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October 17, 2023

SUBMITTED VIA REGULATIONS.GOV

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

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

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

RE: Requirements Related to the Mental Health Parity and Addiction Equity Act

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

I write in opposition to the proposed rules published by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (Tri-Agencies) titled "Requirements Related to the Mental Health Parity and Addiction Equity Act."¹ The proposed rules exceed statutory authority and add complexity and confusion to already opaque and subjective parity requirements, which will hurt patients.

The goal of providing parity between mental health benefits and other medical benefits provided under employer-sponsored health coverage is something that this Committee has endorsed. The Committee has overseen the passage and implementation of the *Mental Health Parity Act of 1996*, the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA), the *Affordable Care Act*, and the *Consolidated Appropriations Act, 2021* (CAA). As a principal committee of jurisdiction, the Committee has long been involved in the mental health parity debate.

¹ 88 Fed. Reg. 51,552 (proposed Aug. 3, 2023) [hereinafter Proposed Rules].

The Committee has grave concerns that the Tri-Agencies' proposed rules will serve only to weaken parity compliance by giving prominence to bureaucratic reporting, paperwork, and audits. This will pull funding, time, and resources away from helping patients struggling with mental health and substance use disorder (MH/SUD) and will shift valuable resources to meaningless paperwork requirements. Additionally, if the Tri-Agencies make it so difficult for virtually all plans to comply with mental health parity reporting requirements, then the Tri-Agencies will find it increasingly difficult to differentiate bad actors from plans that are trying in good faith to comply with parity laws. The Committee additionally has concerns that the lack of specific guidance allows the Tri-Agencies to open an audit and investigation against any plan sponsor it chooses. This unlimited auditing authority violates the constitutional rights of businesses and goes beyond the scope of the law.

The Tri-Agencies' Guidance is Unclear and Subjective

The Committee has repeatedly called on the Tri-Agencies to release additional guidance to define minimum standards for the adequacy of compliance and documentation.² Unfortunately, the proposed rules not only fall short of providing clear guidance, but they also significantly add to the complexity, burden, and subjective nature of demonstrating parity compliance. Fundamental questions remain unanswered about the appropriate scope and design of documentation for many aspects of the comparative analysis.

This ambiguity is highlighted in the proposed rules, which note findings by DOL that after the enactment of the CAA, not one submitted analysis was sufficient to meet the Tri-Agencies' largely unarticulated standards.³ Instead of following Congress' express statutory direction⁴ for the Tri-Agencies to provide additional guidance so that plans can meet their statutory obligation, the proposed rules only add more requirements and complexity.

List of NQTLs

The Tri-Agencies' proposed changes to the definition of "mental health benefits" and "non-quantitative treatment limitations" (NQTLs) make it nearly impossible for plans to demonstrate compliance with reporting requirements. The Tri-Agencies "propose to amend the definition of 'treatment limitation' to clarify that the illustrative list of NQTLs to which the definition refers is non-exhaustive."⁵ By making the list of NQTLs non-exhaustive, the Tri-Agencies place the burden on plans to identify the scope of NQTLs. This creates great ambiguity and leaves plans confused about the scope of documentation required in the reports.

The Tri-Agencies should create an exhaustive list of NQTLs on which plans are required to report. Defining such a list will facilitate plans' responsiveness to regulator requests for information relating to the core NQTLs, particularly upon short notice.

² <https://edworkforce.house.gov/news/documentsingle.aspx?DocumentID=408614>.

³ <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>.

⁴ 29 U.S.C. § 1185a(a)(6).

⁵ Proposed Rules, *supra* note 1, at 51,568.

Additionally, the Committee strongly urges the Tri-Agencies to provide model comparative analyses to illustrate the minimum standards for fulfilling the comparative analysis and documentation requirements. Issuance of standardized de-identified examples of comparative analyses would save tremendous resources and guesswork on the part of health plans and employers, ensure the documentation submitted to regulators is correct and comparable, diminish the time auditors spend on an audit, and help to maintain consistency in enforcement.

