



October 16, 2023

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

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

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

**Re: Requirements Related to the Mental Health Parity and Addiction Equity Act (CMS-9902-P)**

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

Thank you for the opportunity to submit comments on the Mental Health Parity and Addiction Equity Act (MHPAEA) proposed rule, issued by the Treasury Department, the Department of Labor, and the Department of Health and Human Services (the Departments). This proposal would strengthen the standards for insurers and health plans to demonstrate that they are not imposing greater treatment limitations on enrollees' access to treatments for mental health and substance use disorders (MH/SUD) than are applied to medical/surgical (M/S) treatment. We strongly support this proposal but urge the Departments to remove the proposed exceptions outlined below, which threaten to undermine this important progress.

The undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. Our breadth enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion.

In March of 2017, our organizations agreed upon three overarching principles<sup>1</sup> to guide any work to reform and improve the nation’s healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

We applaud the Departments’ efforts to increase access to MH/SUD treatment with these proposed revisions to the requirements for MHPAEA. The growing need for behavioral health services in the United States, particularly since the pandemic, make these efforts all the more urgent.<sup>2</sup> Access to mental health care is particularly important to the patients we represent, given the frequent co-occurrence of mental health and acute or chronic health needs. For example, one study found that up to one-half of people with cancer experience depression.<sup>3</sup> Another found adults with disabilities are more likely to experience mental distress.<sup>4</sup> And there are risks for caregivers, as well. Over half of caregivers of medically complex children say that the routine of caregiving has “severe impacts” on their mental wellness.<sup>5</sup> Below we offer comments on the proposed rule and the technical release relating to required data collection.

### **Stronger Standards for the Application of Non-Quantitative Treatment Limits**

We strongly support the proposal to prohibit insurers and health plans from imposing a non-quantitative treatment limit (NQTL) unless the proposed rule’s three-part test is met. We are particularly supportive of the requirement that insurers and health plans collect data and evaluate it for differences in outcomes for MH/SUD relative to M/S.

Under current regulations, insurers and health plans rely on process-related explanations to justify their approaches to treatment limits, without regard to what that means for outcomes regarding access to providers and services. Our organizations have long supported greater reliance on data to measure and assess access and potential barriers to care across all health services, and data is essential to any analysis of equal treatment of MH/SUD and M/S. We believe it would be impossible to demonstrate compliance with MHPAEA without such data and therefore strongly support the Departments requiring it.

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<sup>1</sup> Consensus Health Reform Principles. Available at: <https://www.lung.org/getmedia/0912cd7f-c2f9-4112-aaa6-f54d690d6e65/ppc-coalition-principles-final.pdf>.

<sup>2</sup> N. Panchal, H. Saunders, R. Rudowitz and C. Cox, “[The Implications of COVID-19 for Mental Health and Substance Use](#),” KFF, Mar. 20, 2023.

<sup>3</sup> DL Rosenstein, *Depression and end-of-life care for patients with cancer*, Dialogues Clin Neurosci. 2011;13(1):101-8. Doi:10.31887/DCNS.2011.13.1/drosentein. PMID:21485750; PMCID: PMC3181973

<sup>4</sup> Cree RA, Okoro CA, Zach MM, Carbone E. Frequent Mental Distress Among Adults, by Disability Status, Disability Type, and Selected Characteristics — United States, 2018. MMWR Morb Mortal Wkly Rep 2020;69:1238–1243. DOI: <http://dx.doi.org/10.15585/mmwr.mm6936a2>

<sup>5</sup> 2023 Child Neurology Foundation Patient Advocate Organization Survey.

