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Client Alert

Federal Regulators Release 2022 MHPAEA Annual Report

January 26, 2022

On January 25, 2022, the Departments of Labor, Health and Human Services ("HHS"), and the Treasury (the "Tri-agencies") released their 2022 annual report to Congress on the Mental Health Parity and Addiction Equity Act ("MHPAEA").

The Consolidated Appropriations Act, 2021 ("CAA"), enacted on December 27, 2020, amended MHPAEA to impose requirements on group health plans and health insurance issuers to "perform and document" comparative analyses of their non-quantitative treatment limitations ("NQTLs"). The same amendments directed the Tri-agencies to issue requests to group health plans and health insurance issuers for comparative analyses and supporting documentation and to issue this annual report detailing their conclusions on compliance with MHPAEA.

Below are several key takeaways from the Tri-agencies' report to Congress:

- The Tri-agencies want plans to have off-the-shelf comparative analyses ready for regulator review upon request, and expressed concern that many plans did not have those analyses available when initially demanded last year.
- The Tri-agencies have initiated numerous ongoing NQTL inquiries, and have issued initial determination letters to various plans identifying areas of non-compliance. However, the Tri-agencies have not yet issued any final determinations of noncompliance under the CAA.
- The Tri-agencies found that ***none*** of the comparative analyses that plans initially submitted were sufficient, and that many analyses lacked sufficient description, detail, or analytical support, particularly analysis of the NQTL "as applied."
- The Tri-agencies have requested follow-up legislation to empower the Departments of Labor, HHS and the Treasury to issue civil monetary penalties to enforce MHPAEA and ensure jurisdiction over plan administrators in addition to plans themselves.

The Report By The Numbers

The report makes clear that the Tri-agencies devoted significant resources to the enforcement of MHPAEA NQTL violations in 2021, and that they will continue to do so in the years ahead. The Department of Labor's Employee Benefits Security Administration ("EBSA") issued 141 comparative analysis requests to group health plans (7 to plans providing fully-insured coverage and 134 to plans providing self-funded coverage) and another 15 comparative analysis requests to health insurance issuers providing insured coverage to group health plans. HHS, through its Center for Consumer Information and Insurance Oversight ("CCIIO"), issued 15 comparative analysis requests to non-federal governmental plans (*e.g.*, state and municipal employee plans) and health

insurance issuers in the few "direct enforcement" states where the state government does not enforce federal law.

EBSA and CCIIO began issuing requests to plans and issuers for comparative analyses in April and May 2021, respectively, and each agency has numerous ongoing investigations of plan and issuer compliance with NQTL requirements. EBSA, for example, issued 80 "insufficiency" letters in response to the comparative analyses received while CCIIO issued 19 of these same communications, each seeking additional information from plans and issuers. EBSA also issued 30 "initial determination" letters that identified 48 non-compliant NQTLs, and CCIIO issued 15 "initial determination" letters that identified 16 non-compliant NQTLs. However, the report indicates that neither agency has issued a final determination of noncompliance.

The report suggests that EBSA is considering corrective action plans submitted by plans in response to the initial determination letters before issuing final determinations of noncompliance, and notes that various actions taken by plans "appear to have addressed EBSA's concerns as to the MHPAEA violations cited in EBSA's initial determination letters." 2022 MHPAEA Report to Congress ("Report") at 25.

Tri-agency Focus on Specific NQTLs

In its FAQs Part 45, EBSA identified the following four NQTLs as areas of focus for FY2021: (1) prior authorization, (2) concurrent review, (3) out-of-network reimbursement rates; and (4) provider network admission and participation criteria, including reimbursement rates. The report to Congress confirms that the Tri-agencies devoted significant resources in examining compliance involving these NQTLs. EBSA noted in the report that it requested comparative analyses for the following NQTLs "listed in descending order of frequency":

- Preauthorization or precertification requirements
- Network provider admission standards
- Concurrent care review
- Limitations on applied behavioral analysis or treatment for autism spectrum disorder
- Out-of-network reimbursement rates
- Treatment plan requirements
- Limitations on medication-assisted treatment for opioid use disorder
- Provider qualification or billing restrictions
- Limitations on residential care or partial hospitalization programs
- Nutritional counseling limitations
- Speech therapy restrictions
- Exclusions based on chronicity or treatability of condition, likelihood of improvement, or functional progress
- Virtual or telephonic visit restrictions
- Fail-first or step therapy requirements.