Outside the Scope of Law

The proposed rules far exceed congressional intent in the MHPAEA. The term “substantially all” is used only in respect to annual and lifetime limits, which are quantitative treatment limitations (QTLs).⁶ It is inappropriate to apply them to NQTL. Additionally, Congress never intended for the Tri-Agencies to require that plan sponsors measure outcomes. Further, the Tri-Agencies have no business determining the reimbursement rates for providers for the purposes of measuring parity. This is beyond the scope of the law.

Substantially All Test and Predominant Test

The Tri-Agencies’ requirements to apply the “substantially all” test and “predominant test” regarding NQTLs is contrary to congressional intent and amounts to a benefit mandate on plans. The proposed rules seek to require plans and issuers to ensure that NQTLs applied to mental health and the “substantially all” test only apply to quantitative treatment limitations. The MHPAEA uses the term “substantially all” when discussing “financial requirements” and “treatment limitations.”⁷ “Financial requirements” is defined as including “deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit,” and “treatment limitations” is defined as including “limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.”⁸ Both of these definitions are considered quantitative treatment limitations because they are clearly numerical standards. The Committee disagrees with the Tri-Agencies’ assessment that the proposed rules “more closely mirrors the statutory language” and is dismayed that the Tri-Agencies provided no further justification for this change in interpretation of the statute.⁹

Congress did not intend to include NQTLs when enacting the MHPAEA. In fact, the Committee report does not contain one mention of an NQTL. It solely describes QTLs, which are similar to the statute:

H.R. 1424 seeks to increase access to mental health treatment by prohibiting group health plans (or health insurance coverage offered in connection with a group health plan) from imposing financial requirements (including deductibles,

⁶ 29 U.S.C. § 1185a(a)(3).

⁷ *Id.*

⁸ *Id.* § 1185a(a)(3)(B).

⁹ Proposed Rules, *supra* note 1, at 51,569.

copayments, coinsurance, out-of-pocket expenses, and annual lifetime limits) or treatment limitations (including limitations on the number of visits, days of coverage, frequency of treatment or other similar limits on the scope and duration of the treatment) on mental health benefits that are more restrictive than those restrictions applied to medical and surgical benefits.¹⁰

Sen. Edward Kennedy (D-MA) said about the Senate version of the MHPAEA, the *Mental Health Parity Act of 2007*:

It guarantees co-payments, deductibles, coinsurance, out of pocket expensive and annual and lifetime limits that apply to mental health benefits are no different than those applied to medical and surgical benefits. It guarantees that the frequency of treatment, number of visits, days of coverage and other limits on scope and duration of treatment for mental health services are no different than those applied to medical and surgical benefits.¹¹

It is clear from both statements that neither the House nor the Senate envisioned the application of the “substantially all” test or “predominant test” to apply to NQTLs because the focus of the legislation was on QTLs. In fact, applying the “substantially all” and “predominate” tests are such onerous and complex policy changes that doing so amounts to a benefit mandate on plans. This benefit mandate essentially requires plans to cover MH/SUD benefits without any use of medical management, which Congress explicitly rejected in its final version of the MHPAEA as signed into law.

Sen. Pete Domenici (R-NM) explicitly stated that the bill “does not mandate coverage of mental health nor does it prohibit a health plan from managing mental health benefits in order to ensure only medically necessary treatments are covered.”¹² Yet the Tri-Agencies have practically eliminated medical management by applying the “substantially all” and “predominant” tests to NQTLs. The proposed rules even acknowledge that plans will likely increase premiums as a result of these tests and state that “plans and issuers might reduce the number of NQTLs employed and increase premiums in order to offset the costs of participants utilizing more mental health and substance disorder benefits.”¹³

Then-Committee Republican Leader Buck McKeon (R-CA) said about the House bill, which contained a benefit mandate on plans, “This bill would give preferential treatment in our health care system to mental health benefits, affording mental illness a special status that is not given to other similarly severe medical illnesses.”¹⁴ Benefit mandates were not included in the final version of the MHPAEA as signed into law, yet the Tri-Agencies are seeking to amend the MHPAEA through rulemaking by creating new benefit mandates and eliminating medical management.

