

October 17, 2023

Secretary Janet Yellen
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Secretary Xavier Becerra
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Acting Secretary Julie Su
Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

RE: Requirements Related to the Mental Health Parity and Addiction Equity Act (88 FR 51552)

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

On behalf of the CEO Members of Business Roundtable, who, collectively, lead companies that employ more than 20 million individuals, we thank the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (collectively, the tri-agencies) for the opportunity to comment on the proposed rules¹ to further implement the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*.

Business Roundtable members recognize that employers play an important role in providing mental health and substance use disorder (MH/SUD) coverage and care. In 2020, 90 percent of employers provided employee assistance programs for mental health services and 86 percent provided mental health coverage.² Employers are prioritizing access to meaningful MH/SUD care for their employees by providing a broad set of tools, such as employee assistance programs, comprehensive health benefits, direct access to care and community-based programs. In addition, plans and issuers are actively working to help expand coverage and connect patients with the right providers. According to a survey of plans and issuers, over the last three years, the number of in-network behavioral health providers grew by an average of 48 percent, with 89 percent of plans actively recruiting more mental health care providers for their networks, and 78 percent of plans increasing payments to providers.³

¹ [Federal Register: Requirements Related to the Mental Health Parity and Addiction Equity Act](#)

² [Employers Enhance Emotional and Mental Health Benefits for 2020 \(shrm.org\)](#)

³ [Employers Are Poised to Expand Mental Health Coverage in 2023 \(shrm.org\)](#)

Employers know that investments in quality mental health services are important to employee satisfaction, retention, absenteeism and economic output. Research shows that 91 percent of employees believe that their employers “should care about their emotional health,” and 85 percent say that “behavioral health benefits are important when evaluating a new job.”⁴ A recent survey demonstrated that employees who rate their mental health as fair or poor are estimated to miss about four times more work than others.⁵ The study conservatively estimates the cost of this missed work time to be “\$340 per day for full-time workers and \$170 per day for part-time workers;” annually, the lost productivity is estimated to cost the economy \$47.6 billion.⁶

Furthermore, during the COVID-19 pandemic, many employers made proactive changes to their mental health coverage to better serve employees struggling with mental health needs, including expanded access to existing services and new employee assistance programs.⁷ For example, many started offering mental health services via telemedicine; as many as 96 percent of employers could offer tele-mental health services by the end of 2023.⁸

U.S. spending on mental health with private insurance surged during the pandemic, according to a new study published in the scientific journal JAMA Health Forum.⁹ The study reviewed diagnosis codes for anxiety disorders, major depressive disorder, bipolar disorder, schizophrenia and post-traumatic stress disorder from claims from about seven million adults from January 2019 to August 2022 by the RAND Corporation and Castlight Health researchers.¹⁰ Most notably, the study concluded that treatment across the board—in person and online—increased during the pandemic. Spending on mental health services jumped 53 percent from March 2020 to August 2022 and mental health services use increased 22 percent from March to December 2020, the acute phase of the pandemic. By August 2022, mental health service use was 39 percent higher than prior to the pandemic.¹¹

Payers have significantly increased access to MH/SUD services during the pandemic. Spending pre-pandemic was about \$2.3 million per 10,000 beneficiaries per month. It increased to about \$3.5 million after the acute period of the pandemic.¹² Similarly, telehealth utilization for MH/SUD services increased by 1,019 percent during the acute phase of the pandemic compared to the pre-pandemic era. By the post-acute pandemic period, telehealth utilization

⁴ [*Mental health in the workplace: The coming revolution \(McKinsey & Company\)*](#)

⁵ [*The Economic Cost of Poor Employee Mental Health \(Gallup\)*](#)

⁶ [*The Economic Cost of Poor Employee Mental Health \(Gallup\)*](#)

⁷ [*2021 Employer Health Benefits Survey \(KFF\)*](#)

⁸ [*Large U.S. Employers Accelerating Adoption of Virtual Care, Mental Health Services for 2021, Business Group on Health Survey Finds \(Business Group on Health\)*](#)

⁹ [*Telehealth and In-Person Mental Health Service Utilization and Spending, 2019 to 2022 \(JAMA Health Forum\)*](#)

¹⁰ [*Telehealth and In-Person Mental Health Service Utilization and Spending, 2019 to 2022 \(JAMA Health Forum\)*](#)

¹¹ [*Telehealth and In-Person Mental Health Service Utilization and Spending, 2019 to 2022 \(JAMA Health Forum\)*](#)

