VOL. 35, NO. 1 SPRING 2022

BENEFITS LAW JOURNAL

2022 Mental Health Parity Report to Congress Highlights Increased Enforcement Efforts

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Regulatory agencies have released their 2022 Annual Report to Congress on the Mental Health Parity and Addiction Equity Act of 2008, titled "Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage." The authors of this article discuss the report and provide top takeaways for employers.

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The U.S. Department of Labor ("DOL"), Department of Health and Human Services, and Department of the Treasury (collectively, "Departments" or "Regulators") have released their 2022 Annual Report to Congress[1] on the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), titled "Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage" ("Report").

The Report was issued to meet the statutory requirement[2] that the Departments issue an annual report to Congress detailing their parity enforcement findings. MHPAEA was amended by the Consolidated Appropriations Act, 2021 ("CAA"),[3] to impose a requirement on group health plans and health insurance issuers that they perform and document comparative analyses of their use of non-quantitative treatment limitations ("NQTLs") to affirmatively establish that they are implementing them in a non-discriminatory manner. The CAA amendments also gave the Departments the authority to request health plans and issuers to submit their NQTL comparative analyses and supporting documentation for review. The Departments used the Report – the first annual report since the passage of the CAA – to share their findings from recent investigations and to provide further guidance to plans and issuers on what they are expecting from an adequate comparability and stringency analysis.

TOP TAKEAWAYS FROM THE REPORT

- The Departments reported that none of the comparative analyses reviewed to date have contained sufficient information upon initial receipt to satisfy the Departments' expectations. The Report suggests that this reflects a lack of motivation or effort by health plans to undertake the work necessary to comply with the substantive requirements of MHPAEA and the documentation requirements of the CAA. However, the Report also acknowledges that additional guidance is forthcoming. Industry representatives have previously requested examples of a model for a comprehensive, fully compliant comparative analysis. The Report remains silent on the extent to which the Departments will take enforcement action based on inadequacy of documentation while health plans and carriers await guidance to further clarify the Regulators' expectations.

- The Report noted that most of the initial findings of non-compliance related to the inadequacy of the comparative

analyses to prove that the NQTLs are not discriminatory. Specifically, the comparative analyses did not provide the specific information, analyses, and supporting documentation the Departments expected.

- There were a comparatively small number of initial findings of noncompliance related to policies that the Departments found to be affirmatively discriminatory. The substantive violations identified in the Report were generally very clear cut and would not require extensive analysis to substantiate.

- To date, the Departments have not issued any final determinations of noncompliance with parity requirements (either as to affirmative discrimination or inadequacy of comparative analyses). However, both the Centers for Medicare & Medicaid Services ("CMS") and the Employee Benefits Security Administration ("EBSA") have issued initial determinations of noncompliance and several health plans and issuers have entered into corrective action plans. In addition, CMS made four findings where they found no evidence of noncompliance.

- The Report describes auditing efforts by the Departments that represent a significant increase in the volume, intensity, and sophistication of investigations into parity compliance compared to prior years. For example, EBSA expanded staffing, increased staff specialization, developed tools for use in investigations, and retained contractor support for enforcement. Because of this significant federal investment in infrastructure dedicated to MHPAEA enforcement, we expect this trend toward expansion to continue.

- The Departments stated they will publish a notice of proposed rulemaking to clarify and amend MHPAEA regulations.

KEY TAKEAWAYS FOR EMPLOYERS

- Employers are still struggling to ascertain what the Regulators are looking for to satisfy the requirement to provide comparative analyses that affirmatively establish the absence of discrimination.

- Of 216 NQTL analyses reviewed by DOL and 21 NQTL analyses reviewed by CMS, none were found to meet the Regulators' expectations.

- Although the CAA requires the Report to identify by name all plans and carriers that are determined to be out of compliance, to date, the Departments have not made any such final determinations of noncompliance. Because the "Conclusions Regarding Compliance with Disclosure Requirements" cited in the Report as the focus for initial determination of noncompliance all center on substantive disparities in benefit design or operations, this may indicate that the Departments are hesitant to use their "naming and shaming" authority where findings are based solely on inadequacy of documentation with no evidence that the limit is in fact applied more stringently to mental health or substance use disorder benefits.

KEY TAKEAWAYS FOR PLAN ATTORNEYS AND COMPLIANCE OFFICERS

- Plans and issuers should review their contracts to determine the allocation of responsibilities for preparation and maintenance of comparative analyses.

