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July 24, 2020

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Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave., NW, Suite N-5653
Washington, D.C. 20210

Submitted via e-mail to e-ohpsca-MHPAEA-SCT-2020@DOL.gov

RE: BCBSA Comments on Draft to Update U.S. Department of Labor's (DOL) 2020 Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Self-Compliance Tool

Dear Ms. Rivers:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the DOL's proposed updates to the 2020 Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Self-Compliance Tool released on June 19, 2020.

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies (Plans) that collectively provide healthcare coverage for one in three Americans. For more than 90 years, Blue Cross and Blue Shield companies have offered quality healthcare coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

We share DOL's commitment to ensuring clarity on the requirements established by the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), including consistent and transparent guidance on how quantitative treatment limitation (QTL) and non-quantitative treatment limitation (NQTL) requirements are reviewed for compliance. We believe that consistent guidance from DOL can help support both health plans and regulators to ensure access to behavioral healthcare for patients, as well as reduce the burden on all parties as they work to ensure compliance with the MHPAEA requirements.

In line with these mutual goals, BCBSA appreciates DOL's efforts to continue to refine its guidance. Over the last few years, BCBSA has encouraged DOL to provide clear information and examples on how health plans can ensure compliance with the requirements, not only avoid specific noncompliance infractions. As such, we support many of the changes in the updated self-compliance tool, including the recommendations on what plans can consider including in an internal MHPAEA compliance plan.

In addition, we support DOL's efforts to improve consistency in the expectations for health plans through its reference to the National Association of Insurance Commissioners' (NAIC's) existing template. We encourage DOL to formalize the proposed recommendation that health plans rely on the existing NAIC template and to continue to engage the NAIC and state officials to ensure alignment moving forward. Coordination and, in turn, consistent standards and expectations across stakeholders are key to supporting patients' access to mental health and substance use disorder (MH/SUD) services.

As DOL looks to finalize its updates to the self-compliance tool, we recommend a number of modifications which are detailed in the subsequent sections. At a high level, these recommendations include:

- Establishing clear, consistent compliance expectations across DOL, NAIC and state officials through the implementation of the internal MHPAEA compliance plan standards and the reference to the existing NAIC data collection tool.
- Maintaining a focus on process and methodology for ensuring compliance, not outcomes, through changes such as not referencing the Medicare Physician Fee Schedule as a benchmark or establishing an implied standard that MH/SUD and M/S services must have identical reimbursement rates.
- Applying any new guidance prospectively for enforcement. For example, if the comparative rate schedule is finalized, it should be made clear that it is for prospective application following a reasonable transition period to come into compliance, and group health plans should not be penalized by investigators for detailed guidance and standards that did not exist previously.
- Further clarifying the non-quantitative treatment limit (NQTL) compliance requirements and reiterate, per the Final Rule, that different results alone do not mean that the NQTLs are not compliant.
- Addressing compliance issues related to medication-assisted treatment (MAT) for opioid use disorder (OUD).
- Removing references to provider directory accuracy so as not to imply provider directories are linked to MHPAEA compliance.

We appreciate your consideration of our comments. BCBSA shares your commitment to ensure that all Americans should have ready access to necessary MH/SUD services, especially critical as we see increased demands on behavioral health services given the challenges and hardships associated with COVID-19.

If you have any questions or want additional information, please contact Anshu Choudhri at 202.626.8606 or Anshuman.Choudhri@bcbsa.com.

Sincerely,

Kris Haltmeyer
Vice President, Legislative and Regulatory Policy

BCBSA DETAILED COMMENTS AND RECOMMENDATIONS REGARDING PROPOSED UPDATES TO THE DOL MHPAEA SELF-COMPLIANCE TOOL

A. Section B: Coverage in All Classifications

Issue: DOL proposes adding a "Note" to the classifying portion of Section B to indicate that a plan must cover room and board for MH/SUD residential care if a plan covers room and board for inpatient medical/surgical (M/S) services (p.11)

Recommendation #1: BCBCSA recommends removing the language relating to plans covering room and board for skilled nursing facilities (SNFs) and other intermediate levels of care.

