# MHPAEA Enforcement Trends Facing Regulatory Uncertainty

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Segal

# Today's Presenters

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# Agenda

**Background on recently issued Mental Health Parity and Addiction Equity Act (MHPAEA) materials**

**Updates on the proposed rule comment process**

**A closer look at the 2023 MHPAEA report to Congress**

**Key takeaways for plan sponsors**

# Recently Issued MHPAEA Materials

# Strengthening Parity Mental Health / Substance Use Disorder

Enacted December 27, 2020

Requires group health plans to perform and document comparative analyses of the design and application of nonquantitative treatment limitations (NQTLs)

Plans were required to be prepared to make these comparative analyses available to the Departments of Labor and/or Health and Human Services upon request beginning 45 days after the date of enactment (February 10, 2021)

# New Mental Health Guidance Released

## On July 25, 2023, the Departments issued a package of guidance

- Proposed rules, later formally published in the FR on August 3
- Technical release seeking information and comments with respect to guidance for proposed data collection and evaluation requirements for nonquantitative treatment limitations related to network composition
- The 2023 MHPAEA Comparative Analysis Report to Congress
- Enforcement Fact Sheet regarding fiscal year 2022 enforcement results
- Press Release announcing guidance

The in-depth Segal Webinar overviewing the proposed rules is available on the Segal website*.

* https://www.segalco.com/consulting-insights/proposed-mhpaea-rules-and-the-challenges-they-would-create

# MHPAEA Proposed Rules General Overview

- Includes changes to the 2013 MHPAEA final regulations and new, additional requirements, including required data collection
- Includes new provisions for the content requirements of the NQTL comparative analyses required under MHPAEA
- Provides a transition period to comply with new requirements. Proposes applicability for plan years beginning on or after January 1, 2025
- Includes HHS-only amendments to implement the sunset provision for self-funded, non-Federal governmental plan elections to opt out of compliance with MHPAEA

# Updates on the Proposed Rule Comment Process

# Comment Deadline

**The Departments solicited comments on all aspects of the proposed rules**

**In addition, the Departments issued a Technical Release requesting information and comments related to network composition**

**Comments deadline was extended, but concluded on October 17, 2023**

# MHPAEA Comment Activity

The Departments of Labor, HHS, and Treasury have received over 9500 comment letters

Many groups and organizations representing the interests of employers and plans sponsors have provided comments raising questions and concerns regarding a broad range of the proposed requirements. These include the American Benefits Council, the National Coordinating Committee of Multiemployer Plans, the ERISA Industry Committee, and the Parity Coalition

Comment letters should be accessible for viewing by the public in the near term

# Key Concerns Raised by Stakeholders

- Reasonable timing to allow for implementation
- Cost estimates
- New named fiduciary certification
- Network composition standards
- Data collection and evaluation standards
- Application of substantially all/predominance testing to NQTLs
- New and expanded definitions and scope, including a “meaningful benefits” rule

# A Closer Look at the 2023 Report to Congress

# Federal Enforcement Has Continued to Increase


Realizing Parity, Reducing Stigma, and Raising Awareness


DOL 2020 Report to Congress


DOL published an updated 2020 MHPAEA Self-Compliance Tool

[2022 MHPAEA Report to Congress (dol.gov)]

[Parity Partnerships: Working Together (dol.gov)]

[https://www.dol.gov/agencies/ebsa/at-a-glance]

Reports to Congress bi-annually since 2012

Annual FY Enforcement Fact Sheets 2015 to 2022 available on the DOL website

# 2023 MHPAEA Comparative Analysis Report to Congress

Issued in July 2023

Overviews enforcement efforts specific to the CAA amendments to MHPAEA, regarding documented comparative analysis

Does not address ongoing investigations that did not close in FY 2022

# Employee Benefits Security Administration (EBSA) Letters Requesting Comparative Analyses

**November 2021 through July 2022**

- **57** Unique NQTLs
- **69** NQTLs
- **25** Letters Requesting Comparative Analyses

**February 2021 through July 2022**

- **270** Unique NQTLs
- **450** NQTLs
- **182** Letters Requesting Comparative Analyses

| January 2021 | February 2021 | March 2021 | April 2021 | November 2021 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|

# EBSA Insufficiency Letters

**November 2021 through July 2022**

- **100** NQTLs
- **52** Insufficiency Letters

**February 2021 through July 2022**

- **290** NQTLs
- **138** Insufficiency Letters

| January 2021 | February 2021 | March 2021 | April 2021 | November 2021 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|