- Plan attorneys and compliance officers should critically review their plan documents, as EBSA and CMS both reported that investigators found potential issues in plan documents (such as the Summary Plan Description ("SPD")), which ultimately triggered an investigation and most of the findings of alleged discriminatory policy.

- Attorneys and compliance officers should review the Report and ensure that their own NQTL analyses address the specific issues and insufficiencies the Regulators identified with respect to those they reviewed.

- The Regulators are interpreting parity to create a duty to ensure that factors, sources, and evidentiary standards are formulated with sufficient specificity that the plan can affirmatively prove that each factor has, in fact, been applied consistently to determinations of whether or not the factor was met. This standard for compliance is much easier to satisfy

when a quantitative evidentiary standard is assigned to each factor (e.g., where a specific dollar threshold is assigned to a factor based on "high cost"), and the Regulators have provided few examples of qualitative evidentiary standards that would be acceptable (e.g., where a factor is based on quality of care or patient safety).

- The Report also identifies a requirement for the plan to create, describe, and be prepared to produce, upon request, documentation to show how it determined whether each factor was or was not met with regard to each benefit or service in the classification. Because DOL has not yet made any final determinations of compliance for any of the investigations that it has opened pursuant to its authority under the CAA, it remains unclear the extent to which the Regulators will seek to enforce this new requirement for affirmative documentation on a retrospective basis.

SHEDDING LIGHT ON THE INVESTIGATIVE PROCESS

The Report sheds light on the investigative processes used by EBSA and CMS's Center for Consumer Information and Insurance Oversight ("CCIIO") to assess parity compliance, and provides insight related to which organizations the Departments elected to send requests for documentation.

EBSA stated that most of its requests for NQTL documentation were issued to organizations where EBSA had previously developed specific investigative leads. Similarly, CMS stated its investigations were often prompted by previous indications of noncompliance in market conduct exams or prior audits. However, leads were also developed by investigators who identified language in plan documents that indicated potential parity noncompliance. EBSA generated other investigative leads using the information gathered from its quality assurance review and stakeholder engagement. As part of this initiative, EBSA established working groups to consider legal theories for enforcement, targeting methods and leads with regard to network accuracy, network adequacy, and coverage of autism. The working groups examined potential investigative leads by using claims data to identify networks with parity "red flags," and then identified specific plans with certain characteristics that use those networks.

While the Report provides examples of how investigators developed investigative leads in some instances, the Report is opaque with respect to how leads ultimately prompt an investigation. Whether a

plan or issuer is targeted for an investigation may be based on size of the organization, investigator review of plan documents, leads developed by targeting service providers (such as third-party administrators or behavioral health organizations), or member complaints. Based on the lack of transparency regarding how investigations into parity compliance are prompted and developed, it is clear the Departments seek to reserve flexibility to pursue investigations at their discretion.

FOCUS ON SPECIFIC NQTLS

The Departments stated in Frequently Asked Questions[4] ("FAQs") guidance issued in April 2021 that they would focus on four NQTLs in fiscal year 2021:

(1) Preauthorization for inpatient services;

(2) Concurrent care review for inpatient and outpatient services;

(3) Out-of-network provider reimbursement rates; and

(4) Provider network admission and participation criteria, including reimbursement rates.

The Departments report that in practice, the NQTL types most commonly requested by EBSA investigators, in order of descending frequency, were:

- Preauthorization or precertification requirements
- Network provider admission standards
- Concurrent care review
- Limitations on applied behavior 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

The inclusion of many of these additional NQTLs not initially identified in the FAQs Part 45[5] is most likely driven by policies DOL identified as potentially discriminatory on their face from a review of the plan's SPD.

Notably, the NQTLs for which EBSA most frequently issued initial determinations of noncompliance were those NQTLs that analyzed exclusions of certain behavioral health treatments. EBSA issued nine initial determinations of noncompliance related to a limitation or exclusion of applied behavior analysis ("ABA") therapy or other services to treat autism spectrum disorder. EBSA also issued seven initial determinations for billing requirements placed disproportionately on mental health or substance use disorder ("MH/SUD") providers. In addition, EBSA issued four initial determinations of noncompliance each for prior authorization NQTLs, limitations of nutritional counseling for MH/SUD conditions, and limitations placed on medication-assisted treatment. Notably, EBSA only issued one initial determination of noncompliance related to concurrent review.

