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To:	EBSA MHPAEA Request for Comments
Cc:	Elizabeth Leight
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Society of Professional Benefit Administrators

October 17, 2023

Responses sent via email to mhpaea.rfc.ebsa@dol.gov

Technical Release 2023-01P

The U.S. Departments of Labor, Internal Revenue Service, the Department of Health and Human Services, and the Department of the Treasury

File Code 1210-AC11

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Requirements Related to the Mental Health Parity and Addiction Equity Act

The Society of Professional Benefit Administrators (SPBA) appreciates the opportunity to submit information based on the expertise of our members who are directly engage in providing support to employers providing health coverage to their employees and their families. SPBA is the largest organization representing Third Party Benefit Administrators with experience in providing administrative support to employers on a wide variety of self-insured health plans.

SPBA urges the Departments to engage SPBA in direct conversation regarding issues relevant to these proposed regulations. We are willing to engage further, and provide any additional information that may be helpful and otherwise support the Departments in protecting the viability and delivery of self-funded health plan benefits.

We remain concerned about the limited number of successful MHPAEA audits and are willing to work more closely with the agencies to ensure the thresholds for which payers are being held accountable are attainable to ensure the success of the effort.

The following represents responses to inquiries proposed by the U.S. Department of Labor in Technical Release 2023-01P. The responses relate to network composition and enforcement for group health plans subject to the Mental Health Parity and Addiction Equity Act (MHPAEA).

The Departments request comments on the issues relating to data that group health plans and issuers would be required to collect and evaluate for NQTLs related to network composition to demonstrate compliance with MHPAEA.

The following responses relate to Department inquiries shown in bold print:

How can the Departments ensure that the data would provide a meaningful representation of whether a plan or issuer is designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to treatment from in-network MH/SUD providers than from in-network M/S providers?

We believe the Departments should consider the shortages of MH/SUD providers in certain geographic areas. Payers are not necessarily limiting the number of participating MH/SUD providers, there are simply fewer of them.

All MH/SUD providers do not have the same credentials or undergo the same clinical training. For example, many practicing counselors have Masters degrees, as opposed to having a Doctorate degree, and Certifications are a mixed bag. This distinction alone could be a consideration for the differential in reimbursement rates.

Should the Departments require plans and issuers to collect and evaluate relevant out-of-network data on specific items and services as outlined, or should the Departments also require data on certain subsets of items and services?

Regarding network data, we are not aware of a uniform standard set of rules and/or metrics that define network composition. Therefore, if there is no rule to pull from, it would be a struggle to establish compliant data. The Departments may end up getting a mix of data based on different interpretations. More clarification of what the Departments are looking for is requested including what is determinative of a failure to provide the data or relevant data.

Should the Departments require plans and issuers to collect and evaluate relevant out-of-network utilization data from the two most recent and complete calendar years that ended at least 90 days prior to the start of the plan or policy year during which the request for a comparative analysis was made?

Some TPAs believe that asking payers to analyze out-of-network data is a wasted effort. Most payers have very little activity OON, so we question the credibility of whatever data they might be able to pull together. For example, in many geographic areas, OON activity is very low.

Requesting data from the two most recent plan years is reasonable, but it should be done on a plan year basis not a calendar year basis.

One issue to review is how we track PBMs and how they determine the categories. Please provide additional clarification of the 90-day requirement and its importance to the data requested. We would like to get additional information on what is an acceptable standard. Can you specify how we can weight factors?

In the past, the Departments work to identify and clarify definitions, should this continue? Should they implement corrective plan penalties?

In order to fully respond to this inquiry, we request that the Departments identify and clarify the kind of information they are seeking to better inform the entities responding to the inquiries. Before implementing corrective penalties, Plan Administrators need meaningful, workable rules.

Should the Departments require plans to collect out-of-network data for recent years?

Administrators are more likely to have current data. Out-of-network data can take more time to acquire because plans need to combine information and seek additional information through providers, which is burdensome to collect and in some cases, may be impossible to collect.

Should different categories of items and services be used instead of the categories described above?

Establishing the categories of information is important. However, we need additional clarification of the data, for example, out-of-network, inpatient, inpatient-out-of-hospital, etc. or can we rely on the six categories?

Should out-of-network utilization data be provided in terms of the percentage of claims, number of claims, total dollar amounts of all claims, and/or something else? Why?

If the data is collected in terms of number of claims, certain clarifications would be helpful. For example, a definition of what should count as a "claim" in cases where multiple items and services are listed in one claim. We believe the Departments should specify data consisting from one year to the next by the same Administrator. Clarification would be helpful, on how to report changes that occur if groups merge or change from one Administrator to another.

How should the Departments' control for treatment received from MH/SUD providers where no claim for benefits was made (i.e., because the participant, beneficiary, or enrollee did not submit a claim for services furnished by an out-of-network provider)?

The guidance should allow for the plan to do what is reasonably permitted for medical claims.

How should the Departments control for claims that are otherwise not covered or for duplicate submissions or incomplete claims?

The Departments should take them out of the analysis.

How should the Departments define geographic areas?

The best way to define geographic areas is to base it on the terms that the plan uses.

Should the Departments do so in a manner that is consistent with other data elements described in this document?

Geographic areas should be based on the plan document. One concern is how to include information and data regarding Telehealth benefits. We request additional insight on how to accomplish this task.

What data, if any, would be analogous to out-of-network utilization for plans or issuers that generally do not provide out-of-network benefits for non-emergency care (such as health maintenance organizations, exclusive provider organizations, and closed network plans)?

We do not believe any exist at this time.

If there is no analogous data, would the other relevant data described in this document for NQTLs related to network composition meaningfully reflect whether these plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits?

If a plan does not place greater restrictions on reference-based pricing plan benefits, which are reimbursable at a fixed percentage of Medicare regardless of service, there should be no problem because they should be the same.

On behalf of our member firms, SPBA respectfully submits these comments. We appreciate the opportunity provided by the Departments to provide additional information, as needed, to further elaborate how these regulations will impact the TPA industry and to explain the importance of timing issues that arise. We would be willing to engage further discussion with the Departments that may be helpful and otherwise support the Departments in protecting the viability and delivery of health benefits through self-funded health plans.

Best regards,

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