## **Assessing Provider Networks as an NQTL**

We also support the proposed rule's approach to assessing provider networks as an NQTL. Networks sufficient to provide timely access to covered services are a priority for the patients and consumers we represent, and we appreciate the Administration's focus on improving network adequacy across government programs. Inadequate networks for MH/SUD providers are an especially acute problem that results in patients experiencing delayed care, higher out-of-pocket costs to obtain care, or forgoing care altogether. The challenges are well documented. A survey of people with private insurance receiving both specialty mental health and medical care found participants were significantly more likely to rate their mental health network as inadequate compared with their medical network.<sup>6</sup> More recently, a study of marketplace enrollees searching for mental health providers found they faced multiple challenges, including difficulty finding an in-network provider and obtaining an appointment at a workable time, and the time-consuming nature of the search itself, with implications for their mental health, physical health, relationships, and ability to function at work or in school.<sup>7</sup>

We strongly support the Departments' proposal that insurers and health plans collect and evaluate data on network composition, including in-network and out-of-network utilization rates, network adequacy metrics such as time and distance data and data on providers accepting new patients, and provider reimbursement rates. This data should also include information on the types of MH/SUD providers available in the network, recognizing the value of ensuring that patients have access to a range of types of providers as needed. We see this data as essential to assessing an insurer or plan's "in operation" compliance with the provider network NQTL. We urge the Departments to also require data on appointment wait times, which are necessary to measure timely access to care. Similar to the approach our organizations supported in the proposed Medicaid Managed Care rule earlier this year, we believe the Departments should require insurers and health plans periodically use independent entities to conduct secret shopper surveys that are shared with the Departments and made publicly available.<sup>8</sup> We also recommend the Departments require insurers and plans demonstrate that they have a readily available process for individuals to request an exception to network rules and obtain care out-of-network with in-network cost-sharing, and to report data on requests for those exceptions, including counts for granted and denied requests.

## **Compliance**

We support the Departments imposing strong consequences when a plan is found to be out of compliance with the parity requirements. At a minimum, that should include barring plans from imposing any plan requirement found to fail the NQTL test proposed in this rule. We also oppose instituting a safe harbor for plans and insurers based on data collection. Given the significant work that the Departments need to do – and likely refinements that are necessary over time – to ensure collected

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<sup>6</sup> Busch SH, Kyanko K. Assessment of Perceptions of Mental Health vs Medical Health Plan Networks Among US Adults With Private Insurance. *JAMA Netw Open*. 2021 Oct 1;4(10):e2130770. doi: 10.1001/jamanetworkopen.2021.30770. Erratum in: *JAMA Netw Open*. 2022 Jul 1;5(7):e2227336. PMID: 34677592; PMCID: PMC8536951.

<sup>7</sup> R Silliman, E McNally, C Vargas-Sullivan and D Schleifer, "[It Leaves Me Feeling Defeated: Searching for In-Network Mental Health Care with Marketplace Insurance](#)," Public Agenda, 2023.

<sup>8</sup> Partnership to Protect Coverage Comments on Medicaid Managed Care Proposed Rule, June 29, 2023. Available at: <https://www.lung.org/getmedia/bfc0c003-2dda-4e76-8a81-25b51d600c60/PPC-Medicaid-Managed-Care-NPRM-FINAL.pdf>.

data is complete, accurate, and meaningful, a safe harbor should not be considered at this time. Such a safe harbor should only be considered when the Departments and key consumer stakeholders are confident that the data collected accurately captures actual access to MH/SUD services.

In defining the data that must be collected and analyzed, we urge the Departments to be as precise and inclusive as possible. Given the range of utilization management tools available to plans and insurers, focusing only on denied claims will fail to capture the many ways patients are denied their provider's recommended treatment or service. For example, adverse determinations based on a coverage exclusion may be based on a parity violation if the service exclusion cannot be supported by an NQTL analysis. Approvals for a lower level of care than was recommended and sought, and informal denials that result from peer-to-peer consultations will also be missed if the definitions are not drafted to capture them. To do this work, and to step up enforcement under current and these proposed rules, we recommend the Departments be given adequate resources and staffing to carry out this important work.