Although EBSA most frequently requested prior authorization NQTLs from plans, which requires the most substantial burden for plans and issuers in terms of providing documentation and lengthy granular analysis, EBSA only issued four determinations of noncompliance for this NQTL. By contrast, EBSA found the most potential parity violations with respect to ABA exclusions, a policy frequently described in SPDs and for which the NQTL comparative analysis requires comparatively basic documentation. Although EBSA previously stated it would focus on prior authorization, concurrent review, network adequacy, and out-of-network reimbursement, it ultimately issued just five initial determinations of noncompliance across all of these NQTLs in total, and most determinations of noncompliance appear to have been driven by coverage limits identified in the plan SPD.

COMMON DEFICIENCIES THE DEPARTMENTS FOUND IN COMPARATIVE ANALYSES

The CAA requires that all comparative analyses contain certain features, documented in a stepwise process to show that the limitations a plan applies to any MH/SUD benefits is comparable to, and no more stringent than, the way a plan applies limitations to medical/surgical ("M/S") benefits. Plans document their NQTLs in this stepwise manner to demonstrate that everything about the design and implementation of the NQTL is not discriminatory.

The 2022 Report provides a list of the most common ways the Departments found the comparative analyses to be deficient, including:

- 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 that apply;
- 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 Departments also cited as a common deficiency, a lack of specificity around the factors used to determine whether an NQTL applies. Namely, the Report noted that plans did not define every factor and did not specify the evidentiary standard used in each factor's

application, especially when the factor was applied or evaluated in a quantitative way. The Departments indicated that factors such as "cost containment" or "high-cost services" require a precise quantitative definition, an explanation of whether and how the plan derived a numerical standard for applying such terms to benefits, and supporting documents showing the term's application. However, in requesting a quantitative definition, the Departments assume plans and issuers utilize quantitative rather than qualitative factor definitions.

As noted above, the MHPAEA statute and regulations do not require that plans utilize quantitative standards, and the law expressly allows plans and issuers the flexibility to define their factors by qualitative means. However, to date, the Regulators have provided few examples of qualitative evidentiary standards that would be acceptable.

In addition, the Departments found that in comparing the processes for deciding whether an NQTL applies to MH/SUD or M/S services, plans and issuers often described a committee-based process used to determine the applicability of the NQTL. The Departments stated that if plans describe committee processes in their NQTLs, those descriptions must provide details about what specifically was done or decided, and by whom, when, or how it related to specific NQTLs. This includes an explanation of precisely how each factor was applied by the committee members, to which benefits, the outcome of the factor's application, and documentation showing this process. However, the Regulators have provided few examples of what this high-level conceptual analysis might look like in an NQTL.

Finally, the Departments noted that many comparative analyses lacked a sufficiently detailed data on the results of the implementation of each NQTL in practice and how those results compare between MH/SUD and M/S benefits, referred to as the "in-operation" analysis. The Report includes a list of suggested metrics, such as denial rates, reasons for denial, utilization rates, frequency of reviews, lengths of reviews, lengths of stays authorized, frequency of elevation to a peer-to-peer review, and review turnaround times in assessing the application of prior authorization or concurrent review to MH/SUD and M/S benefits. The Report stated that operations metrics should be accompanied by a description of the methodology, source data, and calculations used to generate the numbers being compared.

Notably, none of the operations measures that the Regulators suggested in the Report have been set forth in the statute, regulations, or sub-regulatory guidance. The Regulators in their sufficiency letters to plans and issuers requested voluminous amounts of specific operations measures that plans and issuers were not adequately notified they needed to provide, and for which they did not have monitoring systems in place. Despite the Regulators seeking methodologies,

source data, and calculations for operations measures, the lack of technical specifications imposed a substantial burden on plan operations to seek to interpret the narrative data description and develop a methodology that would approximate what the Departments were seeking. This process likely contributed substantially to the delays in the submission of analyses to the Departments and to the audit process itself.