Further, the 30 initial determination letters issued by EBSA identified the following areas of non-compliance with NQTL requirements as of the date of the report:

NQTL	Number of Initial Determinations of Non-Compliance for the NQTL
Limitation or exclusion of applied behavioral analysis therapy or other services to treat autism spectrum disorder	9
Billing requirements – licensed MH/SUD providers can bill the plan only through specific types of other providers	7
Limitation or exclusion of medication-assisted treatment for opioid use disorder	4
Preauthorization or precertification	4
Limitation or exclusion of nutritional counseling for MH/SUD conditions	4
Provider experience requirement beyond licensure	3
Care manager or specific supervision requirement for MH/SUD	2
Exclusion or limitation on residential care or partial hospitalization to treat MH/SUD conditions	2
"Effective treatment" requirement applicable only to SUD benefits	1
Treatment plan requirement	1
Employee assistance program referral requirement	1
Exclusion of care for chronic MH/SUD conditions	1
Exclusion of speech therapy to treat MH/SUD conditions	1
Concurrent care and discharge planning requirements	1
Retrospective review	1
Maximum allowable charge and referenced-based pricing	1
Other exclusions specifically targeting MH/SUD benefits	1
Age, scope, or durational limits	1
Formulary design	1
Limit on telehealth for MH/SUD	1
Restriction on lab testing for MH/SUD	1

Tri-agency Identification of Common Deficiencies in Comparative Analyses

The Tri-agencies found that ***none*** of the initial comparative analyses they reviewed were satisfactory. EBSA identified the following themes in the deficiencies they discovered:

- Failure to identify the benefits, classifications, or plan terms to which the NQTL applies;
- Failure to describe in sufficient detail how the NQTL was designed or how it is applied in practice to MH/SUD benefits and medical/surgical benefits;

- Failure to identify or define in sufficient detail the factors, sources, and evidentiary standards used in designing and applying the NQTL to MH/SUD and medical/surgical benefits;
- Failure to analyze in sufficient detail the stringency with which factors, sources, and evidentiary standards are applied; and
- Failure to demonstrate parity compliance of NQTLs as written and in operation.

Below are specific examples of ways in which EBSA noted the comparative analyses fell short:

- Failure to document comparative analysis before designing and applying the NQTL;
- Conclusory assertions lacking specific supporting evidence or detailed explanation;
- Lack of meaningful comparison or meaningful analysis;
- Non-responsive comparative analysis;
- Documents provided without adequate explanation;
- Failure to identify the specific MH/SUD and medical/surgical benefits or MHPAEA benefit classification(s) affected by an NQTL;
- Limiting scope of analysis to only a portion of the NQTL at issue;
- Failure to identify all factors;
- Lack of sufficient detail about identified factors;
- Failure to demonstrate the application of identified factors in the design of an NQTL; and
- Failure to demonstrate compliance of an NQTL as applied.

The report indicates that the Tri-agencies want plan and issuer comparative analyses to better define the factors identified, and to specify the evidentiary standards used in applying the factors. The Tri-agencies also want plans and issuers to identify quantitative thresholds used by the plan in determining whether the factor applies to a benefit, where applicable.

Moreover, the Tri-agencies are focused on how plans and issuers demonstrate parity compliance for NQTLs as applied. Despite clear regulatory guidance that outcomes are not determinative of MHPAEA compliance, the report continues to note that "disparate outcomes can be relevant, and may constitute warning signs or indicators of potential operational MHPAEA parity non-compliance." Report at 18. The Tri-agencies want to see both (1) a detailed explanation of how an NQTL was applied to MH/SUD versus medical/surgical benefits, and (2) documentation, including data analysis, showing a plan or issuer's review of how an NQTL is applied in operation. The report provides examples of specific data analytics that plans could run for concurrent or preauthorization review and network admission standards to demonstrate comparability:

- Concurrent or preauthorization review – Denial rates, reasons for denial, utilization rates, frequency of reviews, length of reviews, lengths of stays authorized, frequency of elevation to a peer-to-peer review, and review turnaround times.
- Network admission standards – Comparison of rates of acceptance/denial or withdrawal for MH/SUD and medical/surgical providers, application processing time, network reimbursement rates, latitude granted in rate negotiations, and the role of network adequacy measures.

Conclusion

The Tri-agencies' discussion of plans' and issuers' comparative analyses confirm an ongoing need for further guidance. As noted above, the Tri-agencies found that ***none*** of the comparative analyses they reviewed were initially satisfactory. Although the Tri-agencies characterize this as an industry failure, the uniform alleged shortcomings point to a need for more guidance. The Tri-agencies confirm in the report that they intend to promulgate regulatory amendments in 2022 via notice and comment rulemaking.

Finally, the Tri-agencies note in the report that they plan to enhance "proactive and rigorous enforcement" of parity violations and, to this end, they have requested that Congress amend ERISA and MHPAEA to provide the Department of Labor the authority to assess civil monetary penalties for parity violations, and to give the Department of Labor parity enforcement authority over entities that provide administrative services to ERISA group health plans (including health insurance issuers that provide administrative services to ERISA plans and third-party administrators). Further, the Tri-agencies request that Congress amend ERISA and MHPAEA to allow participants and beneficiaries to recover amounts lost due to parity violations, permanently expand access to telehealth and remote care services, and ensure that MH/SUD benefits are defined in an objective and uniform manner pursuant to external standards.

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