MEMORANDUM

DATE: January 25, 2022

TO: REDC Consortium

FROM: Katrina Velasquez and Maddie Schumacher, Center Road Solutions

RE: 2022 MHAPEA Compliance Report to Congress

Summary:

On January 25, 2022, Department of Labor (DOL), Centers for Medicaid and Medicare Services (CMS), and the Department of Treasury (Treasury) issued a report on mental health parity to congress, per their requirements under MHPAEA law and the new Consolidated Appropriations Act (CAA) from 2021. Within this detailed 54-page report, both DOL and CMS detail the new mental health parity enforcement tool requiring a payers and insurers to issue comparative analyses of their compliance with mental health parity's NQTL requirements.

The overall result was astounding, in that almost more than half of payers/insurers did not meet the DOL deadline, and that 100% of the compliance reviews resulted in an initial determination of noncompliance for mental health parity.

As a summary:

- In 2021, DOL issued 156 letters to plans/insurers requesting comparative analysis for 216 unique NQTLs across 86 investigations. This led to the issuance of 30 initial determination letters finding 48 NQTLs imposed on MH/SUD benefits. DOL received 19 corrective action plans, addressing 36 NQTLs, and 28 plans have agreed to make changes to their plans.
- In 2021, CMS issued 15 letters to insurers with 16 NQTLs in states where CMS has direct enforcement (TX, MO, and WY) and to non-Federal governmental plan sponsors in those and other states. Two were found to be impermissible separate treatment limitations, and 14 comparative analyses remained insufficient. CMS received 6 corrective action plans addressing 13 NQTLs.

REDC Consortium's government relations representatives were invited to attend an engagement today with the Department of Labor Secretary Walsh and CMS Assistant Secretary Ali Khawar to discuss the report. Within this presentation, Sec. Walsh shared his recovery story from alcoholism and stated that mental health parity was a high priority for President Biden, himself, and Ass't Sec. Ali Khawar. Particularly he noted he wanted to focus on parity violations for adolescent mental health was high.

A. Mental Health Parity NQTL Violations:

DOL EBSA (ERISA Plans):

1. Preauthorization or precertification requirements (particularly for inpatient services)
2. Network provider admission standards
3. Concurrent care review
4. Limitations on applied behavior analysis or treatment for autism spectrum disorder
5. Out-of-network reimbursement rates
6. Treatment plan requirements
7. Limitations on medication assisted treatment for opioid use disorder

8. Provider qualifications or billing restrictions (including network admission and participation criteria)
9. Limitations on residential care or partial hospitalization programs
10. Nutrition counseling limitations
11. Speech therapy restrictions
12. Exclusions based on chronicity or treatability of condition, likelihood of improvement or functional progress
13. Virtual or telephonic visit restrictions
14. Fail-first or step therapy requirements

NQTL Violations: CMS Plans:

1. Concurrent review
2. Provider credentialing standards
3. Prior authorization
4. Provider network participation requirements
5. Treatment certification requirements

B. Mental Health Parity Non-Compliance Summary:

For DOL, are the summary of non-compliance with parity:

1. Limitation or exclusion of applied behavior analysis therapy or other services to treat autism
2. Billing requirements- licensed MH/SUD providers can bill the plan only through specific types of providers
3. Limitations or exclusions of medication-assisted treatment for opioid use disorder
4. Preauthorization or precertification
5. Limitations or exclusion of nutrition counseling for MH/SUD conditions
6. Provider experience requirement beyond licensure
7. Care manager or specific supervision requirement for MH/SUD
8. Exclusion or limitation on residential care or PHP to treat MH/SUD
9. "effective treatment" requirement applicable only to SUD benefits
10. Treatment plan requirement
11. Employee assistance program referral requirement
12. Exclusion of care for chronic MH/SUD conditions
13. Exclusion of speech therapy to treat MH/SUD conditions
14. Concurrent care and discharge planning requirements
15. Retrospective review
16. Maximum allowable charge and reference-based pricing
17. Other exclusion specifically targeting MH/SUD benefits
18. Age, scope, or durational limits
19. Formulary design
20. Limit on telehealth for MH/SUD
21. Restriction on lab testing for MH/SUD

CMS Non-compliance found:

1. MH/SDU continued-stay criteria, requirement of evident progress for continued coverage

2. MH/SUD discharge criteria, no coverage if no significant improvement in condition
3. MH/SUD discharge criteria, no coverage if enrollee leaves against medical advise
4. MH/SUD covered changes, no coverage if no certification that participant completed full continuum of care necessary and available at the facility