# EBSA Initial Determinations of Non-Compliance

**November 2021 through July 2022**

- **20** Unique NQTLs
- **26** NQTLs
- **22** Initial Determination of Non-Compliance

**February 2021 through July 2022**

- **56** Unique NQTLs
- **76** NQTLs
- **53** Initial Determination of Non-Compliance

| January 2021 | February 2021 | March 2021 | April 2021 | November 2021 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|

# Prospective Plan Changes

**November 2021 through July 2022**

- **24** Unique NQTLs
- **36** NQTLs
- **32** Plans Sent Corrective Action Plans

**February 2021 through July 2022**

- **71** Unique NQTLs
- **135** NQTLs
- **104** Plans Agreed to Make Prospective Changes

| January 2021 | February 2021 | March 2021 | April 2021 | November 2021 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|

# Enforcement Priorities

- Prior authorization for in-network and out-of-network inpatient services
- Concurrent care review for in-network and out-of-network inpatient/outpatient services
- Standards for provider admission to participate in a network, including reimbursement rates
- Methods for determining out-of-network reimbursement rates

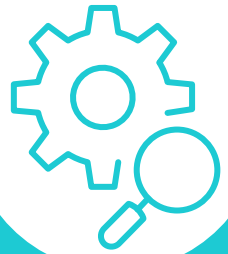
## Increased Focus on Provider Network Adequacy

- Enforcement focus on provider network composition and participation standards
- Review of provider reimbursement rates and monitoring adequacy of provider networks
- EBSA currently pursuing over 20 network admission standards investigations related to NQTLs impacting network adequacy

# FY 2022 DOL Enforcement Overview

## *EBSA Investigation*

**EBSA investigated and closed 145 health plan investigations in FY 2022. Of these investigations, 58 involved fully-insured plans, 65 involved self-insured plans, and 22 involved plans of both types (the plan or service provider offered both fully insured and self-insured options). EBSA has closed 4,231 health plan investigations since FY 2011**



**Of the 145 closed investigations in FY 2022, 86 involved plans subject to MHPAEA. Twenty of these investigations involved fully-insured plans, 50 involved self-insured plans, and 16 involved plans of both types**

**EBSA cited 18 MHPAEA violations in 11 investigations. One of these investigations involved a fully-insured plan, and 10 involved self-insured plans. The violations included:**

- 3 annual/lifetime limits,
- 2 financial requirements,
- 2 QTLs,
- 10 NQTLs, and
- 1 final determination of noncompliance with the NQTL comparative analysis requirements in a closed investigation

# MHPAEA Violation Investigation Categories

**In FY 2022, EBSA and CMS investigated MHPAEA violations in the following categories:**

1. **Annual dollar limits:** dollar limitations on the total amount of specified benefits that may be paid in a 12-month period under a group health plan or health insurance coverage for any coverage unit
2. **Aggregate lifetime dollar limits:** dollar limitations on the total amount of specified benefits that may be paid under a group health plan or health insurance coverage for any coverage unit
3. **Benefits in all classifications:** requirement that if a plan or issuer provides mental health or substance use disorder benefits in any classification described in the MHPAEA final regulations, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided

# MHPAEA Violation Investigation Categories

4. **Financial requirements:** deductibles, copayments, coinsurance, or out-of-pocket maximums

5. **Treatment limitations:** limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations (QTLs), which are expressed numerically, and NQTLs, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage

6. **Cumulative financial requirements and QTLs:** financial requirements and treatment limitations that determine whether or to what extent benefits are provided based on certain accumulated amounts. They include deductibles, out-of-pocket maximums, and annual or lifetime day or visit limits

# EBSA Benefit Advisor Role

EBSA benefits advisors answered 160 MHPAEA-related public inquiries, including 142 complaints, in FY 2022. They have answered 1,729 MHPAEA-related inquiries since FY 2011

The EBSA FY 2022 Enforcement Fact Sheet explains, “Benefits advisors are the public's initial point of contact with EBSA. If a benefits advisor thinks a violation may have occurred and is unable to obtain voluntary compliance from a plan, EBSA may open a formal investigation.”