¹² [*Telehealth and In-Person Mental Health Service Utilization and Spending, 2019 to 2022 \(JAMA Health Forum\)*](#)

had increased by 1,068 percent, while in-person visits increased by 2.2 percent compared to the pre-pandemic era.¹³

Business Roundtable members agree with the tri-agencies' assessment that more needs to be done to increase compliance with the *MHPAEA*, however, this is only one element of ensuring employees have the MH/SUD benefits and care their families need. In determining if companies are making meaningful investments in MH/SUD coverage and care, a holistic approach is needed, one that takes into consideration the other ways in which employers and their third-party administrators (TPAs) are providing MH/SUD services and supports.

As an organization, BRT has supported its companies' efforts by:

- Launching a corporate initiative to help our members by surfacing and sharing resources, highlighting innovative best practices, and creating platforms for conversations around reducing stigma.
- Proposing policy changes¹⁴ for improving access to mental health services. The three areas of focus are:
 - Improving screening for mental health and substance use disorder needs and promoting measurement-based care;
 - Promoting better coordination between the federal government, employers and plans on mental health parity compliance; and
 - Increasing access to behavioral health providers.

This balanced approach allows insurers, plans, providers, employers and government entities to work together to address systemic hurdles to MH/SUD access, while also increasing understanding of how to comply with mental health parity requirements.

While we join the tri-agencies in their dedication to achieving parity for MH/SUD, we are concerned that, if finalized as drafted, the proposed rule would create significant operational challenges to demonstrate compliance with *MHPAEA*, taking focus away from ongoing and increasing efforts by employers and their TPAs to expand MH/SUD benefits for their employees. In general, we believe the following high-level issues must be addressed by the tri-agencies prior to finalization of the regulation:

Complexity. While we appreciate the short extension of the comment period, fewer than 120 days is not an adequate comment period for stakeholders to provide detailed feedback on the proposed *MHPAEA* regulation. The proposed rule is very technical and involves many required elements to ensure compliance. Health plans and issuers, and many other interested

¹³ [Telehealth and In-Person Mental Health Service Utilization and Spending, 2019 to 2022 \(JAMA Health Forum\)](#)

¹⁴ Read the full report here: [Business Roundtable Supports Increased Access to Mental Health and Substance Use Disorder Services](#)

stakeholders, need additional time to understand the full impact of the proposed rule to provide constructive feedback to ensure that the final regulation can be implemented in a manner that helps employees and their families. Similarly, due to the complexity of implementing these requirements, BRT requests that the implementation deadline for employers and their TPAs be extended to January 1, 2026. If the proposed rules are not finalized in 2023, the date for implementation should be further extended to account for the time it takes for plans and issuers to make benefit changes. Both employers and their TPAs start working on benefit changes over a year in advance and must finalize them in time to facilitate open enrollment.

Cost. The regulatory impact analysis (RIA) of the proposed regulation estimates that implementation of the proposed rule, if finalized, will be hundreds of millions of dollars, costs which, in some cases, will be completely covered by some employers, but in others will be passed onto workers in the form of increased premiums. These costs include approximately \$291.0 million in the first year and \$117.6 million in subsequent years for plans and issuers to collect and analyze data and document NQTL comparative analyses. The economic analysis of the proposed rules also assumes a one-time regulatory review cost to plans and issuers of approximately \$64.3 million.¹⁵

BRT believes, in the RIA, the tri-agencies have grossly underestimated the cost of compliance with this rule. For example, the RIA estimates that plans would annually complete four NQTL analyses and issuers would complete eight NQTL analyses, but there is no exhaustive list of NQTLs and no cap on the number of analyses that are required under the proposed rule. In addition, the proposed rule may include a potential increase in cost-sharing requirements and/or treatment limitations for medical and surgical (M/S) care for participants, beneficiaries and enrollees due to plans and issuers trying to achieve parity by imposing new restrictions on M/S coverage rather than by reducing restrictions on access to MH or SUD benefits. Employers, who last year already faced some of the biggest health care cost increases in a decade, are set to see their costs for employer sponsored insurance increase by over five percent next year.¹⁶ While employers are working hard not to shift these cost increases onto their employees, adding additional, expensive regulatory burdens on top of these costs increases will make an already difficult situation much worse. BRT requests that the tri-agencies perform additional economic analyses and make changes where necessary to ensure that the finalized rule does not result in increased health care costs and that the cost of complying with the new regulations does not create a disincentive for issues and plans to make additional investments in MH/SUD services for their employees.