Rationale: This language will likely increase confusion for plans, regulators, consumers and other stakeholders. This example frames NQTL analysis as a direct comparison between two specific provider types rather than focusing on the factors used to establish the limits and apply the benefit. Limits for MH/SUD services must be comparable and no more stringent than those applied to M/S benefits in the same classification, but that does not translate to coverage for specific benefits within a classification being identical.

Specific to the residential care context, if regulators interpret the tool to ensure comparability across specific benefits, health plans may be expected to cover non-evidence-based treatments, such as wilderness therapy for SUDs, which have limited evidence of efficacy for patients. The MHPAEA Final Rules compare SNFs to residential treatment centers (RTCs), so the language specific to SNFs and other intermediate levels of care could be interpreted to also apply to RTCs. This is likely not the intent of DOL and could lead to health plans being expected to cover services that have questionable proven value for the patient. Furthermore, because plans are required to classify RTC and SNF in the same classification, such a limitation may account for the fact that RTCs might offer less intensive services that align more closely with outpatient services, as compared to SNFs which may not offer services at the same lower level of intensity.

Recommendation #2: BCBSA recommends DOL include a coverage example that is specific to how RTCs should be handled, including guidance on how plans should address the following:

- Plans' ability to reimburse only for covered benefits delivered by a licensed clinician in the RTC setting (and excluding care provided by non-licensed professionals) where the same standard is applied to M/S benefits
- Plans' ability to conduct prior authorization (PA) for RTC stays
- Plans' ability to require either state-based licensing or third-party certification of RTC facilities (and to exclude facilities that fail to meet these licensure/certification requirements) where the same standard is applied to M/S benefits

Rationale: RTCs have significant variation in licensing and certification requirements beyond what is typical for other services, as well as variability in the scope and scale of services provided. It reasonable to expect that plans and issuers are likely to provide coverage for some residential treatment types but not others, depending on benefit design as well as existing clinical evidence. Furthermore, with recent concerns of fraud and abuse in the RTC space (e.g., patient brokering of those suffering from SUD), there may be more stringent standards applied on the MH/SUD side to ensure that patients are receiving medically appropriate care.

We believe incorporating this example will not only support health plan compliance with parity requirements specific to RTCs, but also promote safer, evidence-based care for patients accessing these services.

Issue: DOL proposes amending the existing example and illustration in Section B on MAT under MHPAEA (p.11) to indicate plans cannot make MAT contingent on access to psychosocial therapies.

Recommendation: BCBSA recommends revising the language in regard to MAT to acknowledge the differences between MH/SUD and M/S medications and the importance of psychosocial therapies in treating OUD.

Rationale: The example as written implies that, in keeping with the NQTL rules, plans must have a process that results in an analogous limitation on an M/S benefit comparable to MAT in order to apply therapy-related contingencies. We disagree with this application as: 1) MAT is unique to the MH/SUD space, and it may not be possible to identify a meaningful comparator for M/S medications; and 2) NQTLs are based on the methodologies and processes used to set benefits and, therefore, a direct comparator for each item or service is not required. Maintaining the reliance on process in assessing NQTL compliance is critical to ensure plans have the flexibility to account for the variations between M/S and MH/SUD. As such, we ask DOL to revise the language to establish that applying psychosocial therapy requirements in tandem with MAT can be compliant with MHPAEA requirements if a comparable process was used to assess the need for NQTLs across the comparable M/S classification.

Furthermore, we recognize the importance of MAT in the treatment of OUD and appreciate recent research that indicates MAT can have some degree of effectiveness without being administered in conjunction with therapy. However, consistent with guidance from Substance Abuse and Mental Health Services (SAMHSA), as well as other federal agencies and experts, we continue to believe that MAT, in conjunction with therapy, provides the best opportunity for patients to manage and overcome OUD. We would caution the DOL to be judicious in this and any future recommendations to sever the connection between MAT and therapy in treating OUD.