# EBSA Service Provider Initiative

- If impermissible NQTL violation is identified, examine plan service providers to find other plans with same NQTL
- Focus on correcting violations with service providers for all plan clients – "Ripple Effect"
- During Reporting Period, EBSA worked with over 20 service providers as part of this initiative
  - Some preemptive corrections without issuing requests for comparative analyses to plan service providers or plan clients
  - EBSA currently pursuing same process with three large service providers
    - ABA therapy to treat ASD
    - Medication-assisted treatment (MAT) for opioid use disorders
    - Nutritional counseling for eating disorders

# CMS Investigations Overview

## CMS investigations

- In FY 2022, CMS received 5 MHPAEA-related complaints, which were resolved by caseworkers within the Center for Consumer Information and Insurance Oversight (CCIIO)
- In FY 2022, CMS closed 4 self-insured non-federal governmental group health plan MHPAEA investigations and 9 MHPAEA NQTL comparative analysis reviews of non-federal governmental group health plans and health insurance issuers in states where CMS is responsible for MHPAEA enforcement
- CMS cited 7 MHPAEA violations as a result of the NQTL comparative analysis reviews required by the CAA

# Examples of Corrective Measures

- Complete removal of an NQTL;
- Changes to plan document language and disclosures, along with notification to participants and beneficiaries of the change in plan terms;
- Amendments to plan practices or claims processing procedures; Addition of coverage for previously excluded benefits;
- Reduction in the scope of an NQTL's application to MH/SUD benefits;
- Submission of a complete and sufficient comparative analysis, cured of identified deficiencies
- Re-adjudication of claims affected by an impermissible NQTL, with payment of claims wrongfully denied because of the NQTL;
- Notice to participants and beneficiaries of an opportunity to submit previously unsubmitted claims that will now be accepted for processing

# EBSA Initial Determination Letters

## Number of Initial Determinations of Non-Compliance Issued

| Type of NQTL | Total Issued Since February 2021 | Issued During the Reporting Period |
|---|---|---|
| Exclusion of ABA therapy, cognitive, intensive behavioral, habilitative, or rehabilitative interventions to treat MH/SUD conditions | 19 | 9 |
| Prior authorization, precertification | 10 | 6 |
| Provider billing restrictions | 7 | 0 |
| Exclusion of medication-assisted treatment or medications for opioid use disorder | 7 | 3 |
| Exclusion of nutritional counseling for MH conditions | 6 | 1 |
| Provider experience requirement beyond licensure | 4 | 0 |
| Exclusion of residential care or partial hospitalization for MH/SUD conditions | 3 | 1 |
| Treatment plan requirement | 2 | 0 |
| Concurrent care review | 2 | 1 |
| Exclusion of telehealth/virtual visits | 2 | 1 |

# EBSA Initial Determination Letters *Continued*

## Number of Initial Determinations of Non-Compliance Issued

| Type of NQTL | Total Issued Since February 2021 | Issued During the Reporting Period |
|---|---|---|
| Exclusion of speech therapy for MH conditions | 2 | 1 |
| EAP referral/exhaustion requirement | 2 | 1 |
| Case manager or “care manager” requirement | 2 | 0 |
| Out-of-network provider reimbursement methodology/usual, customary, and reasonable (UCR) calculation | 1 | 0 |
| Fail-first policies | 1 | 1 |
| Exclusion based on likelihood of improvement or “treatability” of MH condition/SUD | 1 | 1 |
| Exclusion based on chronic or long-term conditions, chronicity | 1 | 0 |
| Formulary design | 1 | 0 |
| Other | 3 | 0 |
| **Total** | **76** | **26** |

# Identified Deficiencies

## Comparative Analyses Do Not Exist

Many plans and issuers unprepared to submit NQTL comparative analyses upon request

## Deficient Comparative Analyses

**Factor Explanations**: Inadequate details on how factors were applied, definitions, and how sources were used

**Comparability Demonstration**: Failed to demonstrate how factors were equally applied to MH/SUD and medical/surgical benefits

**Operational Application**: Descriptions too general; lack of detail when comparing MH/SUD and medical/surgical benefits

**Operational Data**: Missing data on NQTL's real-world application; when provided, data often lacked explanations on methodology, calculations, and numerical inputs

# Identified Deficiencies
*Continued*

- Failure to document comparative analysis before NQTL design and application
- Conclusory assertion without specific supporting evidence or detailed explanation
- Insufficient comparison or analysis
- Nonresponsive comparative analysis submissions
- Lack of sufficient details about the identified factors
- Failure to demonstrate compliance of an NQTL as applied
- Documents provided without adequate explanation
- Failure to identify the MH/SUD and medical/surgical benefits or MHPAEA classifications to which an NQTL applies
- Limiting scope of analysis to only a portion of the NQTL at issue
- Failure to identify all factors