Clarity. The *Consolidated Appropriations Act of 2021 (CAA, 2021)* required the tri-agencies to promulgate these proposed rules to provide more detail to help plans and issuers comply with

¹⁵ [Federal Register: Requirements Related to the Mental Health Parity and Addiction Equity Act](#)

¹⁶ [Protecting student athletes \(axios.com\)](#)

the NQTL comparative analysis requirements. Unfortunately, as drafted, the proposed rules only add to the lack of clarity. Throughout the proposed rule, there are many essential components of a compliant NQTL comparative analysis that are either undefined or vaguely defined. Without clear definitions and detailed examples, stakeholders are limited in the extent to which they can provide meaningful feedback to the tri-agencies and will eventually face challenges complying with these requirements.

As an example, BRT members see challenges in defining “variation” given how many variations there can be for a given NQTL. Because the scope of potential “variations” is limited only by one’s creativity, the proposed requirement to apply quantitative testing for every different variation creates an impossible task for regulated health plans. As discussed below, BRT recommends that the tri-agencies work with issuers and plans to address the lack of clarity in key terms and requirements.

Distinctions Between MH/SUD and M/S Networks. BRT members believe that network adequacy requirements in the proposed rule need to be revised before finalization to account for the significant differences between the market for MH/SUD providers and the market for M/S providers. In several areas, the proposed regulations fail to account for important distinctions between MH/SUD and M/S networks, such as:

- MH professionals are more often practicing via telehealth and across state lines. The rule does not include telehealth in its network adequacy data requirements.
- M/S professionals are more likely to be in integrated groups and value-based payment models, which may skew reimbursement data.
- There are newer, non-licensed specialties in mental health (e.g., non-licensed peer support specialists, non-licensed behavioral analysts providing therapy to individuals with autism spectrum disorder) that may require additional medical management or oversight.
- Mental health professionals are more often in small or solo practices with limited back-office support, and as a result less willing to take on the administrative burden of joining networks or increase patient loads, an administrative burden that is often dictated by regulatory requirements and not health plans.
- There are new out-of-network access points for the delivery of mental health care that policies should encourage, including crisis care delivery systems and school-based care, but that could impact out-of-network utilization (and data).

Lacks a Comprehensive Approach to Addressing Access to MH/SUD Care. BRT members support the goal of the tri-agencies in increasing access to MH/SUD care. However, the proposed rule would add a new purpose section to existing *MHPAEA* regulations which would include: “in complying with the provisions of *MHPAEA* and its implementing regulations, plans and issuers must not design or apply financial requirements and treatment limitations that impose a *greater burden on access* (that is, are more restrictive) to mental health and substance use disorder benefits under the plan or coverage benefits.” By including this language on access,

the Administration is seeking to codify the view that *MHPAEA* requirements do not only pertain to the coverage of MH/SUD benefits, but that issuers and plans must also take steps to ensure that plan beneficiaries can access MH/SUD benefits in a manner comparable to M/S benefits. In our view, the proposed regulations go beyond the text and intent of the *MHPAEA* statute (which is about coverage of MH/SUD benefits) and will not solve the systemic MH/SUD access issues in communities across the country.

The United States is facing a mental health and substance use disorder crisis unlike anything we have ever experienced, and employers are on the front lines of trying to provide access to the necessary care. BRT member companies are hearing from their employees that they and their family members are struggling to access mental health and substance use disorder services. This systemic problem is particularly acute for teenage children whose mental health is especially vulnerable. It is critical that federal policymakers address the underlying, systemic workforce issues compounding this crisis rather than putting the entire burden on employers, health plans, and third-party administrators to solve longstanding, systemic issues.

BRT recommends that *MHPAEA* regulations retain their current law focus on coverage of MH/SUD services and supports and the tri-agencies look to other programs and authorities to address the systemic issues related to patient access that are outside the control of plans and issuers.

In addition to these overarching themes, we offer feedback on the following three substantive issues:

NQTL Comparative Analysis Requirements. As mentioned above, BRT members seek additional clarity on many of the terms and requirements in the NQTL comparative analysis. For example, it is unclear what “meaningful benefits” means in the requirement that a plan or issuer, which provides any MH/SUD benefits in any classification of benefits, provide “meaningful benefits” for that MH/SUD in every classification in which M/S benefits are provided. There are numerous other examples in the proposed regulation of key terms that are material for compliance with the rule that are undefined or ill-defined.