B. Section D: Financial Requirements and Quantitative Treatment Limitations

Issue: DOL proposes adding a "Warning Sign" to Section D suggesting a plan which applies a specialist copayment to all MH/SUD services and some M/S services may be noncompliant (p. 18).

Recommendation: We recommend that DOL either clarify that applying a certain level of copayment to all MH/SUD services does not indicate noncompliance in the "Warning Sign," or remove the language entirely.

Rationale: While it is possible that a plan applying copayments to all MH/SUD services and not all M/S services may not be in compliance with MHPAEA, this may be a misleading heuristic for all benefit designs. As noted in the compliance tip beneath the example, "a plan may be able to impose the specialist level of a financial requirement or QTL to MH/SUD benefits in a

classification (or an office visit sub-classification) if it is the predominant level that applies to substantially all M/S benefits within the office visit sub-classification." Therefore, to accurately establish whether parity requirements are met, a regulator should more appropriately examine copayment amounts within classifications rather than as a general assessment. We recommend that DOL clarify the language to encourage regulators to not assume noncompliance if a specialist copayment is applied to MH/SUD benefits and instead rely on the financial testing review for each of the benefit classifications.

Alternatively, it may be cleanest for DOL to simply remove the language. Since copays are most often applied to primary care and specialist office visits, health plans will likely be in compliance without this guidance. To prevent increasing the enforcement burden on regulators, it may be better to simply remove the language rather than suggesting to regulators that this should be reviewed for.

C. Section E: Cumulative Financial Requirements and Treatment Limitations

Issue: DOL proposes adding to the illustration in Section E to address how a plan may become compliant when placing visit limitations on MH/SUD differently from M/S, including a statement in the "illustration" that indicates that plans can come into compliance by waiving all day/visit limitations for the in-network inpatient, out-of-network inpatient, in-network outpatient and out-of-network outpatient MH/SUD benefits (p. 20).

Recommendation: We recommend that DOL clarify the illustration to be clear that waiving all day/visit limitations is not the only way for health plans to be compliant in their application of limitations.

Rationale: While this language is a clear example of day/visit limitations that are no more restrictive for MH/SUD than for M/S services, this example represents the upper limit of compliance and does not reflect the more nuanced application of limits that plans typically use to account for the difference between M/S and MH/SUD services. There is variability in the frequency of visits that are appropriate across different treatments and services. For example, the amount of time needed in a facility following a knee replacement is likely different than the amount of time needed for labor and delivery or for SUD treatment. The variations in limits that result from health plans applying a consistent logic in setting the limits is likely clinically appropriate and does not suggest a parity infraction. In line with this, attempting to ensure limits across M/S and MH/SUD are comparable by simply removing them would likely not promote parity in the way desired or ultimately improve patient care. As such, we encourage DOL to either employ a more nuanced example of compliance or clarify that the illustration is one example of how health plans could comply, but not the only approach.

D. Section F: Non-quantitative Treatment Limitations

Issue: DOL proposes adding references to the use of the Medicare physician fee schedule as a payment benchmark for M/S and MH/SUD payment rates to the "Notes" and "Warning Signs" related to NQTL compliance (p. 22).

Recommendation: BCBSA urges DOL to not include the example of the Medicare physician fee schedule as a payment benchmark for M/S and MH/SUD payment rates.