CORRECTIVE ACTION OPTIONS REGARDING NONCOMPLIANCE

The Report discusses a range of corrective approaches for plans and issuers that have been found to have improperly applied an NQTL or prepared inadequate comparative analyses. During the corrective action stage, plans and issuers are required to develop and provide the information the Departments deemed necessary to complete a review of their comparative analysis, correct any issues of specific discriminatory design, and perform a self-audit to identify consumers who were affected by the discriminatory NQTL in order to re-adjudicate claims and/or denials. The Departments noted that they are working with plans and issuers to identify participants and beneficiaries harmed by application of discriminatory NQTLs and to provide relief, including the following types of corrective activity:

- Making retroactive changes to plan terms to remove a limitation, reduce the scope of a limitation, or add a benefit previously excluded;

- Providing notice to participants and beneficiaries of an opportunity to submit or resubmit claims as a result of a retrospective change in plan terms;

- Re-adjudicating or paying claims denied due to application of noncompliant NQTLs;

- Amending medical policies, claims processing policies and procedures, or other practices; and

- Training for claims processing staff.

As noted above, the Departments found a relatively small number of discriminatory policies compared to the majority of initial noncompliance findings related to inadequate analysis documents proving the absence of discrimination.

THE DEPARTMENTS RECOMMEND FUTURE REGULATORY AND LEGISLATIVE ACTION IN ADDITION TO CONTINUED ENFORCEMENT

The Report indicates that the Departments, in additional to their enforcement efforts, intend to clarify MHPAEA requirements through future rulemaking, in particular to implement the new statutory requirements for compliance documentation in the CAA. The Departments may also choose to release sub-regulatory guidance, such as model comparative analyses and technical specifications for operations measures, either of which would be welcome guidance for the industry.

In addition, the Report makes several recommendations to Congress to strengthen MHPAEA's consumer protections and aid the Departments in future enforcement efforts. To increase DOL's enforcement power, the Departments recommend that Congress amend the law to provide DOL with the authority to assess civil monetary penalties for parity violations in order to strengthen the protections of MHPAEA and serve as a deterrent for plans and issuers to commit potential violations. The Departments also ask Congress to amend the Employee Retirement Income Security Act of 1974, or ERISA, to provide a private right of action for participants and beneficiaries, as well as DOL on their behalf, to recover the monetary value of claims denied in violation of MHPAEA.

The Departments state that in the absence of the authority to impose civil monetary penalties, DOL is limited in its ability to ensure appropriate corrective action in response to findings of noncompliance with MHPAEA, and plans may be insufficiently motivated to achieve and document compliance. However, this assessment ignores the substantial concerns that employer health plan sponsors have about the impact on employee and member relations of current "naming and shaming" consequences that are required for determinations of noncompliance under the CAA, and comparable concerns about reputational harm for any third-party administrator that may be implicated. Depending on their size and structure, civil monetary penalties may not significantly increase the already-substantial motivation that plans have to remain compliant.

The Departments also recommend that Congress amend MHPAEA to ensure that MH/SUD benefits are defined in an objective and uniform manner based on a specific set of diagnosis codes. This request may be intended to ensure plans can no longer classify certain conditions (such as autism spectrum disorder and other intellectual or development conditions) as medical-surgical conditions for the purpose of the comparative analyses, therefore allowing more restrictive limitations. The request may also be aimed at categorizing certain services that

can be used to treat both MH/SUD and M/S conditions (such as emergency room admissions, speech therapy, nutritional counseling, etc.).

Currently, neither the MHPAEA regulations nor any FAQ or other federal guidance directly addresses the proper application of parity to benefits for treatments and services that can be delivered to care for both MH/SUD and M/S conditions. The general approach currently taken by many regulators is that parity applies to claims for benefits with a primary diagnostic code that has been defined by the plan to be a MH or SUD condition (in accordance with federal and state law and consistent with generally recognized independent standards of current medical practice). However, other methods exist for defining MH benefits that aid in more effective comparative analyses. For instance, the plan or issuer can determine, using reasonable methods, whether a given treatment or service is covered under an MH benefit, a SUD benefit, or an M/S benefit. This can be accomplished by considering whether the treatment or service is most commonly delivered to treat MH/SUD or M/S conditions, whether the service is most commonly delivered by MH/SUD or M/S providers, or whether the service is most commonly covered by MH/SUD coverage or by M/S coverage.

NOTES

1. *https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf*.

2. Consolidated Appropriations Act, 2021, P.L. 116-260, Division BB, Title II, Section 203 (enacted on Dec. 27, 2020).

3. Consolidated Appropriations Act, 2021, P.L. 116-260 (enacted on Dec. 27, 2020).

4. *https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf*.

5. *Id.*