While additional clarification of terms and requirements is necessary, it likely will not be sufficient. BRT members also seek one or more sample NQTL comparative analyses to further clarify the requirements of the regulation.

The tri-agencies propose to require that the NQTLs applied to MH/SUD benefits cannot be more restrictive, as written or in operation, than the predominant NQTL that is applied to substantially all the M/S benefits in the same classification. This new requirement is not required by the *CAA, 2021*, which focuses on improved NQTL documentation. This requirement could effectively eliminate common medical management programs that both improve outcomes and reduce costs (e.g., prior authorization for MH/SUD benefits in the outpatient

classification). BRT recommends that this provision be dropped from the regulation and that the tri-agencies focus on providing clear, workable guidance implementing the NQTLs as required by the CAA, 2021.

The tri-agencies also propose to require that plans and issuers collect and evaluate outcomes data in a manner reasonably designed to assess the impact of an NQTL on access to MH/SUD benefits. If the relevant data shows “material” differences in access to MH/SUD benefits when compared to M/S benefits, the tri-agencies propose to require plans and issuers to take reasonable action to address that difference and document the steps taken. In addition, for the network composition NQTL, the tri-agencies have proposed to find a plan or issuer noncompliant if the data shows a material difference. BRT is concerned about the “one-way” use of outcomes data: that violations are presumed if there are material differences between MH/SUD and M/S, but compliance is not presumed when there are no material differences. BRT recommends that the tri-agencies codify an exhaustive list of outcomes data required to be evaluated, define “material,” not adopt the standard that material differences constitute a strong indicator of noncompliance, and not finalize the rule that a material difference constitutes a per se violation for the network composition NQTL.

In the Final *MHPAEA* 2013 rules, “The Departments recognized that plans and issuers impose a variety of NQTLs affecting the scope or duration of benefits that are not expressed numerically. Some commenters recommended that the Departments adopt the same quantitative parity analysis for NQTLs. While NQTLs are subject to the parity requirements, the Departments understood that such limitations cannot be evaluated mathematically. These final regulations continue to provide different parity standards with respect to quantitative treatment limitations and NQTLs because, although both kinds of limitations operate to limit the scope or duration of mental health and substance use disorder benefits, they apply to such benefits differently.” However, the proposed rule now seeks to mathematically evaluate NQTLs in the same manner they previously recognized as impossible.¹⁷

In addition, BRT recommends the development of an exhaustive list of NQTLs to eliminate uncertainty, direct activity to the areas of greatest concern, promote consistency across the

¹⁷ See also FAQ Q6: *MHPAEA and its implementing regulations impose mathematical tests for determining whether a financial requirement or quantitative treatment limitation (such as a copay or visit limit) on mental health/substance use disorder benefits is permitted. Are nonquantitative treatment limitations, or NQTLs, (such as medical management standards) analyzed the same way?* No. While the Departments’ regulations set forth mathematical rules for analyzing plan limitations that are expressed numerically, nonquantitative limitations are analyzed differently. With respect to nonquantitative treatment limitations, the Departments’ regulations provide that under the terms of the plan as written and in practice, any processes, strategies, evidentiary standards, or other factors used by a plan or issuer in applying an NQTL to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits, unless recognized clinically appropriate standards of care may permit a difference.

industry and avoid waste. To develop such a list, we recommend the tri-agencies engage stakeholders in a series of working sessions where different common NQTLs can be worked through to ideally produce complete, templated and compliant comparative analyses of acceptable NQTLs.

The proposed rules would require ERISA self-insured plans to include a certification by one or more named fiduciaries who reviewed the comparative analysis to indicate in the analysis whether they found it to be compliant with the proposed rule's requirements. BRT encourages the DOL not to finalize the fiduciary certification requirement as Congress did not include this requirement in the *CAA, 2021*.

Finally, under the proposed rule, if the relevant tri-agency makes a final determination that the plan or issuer is noncompliant, the tri-agencies propose that, within seven calendar days of the receipt of the final determination of noncompliance, the plan or issuer must provide a standalone notice to all participants and beneficiaries enrolled in the plan or coverage that the plan or issuer is not in compliance with the requirements of these proposed rules. We request that the tri-agencies extend this period to 30 calendar days, or something else more reasonable, as seven calendar days does not give plans or issuers enough time to provide the required notification.