# EBSA

| Issue | Finding | Corrective Action |
|---|---|---|
| Reprocessing of improperly denied drug testing claims and adoption of operational drug testing policies and procedures. | During a plan-level investigation, EBSA's Kansas City Regional Office found a service provider had failed to follow certain of the plan document's substance use disorder benefits provisions. The office conducted an investigation at the service-provider level to determine whether the issue was systemic across all of the service provider's clients. | This investigation caused the service provider to reprocess thousands of claims, resulting in $1,006,857 in additional claim payments, impacting 533 participants across 30 plans. It also resulted in $927,755 in network savings, which impacted 145 participants across 22 plans. Although this issue did not involve a MHPAEA violation, this correction directly impacted participants receiving substance use disorder treatment. |
| Elimination of impermissible preauthorization requirements and payment of improperly denied claims. | EBSA's Atlanta Regional Office investigated a service provider that provided administrative services to 97 ERISA-covered self-insured group health plans. Investigators found that several of these plans contained blanket preauthorization requirements for all outpatient mental health and substance use disorder benefits but contained preauthorization requirements for only some outpatient medical/surgical benefits. | The investigation led to the blanket preauthorization requirement being eliminated and replaced with a limited list of outpatient mental health and substance use disorder benefits requiring preauthorization. This change affected 97 plans and 319,458 participants. The service provider also reprocessed 126 improperly denied claims, resulting in $44,277 in additional claim payments. |
| Elimination of impermissible preauthorization requirements and obtaining coverage for residential treatment and treatment of chronic conditions found to have achieved the maximum therapeutic benefit. | EBSA's Philadelphia Regional Office investigated a self-insured multiemployer plan and found multiple MHPAEA violations. The plan imposed a preauthorization requirement for mental health benefits and substance use disorder benefits but imposed no comparable preauthorization requirement on medical/surgical benefits. It excluded coverage for all residential treatment for mental health and substance use disorders, while containing no comparable exclusion for medical/surgical care in the relevant classifications. Finally, the plan also excluded coverage for treatment of chronic mental health or substance use disorder conditions found to have achieved the maximum therapeutic benefit but did not find a comparable exclusion for medical/surgical benefits. | As a result of the investigation, the plan made amendments eliminating the impermissible preauthorization requirements and the exclusions, affecting all 2,954 participants. |

# EBSA

| Issue | Finding | Corrective Action |
|---|---|---|
| Obtained coverage for nutritional counseling. | EBSA's Boston Regional Office investigated a self-insured single employer plan and discovered that the plan limited coverage of nutritional counseling to three visits per calendar year. The plan carved out an exception to this limitation for the treatment of diabetes (a medical/surgical condition) but included no carve out for any mental health or substance use disorder benefits. | In response to the investigation, the plan was amended to state that the three-visit limitation did not apply to the treatment of any mental or behavioral health diagnoses (including eating disorders), and all 300 affected participants were notified of the change. |
| Reimbursement of excessive cost sharing based on impermissible financial requirement. | EBSA's Philadelphia Regional Office investigators found that a plan imposed a higher copay for outpatient, in-network mental health and substance use disorder benefits than the predominant copay applied to substantially all medical/surgical benefits in that same benefit classification. | The investigation resulted in the plan issuing reimbursements to those charged an impermissibly high copay, totaling $5,488 to 29 plan participants and ensured compliance going forward. |
| Higher copays reduced. | EBSA's New York Regional Office determined that a plan's financial requirements were not in compliance with MHPAEA. The plan placed improper financial requirements on in-network, outpatient mental health and substance use disorder benefits when compared to in-network, outpatient medical/surgical benefits, and participants were paying impermissibly high copays. | As a result of the investigation, claims spanning a 4-year period were re-adjudicated and adjusted, recovering $1,160 for 37 affected participants. |

# EBSA

| Issue | Finding | Corrective Action |
|---|---|---|
| Access to Applied Behavior Analysis (ABA) therapy obtained. | EBSA's Los Angeles Regional Office determined that a self-insured plan violated MHPAEA as it contained an impermissible separate treatment limitation for applied ABA therapy, a primary treatment for autism. Upon review of denied or outstanding ABA therapy claims, EBSA discovered an additional requirement of a treatment plan prior to the therapy. | As a result of EBSA's investigation, the plan sponsor removed the ABA therapy exclusion from the plan, affecting 1,229 participants. The plan also removed the treatment plan requirement, and three claims were re-adjudicated, recovering $182. |
| Reimbursement rates recalculated. | A state insurance commissioner referred a participant to EBSA because the participant's health plan was self-insured. The participant sought outpatient mental health care from an out-of-network provider. The plan informed her that the reimbursement rate for these behavioral health visits would be $195/visit. When the plan processed the claims, the reimbursement rate was $143/visit. Also, the plan sent payment to the provider, but the payment should have been sent to the participant to reimburse her for services she paid for in-full out-of-pocket. The EBSA benefits advisor contacted the plan to inquire into the discrepancy in the quoted reimbursement rate and assisted in getting the payments sent to the participant. | The reimbursement rate was corrected so that the plan paid an additional $2,756 on the claims. |
| ABA therapy claims corrected. | A state insurance commissioner referred a participant to EBSA because the participant's health plan was self-insured. The participant complained that the plan was not properly reimbursing out-of-network claims for ABA therapy. The EBSA benefits advisor contacted the plan for a review and explanation of the claims processing. | After the benefits advisor's intervention, the plan paid an additional $1,879 on the claims. |