¹⁰ <https://www.govinfo.gov/content/pkg/CRPT-110hrpt374/pdf/CRPT-110hrpt374-pt1.pdf> (p. 13).

¹¹ <https://www.congress.gov/crec/2007/02/12/CREC-2007-02-12-pt1-PgS1850.pdf> (p. S1864).

¹² *Id.* at S1865.

¹³ Proposed Rules, *supra* note 1, at 51,610.

¹⁴ <https://www.govinfo.gov/content/pkg/CRECB-2008-pt3/pdf/CRECB-2008-pt3-Pg3250-3.pdf> (p. 3269).

Congress intended for NQTLs to be “comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification” as written in the statute.¹⁵ The Tri-Agencies have decided to adopt a more stringent test by requiring that benefits must be no more restrictive than the predominant NQTL that applies to substantially all medical and surgical benefits in the same classification. This is impractical and utterly contradicts the statute.

Measuring Outcomes Data

The proposed rules establish that plans and issuers must measure and analyze outcomes data to ensure compliance with parity requirements. This approach is not only impractical but also exceeds the scope of the law.

It is perplexing that the Tri-Agencies believe the authority to require plans to measure outcomes data stems from the statutory language, which states:

[T]he comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and **in operation**, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.¹⁶

The proposed rules state that “in evaluating how such processes, strategies, evidentiary standards, and other factors are applied in operation, it is necessary to look at how the plan is administered in operation, which in the Departments’ view necessarily requires review and consideration of quantitative outcomes data.”¹⁷ The Tri-Agencies inexplicably interpret the term “operation” as a requirement that plans and issuers measure outcomes.

The Tri-Agencies’ previous approach was correct in viewing negative outcomes data as a red flag and “NOT determinative of compliance.”¹⁸ A plan or issuer may have negative outcomes data for a myriad of reasons including provider shortages, stigma associated with seeking mental health treatment, and treatment guidelines set by a physician, none of which are within the control of the plan or issuer. The burden associated with requiring plans to collect outcomes data is not worth the benefit gained. It is also questionable that plan sponsors would even have access to the claims data necessary to measure outcomes.

¹⁵ 29 U.S.C. § 1185a(a)(8)(A)(iv).

¹⁶ *Id.*

¹⁷ Proposed Rules, *supra* note 1, at 51,575.

¹⁸ <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf>.

Reimbursement Rates

The Committee strongly opposes the Tri-Agencies using reimbursement rates as a measure for parity compliance. It is inappropriate for the Tri-Agencies to put the thumb on the scale on private payer reimbursement rates. Reimbursement rates are determined through private negotiations between plans and providers, and plans should be empowered to negotiate equitable reimbursement for services and to maintain the incentive to provide access to mental health care at lower costs for patients. The Tri-Agencies recognize that reimbursement rates are not a factor in determining network adequacy elsewhere in law. Specifically, the Tri-Agencies do not consider reimbursement rates when measuring network adequacy for Medicare Advantage plans or *Affordable Care Act* marketplace plans. Doing so in the commercial market via regulations to enforce mental health parity is an egregious workaround and sets a dangerous precedent for future federal overreach into commercial health insurance. If the reimbursement for a specific specialty is near Medicare rates, this does not indicate a parity violation but rather indicates the fair market value of the specialty. Artificially increasing reimbursement by conditioning mental health parity compliance will only serve to raise costs and in no way guarantees higher quality or access to care. Tri-Agency interference with market rates will likely raise premiums without expanding access or quality for patients.

Network adequacy measurements disadvantage plans serving rural and underserved areas due to provider shortages.