C. Highlighted Example Non-Compliance- Including Residential Treatment and Eating Disorders Nutrition Counseling:

DOL and CMS provided a number of examples of non-compliance and enforcement, many of which directly related to eating disorders treatment and community:

- **Example #3 – Removal of Nutritional Counseling Exclusion for MH/SUD Conditions** Two large plans using similar fully-insured products (an exclusive provider organization (EPO) product and a preferred provider organization (PPO) product) offered by the same health insurance issuer covered nutritional counseling for medical/surgical conditions like diabetes, but not for mental health conditions like anorexia nervosa, bulimia nervosa, and binge-eating disorder. Eating disorders are serious and often fatal illnesses associated with severe disturbances in people's eating behaviors and related thoughts and emotions.44 Eating disorders are among the deadliest MH/SUD conditions, and anorexia nervosa has the highest mortality rate of any mental health disorder.45 EBSA's New York Regional Office requested comparative analyses for the nutritional counseling limitation from both plans and directly from the issuer offering the fully-insured products used by the plans. The responses received from the plans and the issuer did not explain or demonstrate that the facially-discriminatory exclusion, which affected only MH benefits, was compliant with parity requirements. As a result, both plans have amended their coverage documents to remove the exclusion, and the issuer is in the process of submitting forms to state regulators to remove the NQTL from the fullyinsured products. This correction will impact over 1.2 million participants covered by 602 ERISA-covered plans using the issuer's fully-insured EPO and PPO products. The New York Regional Office is working with the plans and issuer to identify and specify appropriate retrospective corrective action for the NQTL.

- **Example #1 – Removal of Criteria Limiting Coverage of MH/SUD Benefits** One of the issuers reviewed was found to have impermissible separate treatment limitations in the form of MH/SUD continued-stay criteria requiring demonstrable progress for continued care coverage, as well as MH/SUD discharge criteria resulting in a loss of coverage if there was no significant improvement in an enrollee's condition or if the enrollee left against medical advice. There were no similar criteria applied to medical/surgical benefits in the same benefit classification. After receiving CMS's initial determination letter, the issuer included revised continued-stay and discharge criteria along with supporting documentation showing that the more stringent limitations on MH/SUD benefits were removed and no longer in effect in its corrective action plan submission for this review. In addition, since the impermissible separate treatment limitations may have affected enrollees while the limitations were in effect, the issuer also initiated a self-audit to identify claims impacted by the criteria described in the initial determination letter and has committed to re-adjudicating claims. The issuer is currently undertaking the self-audit process and CMS will report on the results of this review in the next annual report to Congress.

- **Enforcement Example:**

- Exclusion of Out-of-Network Residential Treatment: EBSA's Boston Regional Office determined that a self-insured plan violated MHPAEA by excluding coverage for out-of-network residential treatment for MH/SUD conditions. The coverage exclusion did not apply to medical/surgical benefits in the same classification. As a result of EBSA's investigation, the plan reprocessed and paid two denied residential treatment claims totaling $88,402 and agreed to amend its plan language to eliminate the exclusion and to change claims processing procedures to prevent similar claims denials in the future.
- Higher Co-Pays for MH/SUD Than Med/Surg: In a plan-level investigation, EBSA's Philadelphia Regional Office found that a plan's financial requirements were not compliant with MHPAEA in the classification of outpatient/in-network services, where participants seeking MH/SUD benefits were charged higher co-pays when compared to medical/surgical benefits in the same classification. As a result of the investigation, plan fiduciaries readjudicated claims spanning a four-year period that were not in parity and reimbursements of overpaid cost sharing were made to 1,945 affected participants in the aggregate amount of $82,065.
- Exclusion of Residential SUD: EBSA was contacted on behalf of a residential SUD treatment facility that was having difficulty getting reimbursed for care rendered to a patient. The patient had coverage through an employment-based group health plan. The claim and appeal were denied on the grounds that treatment at a residential care facility was not covered under the terms of the plan. EBSA reviewed the claims at issue and plan documents, and saw a potential MHPAEA violation in that the plan appeared to have an NQTL that it applied only to in-patient SUD benefits, but did not apply a comparable exclusion to medical/surgical benefits in the same classification. The inquiry was transferred to the Atlanta Regional Office, which has jurisdiction over the health plan. That office opened an investigation.
- Inaccurate Provider List and Network Adequacy: EBSA's Boston Regional Office received a complaint from a group health plan participant who was having difficulty finding an in-network mental health provider. The participant stated that the list of participating providers offered by the insurer was inaccurate; when she called the providers on the list, she discovered that many of them were no longer participating providers or they had moved out of the area. The benefits advisor referred the complaint for investigation.