Safe Harbors. While the proposed rules seek to be expansive in their approach to reducing barriers to receiving MH/SUD services, there are many strategies that employers and their TPAs use to improve access to these services that are not captured in these requirements. This includes services, such as staffing crisis lines, providing care navigators, direct contracting with MH/SUD clinics and improving access to MH/SUD services, which are not captured in the proposed comparative analysis requirements. BRT recommends the tri-agencies work with stakeholders to develop a set of objective metrics for meaningful investment in MH/SUD coverage and care. If employers and their TPAs meet or exceed these metrics, then the plans or issuers should earn a safe harbor from producing the full NQTL comparative analysis across plans in the applicable business line and region. One potential metric could be to compare the use of prior authorization between MH/SUD and M/S. If these results were comparable and below certain market thresholds, then prior authorization NQTLs could be deemed compliant without conducting the full NQTL comparative analysis. This type of approach would encourage employers and their TPAs to use prior authorizations in the areas where they will be of the most value to patient care. It would also provide plans greater flexibility to meet access demand through more innovative mechanisms that may not count in the prescribed analyses.

Network Adequacy. The proposed rule creates significant new requirements on plans and issuers to assess and improve network adequacy for MH/SUD providers. These new requirements fail to consider the significant systemic barriers that impact access to in-network MH/SUD services. According to the National Alliance on Mental Illness, "over half of U.S. counties have no psychiatrists, and even in areas that have mental health providers, there are

often not enough to meet the needs of the community—especially if patients must travel long distances to reach available providers.”¹⁸ Telemedicine flexibilities granted to employer sponsored insurance during the COVID-19 pandemic have been a welcomed tool for bridging the access-to-care gap, but it will take time for tele-mental health services to proliferate in a manner that meaningfully reduces the provider shortage dynamics.

Even in instances where providers are in an area, many mental health specialists refuse to contract with insurance. For some, as we mentioned above, it is because they are in small or solo practices with limited back-office support, and, as a result, less willing to take on the administrative burden of joining networks or increased patient loads. For others, it is because the provider shortage allows them to exploit the market conditions, refuse to negotiate with plans and charge patients whatever they want. Both dynamics are systemic and outside the control of plans and issuers and drive up out-of-network utilization rates. In these instances, many patients will not file an out-of-network claim for the MH/SUD services they receive, even encouraged by the provider to do so. Unfortunately, plans and issuers lack insight and key data to understand the scope of this problem as it is not possible for plans and issuers to track down instances where a patient receives care, but a claim is not filed by either the provider or patient.

The specialty provider shortage and out-of-network dynamics lead to misleading data and systemic barriers to complying with more stringent network adequacy standards. BRT recommends that the tri-agencies reconsider the special rule for network composition NQTLs, which would subject outcomes data related to network composition to a higher level of scrutiny than other data—if the relevant data show material differences in access to in-network MH/SUD benefits as compared to in-network M/S benefits, a health plan is per se noncompliant." In addition, BRT requests that the tri-agencies look to other programs and authorities, such as CMMI models and workforce education and training programs, which are better situated than employers and health plans to increase provider access.

The good news is that telemedicine is playing an important role in increasing access to MH/SUD services. Plans and issuers have worked hard to expand coverage for and access to tele-mental health services in the wake of the pandemic, and to make sure this is done in a way that is compliant with *MHPAEA*. BRT members are seeing the benefits that telemedicine is bringing to our employees in their ability to access the MH/SUD services they need. This is particularly important for geographic areas experiencing a provider shortage or in areas where providers refuse to contract to be in-network. These developments are still new, so we encourage the tri-agencies to incorporate telemedicine into its relevant data collection requirements to ensure that it is reflected in how coverage for MH/SUD services are being evaluated and measured. Thank you for the opportunity to comment on these proposed rules. Business Roundtable members stand ready to work with the tri-agencies to advance policies that improve mental

¹⁸ [Telehealth | NAMI: National Alliance on Mental Illness](#)

October 5, 2023

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health parity compliance and access to MH/SUD services for our employees and their families. We would be happy to discuss these comments or any other matters you believe would be helpful. Please contact Corey Astill, Vice President of the Health and Retirement Committee at the Business Roundtable, at castill@brt.org or (202) 421-9166.

Sincerely,

A handwritten signature in black ink, appearing to read 'CA', with a stylized flourish extending to the right.

Corey Astill, Vice President, Health and Retirement
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Washington, DC 20024
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