Rationale: The use of Medicare's physician fee schedule in assessing parity is not appropriate in all circumstances and would often not account for the variety of factors private health plans employ to establish provider reimbursement amounts, including negotiations with providers and independent evaluations of individual providers based on education, licensure and/or training. As DOL has already affirmed,[1] health plans have the ability to consider a wide array of factors in determining provider reimbursement rates for both M/S services and MH/SUD services, including service type, geographic market, demand for services, supply of providers and provider practice size. While health plans have the flexibility to employ the Medicare fee schedule (or a different fee schedule) as a factor in setting reimbursement, rates are often determined independent of the Medicare fee schedule or in combination with a myriad of other factors. If used, the Medicare fee schedule is often employed as a common language rather than a negotiation point. Encouraging regulators to rely on the Medicare fee schedule amounts could have the unintended effect of constraining health plans' ability to effectively negotiate and establish high-performing provider networks, ultimately driving increased costs for consumers. Further, reliance on the Medicare fee schedule could unintentionally carry forward certain constraints, such as budget neutrality, that should not apply to private payers. Additionally, Medicare uses bundled payments for certain MH/SUD services, which could make the rates paid by the fee schedule and private payers incomparable.[2]

Furthermore, the language, as written, implies that the only way a reimbursement rate methodology could be MHPAEA-compliant is if it uses an identical process for developing M/S and MH/SUD provider reimbursement rates and that those rates are equal. However, the MHPAEA standard is that the processes are comparable, not identical or have equal outcomes. While it may be that there is no comparable approach to establish MH/SUD reimbursement rates if the Medicare Physician Fee Schedule is the single determining factor, we are concerned that language could be relied on by regulators to require plans to use identical methodologies in all instances. As discussed, in many instances, plans rely on a variety of factors to establish reimbursement rates, and the weight of specific factors may vary across providers. As such, an identical methodology may not be appropriate in all instances and is not required by the regulation.

Instead, we encourage DOL to emphasis parity in the processes used for setting reimbursement rates and comparability in the methodologies used. In some instances this will mean that outcomes for different providers may vary, while health plans remain compliant.

Issue: DOL proposes adding a "Note" to Section F suggesting health plans may modify network standards with higher provider payment rates to enhance networks (p.22).

Recommendation: We recommend DOL remove the following statement from the proposed language: "Plans and issuers may attempt to address shortages in M/S specialist providers and to ensure reasonable patient wait times for appointments by adjusting provider admission standards through increased reimbursement rates and by developing a process for accelerating enrollment in their networks to improve network adequacy."

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[1] 78 Fed. Reg. 68240, 68246 https://www.govinfo.gov/content/pkg/FR-2013-11-13/pdf/2013-27086.pdf

[2] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Opioid-Treatment-Program

Rationale: While we share the desire to ensure that patients have robust access to MH/SUD providers, it is important to recognize that the availability of these providers is not uniform across the country. In many regions, particularly in rural communities, there is limited availability of these providers. In these instances, simply increasing reimbursement or adjusting admission standards will not solve the problem.

Furthermore, we would caution DOL against establishing any requirement, implied or otherwise, that indicates health plans should lower participation standards. These standards are established to protect patients from low-performing or unethical providers, not to restrict access. Efforts to improve parity between M/S and MH/SUD should not be at the expense of the quality of the care received or the ultimate well-being of the patient.

Issue: DOL proposes adding a "Warning Sign" to Section F identifying inequitable or lower reimbursement rates for MH/SUD providers as indicative of noncompliance (p. 23).

Recommendation: We recommend DOL revise the "Warning Sign" to include the following language to clarify that outcomes are not determinative of MHPAEA compliance: "Outcomes are not determinative of noncompliance. A plan may be in compliance even where reimbursement rates to MH/SUD providers are not identical to reimbursement rates to M/S providers. The above Warning Signs may indicate that further review is required but does not alone demonstrate noncompliance."

Rationale: BCBSA recommends the above addition to ensure regulators, health plans and other stakeholders are certain that outcomes are not driving compliance. There are many factors that can result in disparate reimbursement rates that are compliant with parity standards, including market dynamics, needs and availability. As DOL stated in its Final Rule, ""Again, disparate results alone do not mean that the NQTLs in use fail to comply with these requirements." The addition of the above is consistent with similar reminder statements throughout the self-compliance tool.

Issue: DOL proposes adding language to the compliance tip in Step 2 of its NQTL compliance process that health plans include data used in their determinations (p. 24) when reporting the relative weights of different factors used to assess compliance.