# CMS Actions

| Issue | Finding | Corrective Action |
|---|---|---|
| Identification of impermissible "full continuum of care" requirements for mental health and substance use disorder benefits. | During an NQTL investigation, a non-federal governmental group health plan was found to have an impermissible separate treatment limitation for mental health and substance use disorder benefits coverage, as it required the treating facility to certify that the patient completed the "full continuum of care necessary and available at that facility." If the patient did not fulfill that requirement, then the plan would not provide coverage of the mental health and substance use disorder benefit. There was no similar requirement applied to medical/surgical benefits in the classification. | The plan completed a self-audit to identify claims impacted by the impermissible separate treatment limitation and determined that no claims were denied as a result of the limitation. There was no need to eliminate the NQTL in future plan years as the plan was terminated. |
| Removal of MH/SUD progress and improvement requirements. | An NQTL investigation revealed impermissible separate treatment limitations in the form of continued-stay criteria for mental health and substance use disorder benefits requiring evident progress for continued care coverage. The investigation also revealed discharge criteria for mental health and substance use disorder benefits resulting in loss of coverage if no significant improvement in condition occurred or if the member left against medical advice. There were no similar criteria applied to medical/surgical benefits in the same benefit classification. | The issuer revised its continued stay and discharge criteria and provided supporting documentation to show that these limitations on mental health and substance use disorder benefits were removed. In addition, the issuer completed a self-audit to identify and re-adjudicate wrongly denied claims. The issuer did not identify any wrongly denied claims. Finally, the issuer revised external facing websites to remove references to the treatment progress and improvement criteria for mental health and substance use disorder benefits. |
| Updated provider network participation standards. | In its NQTL comparative analysis, an issuer provided information about distance and time standards used to determine sufficient network access and availability of inpatient facilities. This network access and availability information was one factor used to determine standards for provider admission to their network. The NQTL investigation revealed the issuer used distance and time standards that were not comparable for medical/surgical and mental health and substance use disorder inpatient facilities. | As a result of the investigation, the issuer updated its distance and time standards for mental health and substance use disorder provider types to be in parity with the distance and time standards for medical/surgical provider types. |

# Final Determinations of Noncompliance

- The plan or issuer must submit additional comparative analyses that demonstrate compliance not later than 45 days after the initial determination of noncompliance.
- Following the 45-day corrective action period, if the Departments make a final determination that the plan or issuer is still not in compliance, the plan will then have seven days to notify covered individuals that the plan is not in compliance.
- The 2023 Report does reference the issuance of some final determinations.

# Key Takeaways for Plan Sponsors

# Be Prepared for an Audit

- Ensure plan documents have been reviewed and accurately reflect how benefits are administered
- Ensure plan documents reflect MHPAEA compliant terms
- Investigate any terms which suggest noncompliance or which lack clarity regarding whether or how the term relates to MH/SUD benefits
- Ensure the plan has documented comparative analysis from **all** relevant vendors
- Investigate any discrepancies between a vendor analysis and a plan's understanding of its benefits or operations
- Make plan document and/or request comparative analysis revisions as appropriate

# What plan sponsors can do now?

**Read** the proposed regulations and watch for new guidance

**Continue compliance efforts** and for plans whose sunset is expiring don't forget to focus on **all** MHPAEA requirements

**Contact vendors** to ascertain their capabilities to support compliance efforts, including their ability to provide the proposed data and claims reporting

**Consider revising agreements,** such as adding details to administrative service agreements related to expected obligations under MHPAEA

**Resolve complaints.** As always, plans should work diligently to investigate and resolve any parity compliance complaint to help avoid it advancing to a complaint to DOL or HHS

# Questions?

**Scan QR code to provide feedback on today's presentation**

# Thank You