### **Exceptions**

We strongly oppose the exceptions proposed in this rule for "independent professional medical or clinical standards" and for "waste, fraud and abuse." We have deep concerns that the current ambiguity of "independent professional medical or clinical standards" in federal regulation will allow this exception to swallow the proposed strengthened NQTL requirements and potentially undermine even existing regulations. Similarly, while we strongly support efforts to ensure individuals needing MH/SUD care receive the most clinically appropriate care, we know that many plans and insurers have sought to exploit claims of "waste, fraud and abuse" to deny or limit access to medically necessary care. If adopted, the proposed exception will be used to undermine protections proposed in this rule. Our organizations urge the Departments to eliminate the proposed exceptions from the final rule.

### **State and Local Government Employee Plans**

We support the language implementing the elimination of self-funded non-federal government plans' ability to opt out of MHPAEA. It is unacceptable that hundreds of thousands of public employees and their family members have been denied critical MHPAEA protections because their employer chose to exempt their coverage from the law. 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.

### **Crisis Services**

The Departments have requested feedback relating to MH/SUD crisis services under MHPAEA and the Affordable Care Act's (ACA) 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.<sup>9</sup> While every benchmark plan includes EMS and emergency transport services, very few include mental health crisis (i.e., emergency) response or crisis stabilization services. A number of states have recently required health plans to cover MH/SUD crisis services. Washington has made clear that health plans must cover MH/SUD crisis services in order to comply with MHPAEA. We recommend HHS require coverage of MH/SUD crisis

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<sup>9</sup> See, for example, [Measuring disparities in police use of force and injury among persons with serious mental illness](#), BMC Psychology, Oct. 2021.

services as part of EHB in order to meet parity and establish a federal floor for protections for patients and callers to 988.

### **Provider Directories**

The Departments have requested comment on how to improve provider directories. Provider directories are notoriously inaccurate when it comes to listings for mental health providers, putting up barriers to patients getting care.<sup>10</sup> Current regulations requiring providers and plans maintain a process for regularly updating provider directories must be strongly enforced, and should be expanded to require those updates to include information on whether providers are taking new patients. To enforce these provisions, we suggest the Departments require insurers and plans to conduct secret shopper surveys. As noted above, such studies should occur periodically and be carried out by independent third-parties. Critically, the results of secret shopper surveys must be submitted to HHS and made publicly available.

### **MHPAEA and Medicaid**

It is imperative that HHS move quickly to propose and finalize MHPAEA rules for Medicaid managed care, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans (ABPs) without delay. The Administration must not apply a strong set of MHPAEA rules for those who receive coverage in the commercial market and allow a weaker set of rules for individuals in Medicaid managed care, CHIP, and ABPs. This is particularly critical given that these plans serve individuals and families with lower incomes and who are disproportionately Black, Latino, Native American, and from other marginalized and underserved communities, who, data show, are more likely to struggle with mental health and substance use disorders than white individuals.

Thank you for the opportunity to provide these comments. If you have any questions, please contact Hannah Green with the American Lung Association at [hannah.green@lung.org](mailto:hannah.green@lung.org).

Sincerely,

American Cancer Society Cancer Action Network  
American Kidney Fund  
American Lung Association  
Autism Speaks  
CancerCare  
Child Neurology Foundation  
Cystic Fibrosis Foundation  
Epilepsy Foundation  
Foundation for Sarcoidosis Research  
Hemophilia Federation of America

Lupus Foundation of America  
Muscular Dystrophy Association  
National Alliance on Mental Illness  
National Bleeding Disorders Foundation  
National Kidney Foundation  
National Multiple Sclerosis Society  
National Organization for Rare Disorders  
National Patient Advocate Foundation  
The AIDS Institute  
The Leukemia & Lymphoma Society

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<sup>10</sup> See, for example, A Burman and S Haeder, “[Provider Directory Inaccuracy and Timely Access for Mental Health Care](#),” American Journal of Managed Care, Feb. 2023; and K. Ellison, “[73 Doctors and None Available: How Ghost Networks Hamper Mental Health Care](#),” The Washington Post, Feb. 19, 2022.