Recommendation: BCBSA recommends DOL not include a recommendation that health plans include the data used in its process.

Rationale: We would reiterate that compliance should be based on process and methodology, not outcomes. As such, to demonstrate compliance, health plans should be assessed regarding whether they are applying comparable standards across MH/SUD and M/S and not the appropriateness of the standards themselves, if applied consistently. This assessment does not require the underlying data used in the determination, and recommending health plans share that information imposes an unnecessary burden on plans with limited to no benefit for regulators.

Issue: DOL proposes adding a note and compliance tip to Step 3 to discuss the use of clinical experts for developing NQTLs, including considerations for assessing "high cost" (p. 26).

Recommendation #1: While BCBSA supports the note added on refinements in the use of expert panels in the NQTL analysis on pg. 25, we recommend DOL clarify that the new bullet for documentation of internal experts' review of every NQTL decision that was added to the compliance tip section on pg. 26 is one potential approach and not required.

Rationale: BCBSA commends DOL for adding a helpful "Note" to support allowance of expert panels, as opposed to quantified metrics, to determine which services are subject to PA. However, this type of review would demand significant resources and may not be feasible or necessary for every NQTL for every health plan. In many cases, relying on internal experts, such as clinical leaders or other personnel, can meet the same goal. As such, we support offering this as a potential approach, but encourage DOL to clarify that this is one potential option for compliance, not a requirement.

Recommendation #2: We recommend that DOL clarify that the use of a comparable high-cost standard for MH/SUD and M/S benefits as the basis for PA is sufficient to meet parity standards without a health plan providing underlying proprietary data used to set the threshold.

Rationale: If a plan defines high cost for both MH/SUD and M/S as "anything over 1,000 dollars" for a PA, there may not need to be an examination of the evidentiary standard since it is a comparable standard across M/S and MH/SUD services. The language suggesting that data must be provided to assess the validity of the threshold is beyond the scope of the MHPAEA requirements to ensure parity. As mentioned previously, we urge DOL to focus on establishing expectations for compliance which focus on the methodology and process employed for benefit design rather than the outcomes.

Issue: DOL proposes a compliance tip that plans check a sample of claims to examine how an NQTL operates in practice (p. 28).

Recommendation: We recommend that DOL remove this language from the final version of the tool.

Rationale: This compliance tip relies on outcomes rather than process and methodology, which is not the intent of the MHPAEA. Including this language may be misleading to state regulators using this as a resource when reviewing health plans for compliance.

Issue: DOL proposes adding "Warning Signs" to Section F that suggest use of prior authorization for medication for OUD or denying all drug screening tests for SUD patients may be indicative of noncompliance (p. 28).

Recommendation: Remove the "Warning Signs" as the examples provided are not necessarily examples of noncompliance.

Rationale: The examples proposed as "Warning Signs" do not account for health plans' appropriate use of utilization management tools and may be inaccurately interpreted as discrete examples of noncompliance. For instance, the first example in this section does not account for use of PA to ensure patient safety for certain MAT. Medical management, including PA, is sometimes even required by Medicaid programs and is used to protect against diversion and ensure care coordination. Simply removing PA in these instances in the spirit of comparability

with M/S medications could put health plans out of compliance with other requirements and/or place members at considerable and avoidable risk. Additionally, the second example fails to note that denying drug screening tests occurs because MH/SUD drug testing has been subject to fraud and abuse. We do not believe it is DOL's intent to promote these as examples of noncompliance and recommend DOL remove this language so that the guidance is not inappropriately interpreted by regulators.

Furthermore, the example of a health plan denying all drug tests is a somewhat extreme example and likely not representative of any common plan design or coverage limit. As such, it may not serve to help clarify any of the areas of uncertainty for plans or regulators looking for guidance on how to ensure compliance with the requirements.

E. Section G: Disclosure Requirements

Issue: DOL proposes adding an example to a note in Section G that a plan may have more restrictive coverage than the standard of care for MH/SUD and M/S services as long as the plan has internal documents to support the policy and reiterates that ERISA-covered plans must provide a summary plan description with the composition of the provider network.

