**DATE:** September 29, 2022

**TO:** REDC Consortium Members

**FROM:** Center Road Solutions

**RE:** DOL EBSA’s MHPAEA Roundtable

On Friday, September 16, 2022 Center Road Solutions represented the REDC Consortium at the U.S. Department of Labor (DOL), Employee Benefits and Securities Administration (EBSA) Mental Health Parity and Addiction Equity Act (MHPAEA) Roundtable Discussion.

The roundtable featured the following topic areas for discussion:

1. Access to care and network adequacy through the lens of parity
2. Advancing NQTL (non-quantitative treatment limitations) compliance in general
3. Ensuring operational compliance under the Consolidated Appropriations Act

Attendees included officials from the U.S. Department of Labor, U.S. Department of the Treasury, Center for Consumer Information and Insurance Oversight (CCIIO) within the Centers for Medicare and Medicaid Services, AHIP, American Psychological Association, American Psychiatric Association, American Benefits Council, Association for Behavioral Health and Wellness, BlueCross BlueShield, 2020 Mom, AFL-CIO, Kennedy Forum, Georgetown University’s Health Policy Institute, Elevance Health, Business Group on Health, National Alliance on Mental Illness, National Coordinating Committee for Multiemployer Plans, National Association for Professional Employer Organizations, Autism Speaks, Autism Legal Resource Center, United Healthcare, Optum Behavioral Health Services, Washington State Insurance Commissioner Jane Beyer, Zuckerman Spaeder LLP, and others.

The bulk of the discussion was related to access to care, network adequacy and reimbursement. Below are some of the comments/discussion points by various attendees.

1. **Access to care and network adequacy through the lens of parity**

WA State Insurance Commissioner, Jane Beyer: An insurer can come in with a super star looking network, but we don’t know what clinicians within that network are actually seeing enrollees within that health plan. We are working to figure out how best to find that information and/or ask for that information from the plan or TPA.

We are also working heavily on 988 implementation and building a crisis system to support the influx of calls. There is a role for private payors in crisis services and partnering with us in this space. Unfortunately, behavioral health crisis services are usually payor blind, so we can work on how to bring those services mainstream.

AHIP: Our members are working extremely hard to grow their networks and one of the ways plans are going about this is integration with primary care.

Association for Behavioral Health and Wellness: We are focused on telehealth access and expanding that access. Exploring what flexibilities should be retained after the Public Health Emergency.

BlueCross BlueShield Private Markets of IL, MT, NM, OK & TX: During COVID we went from having 99% of mental health services conducted in person to 60% virtual in a matter of two weeks. Telehealth has assisted in patient retention and cuts down on no-shows.

AFL-CIO: Collective bargaining can get challenging in the health plan benefit space.

American Psychological Association: Our therapists are telling us that payors are now instituting pre-audits and then immediately auditing therapists again. Another issue is state laws around telehealth expansion that don’t align with what is happening at the federal level for ERISA plans. How do we figure out better alignment in policies?

American Psychiatric Association: We talk about providers moving to cash pay as a negative characteristic of the provider. However, if the rates they’re being offered aren’t sustainable, how can you blame them for moving to cash pay? Question for the payors in the room: when you know you’re working with a provider shortage in a particular specialty, do you adjust your rates or not?

Business Group on Health: Confused how network adequacy had anything to do with parity.

1. **Advancing NQTL (non-quantitative treatment limitations) compliance in general**

Discussion from multiple attendees that there is a gap in the current law given there is no agreement upon a statistical model to conduct comparative analyses. The biggest obstacle for plans is figuring out what data is needed and when do they need to pull it.

DOL’s creation of the appendix using Medicare as the benchmark is not great because Medicare is not subject to parity. DOL is inadvertently baking in discrimination. The appendix is a great idea, but let’s not use Medicare and use a “market rate.”

1. **Ensuring operational compliance under the Consolidated Appropriations Act**

Implementation of the No Surprises Act and the provision the requires plan network directories be up to date was part of the discussion.

Every 90-days providers need to update with the health plan. A gap in the requirement is not letting the health plan know if the provider is taking new patients.

Plans usually look if the provider has filed a claim in at least one year and determines from that claim filing as taking new patients or not.