The Committee shares the Tri-Agencies' concerns about the lack of access to mental health providers and services in rural areas. Unfortunately, the proposed rules do nothing to alleviate provider shortages and instead will only penalize plans covering patients in rural areas. As noted in the proposed rules, 60 percent of rural Americans live in mental health professional shortage areas,¹⁹ and as many as 65 percent of nonmetropolitan counties lack psychiatrists.²⁰ The American Journal of Preventive Medicine states that the lack of mental health providers is the biggest challenge to access to mental health services in rural areas.²¹ HHS' Health Resources and Services Administration estimates it would take an additional 5,233 mental health professionals to serve the 5,467 Mental Health Professional Shortage Areas in rural areas.²²

There are a variety of economic and cultural factors contributing to the mental health provider shortages in rural areas, which in turn create challenges for network adequacy. For example, lack of education of certified providers, stigma in seeking mental health care, lack of transportation, and higher poverty rates, along with insurance coverage, are causes of the provider shortages.²³

Plans and issuers serving rural areas with provider shortages will ipso facto be deemed noncompliant due to the existing shortages. Plans and issuers cannot create new providers on

¹⁹ <https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport>.

²⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7681156/#r25>.

²¹ [https://www.ajpmonline.org/article/S0749-3797\(18\)30005-9/fulltext](https://www.ajpmonline.org/article/S0749-3797(18)30005-9/fulltext).

²² <https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport>.

²³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7681156/#r25>.

their own; they can only take steps to ensure the patients they serve can access available providers. Even if plans had the ability to eliminate provider shortages singlehandedly, doing so would take years of investment and support from the Tri-Agencies. Plans making good faith efforts to ensure mental health access should not be punished for factors beyond their control. The proposed rules seeking to solve a societal problem by placing the blame on plans and deeming them noncompliant with mental health parity standards erode genuine efforts to improve access.

The Tri-Agencies should provide a safe harbor for plans in areas with mental health provider shortages. Language in the proposed rules regarding provider shortages through no fault of the plan should be retained and expanded in final rules.

The Tri-Agencies Should Expand Telemedicine Options

One way to alleviate potential provider shortages, particularly in rural areas, is through expanded access to telehealth services. During the COVID-19 pandemic, 55 percent of mental health and substance use disorder outpatient visits for rural patients were provided via telehealth.²⁴ The Committee supports many of the efforts to continue expanded access to telehealth services, as permitted during the COVID-19 pandemic.

The Committee passed legislation, the *Telehealth Benefit Expansion for Workers Act of 2023* (H.R. 824), which would permit plans to offer stand-alone excepted telehealth benefits to patients. The Committee urges the Tri-Agencies to join us in these efforts to expand access to telehealth services, especially for mental health care. Expanding the pool of patients utilizing telehealth may encourage more mental health providers to enter the market, alleviating shortage concerns.

The Tri-Agencies can take further steps to work with Congress to soften licensure rules to allow patients to receive telehealth services across state lines. This may reduce issues associated with provider shortages in rural areas. This would also allow rural patients to access a broader network of potential providers and give plans more flexibility to contract with more providers in-network, improving network adequacy.

Conclusion

The Committee shares the Tri-Agencies' goals in improving mental health parity and increasing patient access to mental health services. However, the Tri-Agencies' efforts to increase mental health parity through these rules fail as a matter of policy. The proposed rules far exceed the statutory authority of the Tri-Agencies, which has been typical for this administration. The proposed rules also add regulatory burdens that will make it more difficult for plans to comply with the law, raising costs and doing little to improve access to mental health services. The

²⁴ <https://www.kff.org/mental-health/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/>.

The Honorable Julie A. Su et al.

October 17, 2023

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Committee looks forward to working with the Tri-Agencies to revise this proposal prior to issuance of final rules.

Sincerely,

A handwritten signature in blue ink that reads "Virginia Foxx". The signature is written in a cursive, flowing style.

Virginia Foxx
Chairwoman