Recommendation #1: Remove the example which includes a reference to *Cf. Wit v. United Behavioral Health* in the note (pg. 33).

Rationale: The example which includes a reference to *Cf. Wit v. United Behavioral Health* is citing ongoing litigation. We believe it is wholly inappropriate, in the context of a federal mental health parity compliance guide, to cite a case that does not relate to mental health parity compliance. Furthermore, the case is ongoing and, therefore, not precedential. There are other cases that have rejected the idea that creating clinical policies is, in and of itself, a fiduciary action that can be challenged under ERISA. It does not make sense for DOL to endorse the *Wit* case in this context, and the reference should be removed.

Recommendation #2: DOL should clearly state that provider directories are not considered an NQTL (pg. 33).

Rationale #2: The reference to provider directories in the updated tool could result in regulators interpreting provider directories as an NQTL. Most, if not all, health plans do not currently track provider directories as a separate NQTL, and we do not believe it would be appropriate to do so. This language suggests a through line from NQTLs to provider directories which does not, and should not, exist. Furthermore, implying a standard of 100 percent accuracy is not feasible and is not consistent with what is expected in for employers engaging third-party administrators. We do not believe it is the intent of DOL to treat these directories as NQTLs, and we urge DOL to modify the guidance to clearly state that provider directories are not considered NQTLs.

F. Section H: Establishing an Internal MHPAEA Compliance Plan

Issue: DOL proposes an update to Section H of the tool to include a recommendation that health plans establish compliance plans which include a series of specific characteristics (p. 35). These plans are intended to improve compliance with the law and provide a list of possible materials that may be audited if DOL investigates a plan.

Recommendation #1: BCBSA appreciates the DOL's effort to outline the characteristics for compliance with greater clarity and supports the reference to use the NAIC Data Collection Tool. BCBSA further recommends that DOL promote alignment across NAIC and DOL guidance to improve consistency and clarity in interpreting the MHPAEA requirements and reducing administrative burden on health plans to comply.

Rationale: BCBSA believes there is a need for more consistent application of the federal law across states, and this guidance from DOL helps to establish a federal baseline for parity requirements. Health plans already perform many of these efforts, and this section serves as a useful guide on what information plans can volunteer to demonstrate their compliance. It provides details on what health plans should do, rather than relying solely on examples of what plans should not do, and so provides a clearer roadmap to compliance. We support inclusion of this new section and continue to encourage DOL to make clear that health plans maintain flexibility to conduct their own assessments, and these recommendations serve as examples of common successful practices.

Furthermore, BCBSA supports the reference to and possible use of the current NAIC Data Collection Tool (developed in 2015). The current NAIC Data Collection Tool is clear and easy to read, which can aid examiners in conducting efficient and productive NQTL examinations. It also provides meaningful direction to health plans while maintaining necessary flexibility on disclosure of "any processes, strategies, evidentiary standards or other factors" utilized by the issuer that may be proprietary. Finally, the NAIC Data Collection Tool does not rely on a "step-wise" approach or hierarchy when evaluating NQTL compliance, which can be confusing and administratively burdensome and does not appropriately assess NQTL compliance in accordance with the MHPAEA regulations. Alignment between NAIC and DOL through this tool would help promote a consistent assessment framework, reducing confusion with the MHPAEA requirements, facilitating improved compliance and limiting unnecessary payer administrative burden.

Recommendation #2: BCBSA recommends removing the reference to retroactive relief and notices from characteristic 4, "Responding promptly to detected offenses and developing corrective action" (pg. 34).

Rationale: While the reference to "providing retroactive relief and notice to potentially affected participants and beneficiaries" may be appropriate in certain instances, in some instances, it can be burdensome to members and providers. For example, if a plan were to retroactively re-process claims from several years prior to the current plan year, those adjustments may cause confusion. Providers have likely already closed the books for prior years and this would create administrative burden. Members may also need to seek a refund from the providers which may cause confusion and additional activity for the member for a claim that is in the distant past.

