory treatment limitations on MH/SUD benefits. The Department should immediately request plans' NQTL compliance analyses to ensure they are taking the necessary steps to comply with MHPAEA.

OTHER ISSUES

Third-Party Administrators (TPAs)

The Departments have asked for feedback on how third-party administrators (TPAs) “could be further incentivized to facilitate compliance with MHPAEA.” We agree with the Departments concern about this issue and urge the Departments (but particularly the Department of Labor, or “DOL”) to use all possible avenues to hold both self-funded plan sponsors and TPAs administrators accountable for MHPAEA compliance. Recent [reports](#) have highlighted ongoing problems where TPAs, who are the experts in health plan design and administration and who make critical coverage decisions, refuse to provide essential information, including data, to the employer plan sponsor by claiming that such information is “proprietary” or has “commercial value.” TPAs’ refusal to provide information and data on plan design and access to benefits fundamentally inhibit MHPAEA compliance and cannot be allowed to stand. The Departments should require in the 2023 Proposed Rule that plan sponsors must, as part of MHPAEA compliance, insert provisions into their contracts with TPAs that any information or data that may be relevant to MHPAEA compliance must be provided to the plan sponsor. In 2015’s MHPAEA [FAQ XXIX](#) (Q12), the Departments made clear that information purported to be of “proprietary” or “commercial value” must be provided to plan members’ upon request. The Departments have also reiterated this in the 2023 Proposed Rule’s [preamble](#). Relatedly, we urge the Departments in (d)(3), “Provisions of other law,” to add the following sentence, with any adjustment for code-specific terms, so that the regulations make clear no part of the comparative analyses or other application information required by 29 CFR § 2590.712-1 / 45 CFR § 146.137 / 26 CFR § 54.9812-2 may be withheld: “All requested plan information shall be made available to claimant and may not be withheld as proprietary or commercially protected information.”

We believe that, particularly for DOL (the Department for which this question is most relevant), the suggestion that plans need to be “further incentivized” to comply with MHPAEA is problematic. Rather, we urge DOL to hold TPAs accountable as ERISA fiduciaries and co-fiduciaries. Under 29 U.S.C. 1132(a)(5), DOL may bring legal action against any fiduciaries that violate MHPAEA, including TPAs, as incorporated into ERISA through 29 U.S.C. 1185a. Further, under 29 U.S.C. 1134, DOL is granted the power, “in order to determine whether any person has violated or is about to violate any provision of this subchapter,” including MHPAEA, and to “make an investigation” and to “inspect such books and records and question such persons as he [the Secretary] may deem necessary to enable him [the Secretary] to determine the facts relative to such investigation.” Thus, DOL may investigate TPAs for acts or practices that violate MHPAEA and can sue to enjoin such practices. Finally, DOL is authorized under 29 U.S.C. 1135 to “prescribe such regulations as he finds necessary or appropriate to carry out the provisions of this subchapter.” We urge DOL to use its substantial authority and discretion to ensure that TPAs have adopted policies and procedures that are MHPAEA-compliant.

MH/SUD Emergency (“Crisis”) Services

The Departments have requested feedback relating to MH/SUD crisis services under MHPAEA and the Affordable Care Act’s Essential Health Benefits (EHB) categories for non-grandfathered individual and small group coverage. Federal policymakers have dedicated enormous effort to standing up the 988 Suicide and Crisis Lifeline and expanding MH/SUD crisis services, which help people get the help they need and avoid needless, and often tragic, encounters with law enforcement. Yet, while every benchmark plan includes EMS and emergency transport services, none includes appropriate MH/SUD crisis (i.e., emergency) services. This failure to include MH/SUD crisis services under EHB means that many people do not have appropriate coverage of these services. Most mobile crisis services are supported by a combination of Medicaid coverage and local tax funds, where crisis providers report

regularly providing crisis services to persons covered by commercial coverage and Medicare since it is not appropriate or feasible to acquire insurance coverage crisis. Commercial coverage and Medicare should be carrying their fair share of the cost of this new national emergency first responder system. A number of states, including [California](#), [Virginia](#), and [Washington](#), have recently required health plans to cover MH/SUD crisis services. Washington has made clear that [coverage of MH/SUD crisis services is necessary for health plans to comply with MHPAEA](#). The Department of Health and Human Services (HHS) should include MH/SUD crisis services within the MH/SUD EHB category, and the Departments should make clear in the 2023 Proposed Rule that, if a plan/issuer covers physical health emergency services (including EMS and emergency transport), it must cover comparable MH/SUD emergency/crisis services (including mobile crisis response) under the same standards (e.g., no prior authorization).