We appreciate DOL's intent that health plans should have mechanisms in place to swiftly address violations; however, we believe these processes should not negatively impact patients' access to services. As such, we do not believe this is the optimal approach to highlight and encourage DOL to remove the language highlighting retroactive relief and notice from the compliance plan recommendations.

Recommendation #3: BCBSA recommends DOL include a note that when protected health information (PHI) is requested, it is not beyond what is necessary (pgs. 34-35). We also encourage DOL to include a reference to personally identifiable information (PII) in the language.

Rationale: We commend DOL for establishing reasonable expectations for what a plan may expect under an audit. However, in all circumstances where PHI or PII is shared, we urge limiting the transfer to essential information only to protect patients' privacy. To this end, we encourage DOL to explicitly note that when PHI and/or PII is requested, it is not beyond what is necessary to address the allegations of noncompliance.

Recommendation #4: BCBSA encourages DOL to consider whether the level of information to support NQTL analyses as described (pgs. 34-35) is necessary and beyond the requirements established by MHPAEA.

Rationale: BCBSA is concerned that the tool implies a level of detail needed to support an NQTL analysis that will not provide health plans with the necessary flexibility to design benefits which reflect the nuances of MH/SUD services. For example, MHPAEA specifies that "any processes, strategies, evidentiary standards, or other factors" used in applying NQTLs should be provided to establish compliance. We are supportive of this requirement, but recommend that plans maintain the existing flexibility under MHPAEA to define and apply these terms as appropriate based on plan design and/or operational procedure.

A tool that is overly detailed and prescriptive can undermine plans' ability to design robust and evidence-based MH/SUD benefits. It is often not in the best interest of the patient for a plan to impose NQTLs in the same manner for MH/SUD benefits as it is for M/S benefits. Many of these services are provided differently based on the type of condition and needs of the patient. For example, treatment for MH/SUD conditions often focuses on less discrete services (e.g., ongoing therapy rather than an MRI or surgical procedure), and it is rarely linear (e.g., many patients will have regressions and gaps in treatments that will require backtracking or adjustments to a treatment plan). As such, health plans must be able to account for the nuances that impact coverage and reimbursement in real-world scenarios, reflecting the flexibility that plans have under the parity standard.

Furthermore, this information is increasingly being repurposed for disclosures to consumers. While we have concerns with how useful this information is for consumers, we would note that if DOL supports efforts to provide consumers with the results of parity analysis, it is likely most helpful to streamline the information by reducing the quantity of technical information included (e.g., clinical trials, professional protocols).

G. Appendix I: Additional Illustrations

Issue: DOL proposes adding an illustration to Appendix I to provide an example of NQTL compliant use of PA.

Recommendation: BCBSA supports the addition of new examples relating to PA in the Appendix I: Additional Illustrations section (pgs. 37-38).

Rationale: BCBSA supports including the new examples relating to PA as they provide helpful information for demonstrating how plans may use PA to address fraud concerns with psychological testing without becoming noncompliant with the parity requirements.

H. Appendix II: Tool for Comparing Plan Reimbursement Rates to Medicare

Issue: Building off Section F, DOL proposes to include a tool health plans can use to compare reimbursement rates to the Medicare Physician Fee Schedule (p. 39).

Recommendation: Consistent with our recommendations that DOL not include a reference to use of the Medicare Physician Fee Schedule as a benchmark for parity, we recommend that DOL remove this appendix from the tool.

Rationale: As stated above, we encourage DOL to consider the process used for setting reimbursement rates when evaluating parity and not establish a precedent that requires identical rates across M/S and MH/SUD providers. Furthermore, we believe relying solely on the Medicare Physician Fee Schedule to assess parity does not account for the myriad of factors used in developing reimbursement rates. As such, we recommend DOL remove this Appendix which is intended to support the language in Section F.