Provider Directory Requirements

The Departments have requested feedback on how to improve provider directories through rulemaking. We urge the Departments to **require periodic independent third-party testing of provider directories to assess the accuracy of information and that a sufficient percentage of providers are accepting new patients**. HHS has already put forward strong proposed standards for Medicaid managed care and the Children’s Health Insurance Program ([CMS-2439-P](#)), which establish maximum appointment wait time standards for routine outpatient mental health and substance use disorder services of 10 business days and require such independent secret shopper surveys. This proposed rule should be a model for the Departments in individual and group plans. Additionally, plans and issuers should be required to identify providers who are available via telehealth. Finally, the Departments should ensure that **participants/beneficiaries who cannot access in-network services on a timely basis can access out-of-network services, with their out-of-pocket costs no greater than the amounts that they would have paid for the same services received from an in-network provider**.

Claims Procedure Requirements

The Departments have requested feedback on how the ACA and ERISA’s existing claims procedure requirements can facilitate access to MH/SUD benefits. Most fundamentally, the HHS and DOL must strengthen enforcement with existing claims procedure requirements, which in our experience are frequently not followed with little apparent consequence. To strengthen participants/beneficiaries’ ability to challenge inappropriate denials of MH/SUD care, HHS and DOL should, at minimum, make clear that plans/issuers’ NQTL compliance analysis must be made available upon request, with no restrictions for information purported to be “proprietary” or “commercial value.” While we believe this is HHS and DOL’s interpretation of existing law, making this explicit in the claims procedure requirements is important. HHS and DOL should also require that, for any adverse benefit determination relating to MH/SUD, the explanation of benefits should contain instructions on how to request and receive any NQTL compliance analysis(es) related to the determination. The requirements should include phone number, email, and address where such a request could be submitted. We also support the Departments’ suggestion that a plan/issuer be required to identify a lower level of care that it believes would be more appropriate along with information related to the coverage of such service in the plan and the availability of network providers to deliver the lower level of service, as well as the Departments’ suggestion that the plan/issuer provide an explanation of how a particular NQTL was applied to particular benefits. Finally, HHS and DOL should put in place meaningful enforcement mechanisms to ensure that plans/issuers fulfill their obligation to provide participants/beneficiaries with legally required information, upon request. We believe meaningful consequences must include reversal of any adverse benefit determination associated with the request. A potential mechanism is directing independent review organizations (IROs) to reverse adverse benefit determinations when plans fail to provide claimants with information requested during the internal appeals process. Otherwise, the

claims' procedure requirements to provide information are toothless, and the external appeal process is a meaningless alternative to litigation.

HHS Must Propose and Finalize MHPAEA Rules for Medicaid

While we appreciate the 2023 Proposed Rule, which affects individual and group health plans, it is imperative that HHS move quickly to propose and finalize rules for Medicaid managed care, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans (ABPs) without delay after the finalization of this proposed rule. *The Administration must not allow a strong set of MHPAEA rules for individuals in individual and group plans, but a weaker set of rules for individuals in Medicaid managed care, CHIP, and ABPs.* This is particularly critical given that these plans serve lower-income individuals and families who are disproportionately Black, Latino, Native American, and from other marginalized and underserved communities. HHS must also finally hold state Medicaid agencies accountable for strong oversight, given most states' deeply inadequate MHPAEA enforcement efforts.

The NYS Council appreciates the opportunity to provide these comments. We welcome any questions or further discussion about the recommendations described here. Please contact Lauri Cole, Executive Director, at lauri@nyscouncil.org. Thank you for your time and consideration.

Sincerely,

A handwritten signature in black ink that reads "Lauri Cole". The signature is written in a cursive, flowing style.

Lauri Cole
Executive Director
NYS Council for Community Behavioral Health