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Compliance Directions

Mental Health Parity Report to Congress: Plans (and Insurers) Are Motivated to Avoid Noncompliance

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On January 17, 2025, the Employee Benefits Security Administration (EBSA) and the Centers for Medicare & Medicaid Services (CMS) (Agencies) released their annual MHPAEA Report to Congress and enforcement fact sheet. The 2024 MHPAEA Report to Congress (the Report) reflects their most recent enforcement efforts. While benefit exclusions and limitations are still a top priority, the Report indicates that the Agencies are broadening their scope. For a discussion of how plans and insurers complied with comparative analyses requests, see our prior article *Mental Health Parity Enforcement: Comparative Analyses Remain Deficient.*

Enforcement Priorities

EBSA deepened its focus on NQTLs relating to network composition and access. CMS placed a new emphasis on comparative analyses for provider reimbursement treatment limitations and pharmacy benefit formulary design (including step therapy and quantity limits). Many of the comparative analyses focused on prior authorizations, concurrent review, and provider reimbursements.

EBSA

Network Adequacy and Composition

Network adequacy refers to a health plan's or insurer's ability to provide timely access to in-network providers for covered benefits. If participants find that providers in their network are distant or have limited availability, the network may be inadequate. The term "network composition" describes the number, types, and identity of care providers in a network, which typically includes various healthcare professionals across different practice areas. MHPAEA requires plans to provide parity in NQTL related to network composition for MH/SUD benefits compared to medical/surgical (M/S) benefits.

EBSA surveyed over 4,300 randomly selected outpatient providers listed in plan network directories as accepting new patients. The surveys found that an alarming proportion of providers were unresponsive or unreachable. While this was true for both MH/SUD and M/S providers, the results were consistently worse for MH/SUD providers.

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The report highlights five areas in which EBSA found disparities in network adequacy and composition:

- Out-of-network utilization and other outcomes reflecting access to care,
- Disparities in access standards and processes for monitoring network adequacy and composition,
- Secret shopper surveys found troubling results about disparate access to services,
- Disparities in network provider reimbursement rates and found that plans and insurers could not explain methodologies resulting in reimbursement rate disparities, and
- Plans and insurer's offered unsupported conclusions to explain how they complied with MHPAEA's parity requirements.

In response to inquiries regarding aspects of plan design, such as disparate access standards, many plans and insurers provided general justifications, often citing industry practices or external entities not subject to MHPAEA as the basis for their standards. When questioned about disparate reimbursement rates and the processes for developing those rates, plans and insurers frequently referenced broad concepts like "market dynamics," "supply and demand," and "bargaining power" to justify higher payments to M/S providers compared to MH/SUD providers. However, they failed to clarify how these factors were applied comparably to both M/S and MH/SUD benefits, particularly in cases where high demand for MH/SUD services did not result in higher reimbursement rates.

Additionally, many plans and insurers cited shortages of MH/SUD providers as a reason for the disparities identified by EBSA. EBSA observed that plans and insurers often take proactive measures to address shortages of M/S providers but not MH/SUD providers. This lack of effort to attract and retain MH/SUD providers suggested a focus on justifying existing practices rather than making necessary changes to comply with MHPAEA requirements.

Impermissible Exclusions of Key Treatment for Mental Health Conditions and Substance Use Disorders

During the reporting period, EBSA continued to investigate plans and service providers that excluded key treatments for covered mental health conditions and substance use disorders. These kinds of exclusions are impermissible when a plan or insurer does not apply a comparable limitation to benefits for M/S conditions. Examples include

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exclusions of ABA therapy for ASD, medication-assisted treatment (MAT), or medication for opioid use disorder, and nutritional counseling for eating disorders.

EBSA found plans and insurers impermissibly excluding key treatments in plan document language or in practice by denying related claims. EBSA also found that plans and insurers are rarely able to provide a complete comparative analysis detailing these exclusions or offer any justification for the exclusions. When EBSA's investigators asked for basic information, plans and insurers often removed, rather than justify, the exclusions to come into compliance with MHPAEA.

EBSA addressed other key MH/SUD benefits without comparable limitations on M/S benefits. These exclusions include:

- Residential treatment for mental health conditions and substance use disorders,
- Partial hospitalization for mental health conditions and substance use disorders,
- Speech therapy for mental health conditions, and
- ASD treatment based on age.

EBSA expects plans, insurers, and service providers to proactively address these treatment limitations, including exclusions, before EBSA initiates an investigation.

Enforcement Outcomes

Corrective actions varied depending on the type of NQTL involved and its practical application. EBSA's efforts included revising written plan provisions, altering practices and procedures, ensuring disclosures to participants, and re-adjudicating and paying affected claims. Notably, many plans and insurers proactively addressed potential NQTL issues early in the comparative analysis review process to avoid noncompliance determinations. This proactive approach led to most corrections being made without the need for formal determinations of noncompliance, and as a result, EBSA did not issue any final determinations of noncompliance during the reporting period.

CMS

Comparability and Stringency

CMS reviewed plan designs to demonstrate that the processes, strategies, evidentiary standards, and other factors used to design and apply an NQTL to MH/SUD benefits are comparable to and applied no more stringently than those used to design and apply the NQTL for M/S benefits.

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Many of the reviews lacked a sufficient assessment or reasoned discussion to demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits were comparable to, and no more stringently applied than, those applied to M/S benefits. Plans and insurers often made assertions regarding the standards, processes, sources, or factors used in the design and application of the applicable NQTL without providing supporting documentation to verify the assertions made. Furthermore, some provided conclusory statements regarding their compliance with MHPAEA without providing supporting evidence demonstrating compliance.

Enforcement Outcomes

CMS offered numerous examples of corrective actions taken by plans and insurers to avoid noncompliance. These actions included significant changes to prior authorization requirements, enhanced assessments of operational comparability and stringency, such as implementing new annual reviews of inpatient utilization analytics and providing updated operational metrics analyses and providing additional supporting documentation. For example, insurers provided documentation related to utilization management standards, such as medical necessity review processes and peer-to-peer review guidelines, to support their compliance with MHPAEA.

CMS provided a detailed outline of actions taken with one insurer in Texas that was issued a final determination of noncompliance due to insufficient information and documentation in their comparative analyses. The analyses failed to show that the NQTLs applied to MH/SUD benefits were comparable to and no more stringent than those applied to M/S benefits:

- **Provider Network Participation Requirements**. The insurer was cited for not providing a sufficient comparative analysis of NQTLs related to provider network participation requirements for both inpatient and outpatient, in-network providers. The analysis lacked a stringency assessment. CMS instructed the insurer to provide a detailed discussion of comparability and stringency, define the "75 miles" metric, clarify units of measurement, and submit additional comparative analyses.
- **Prior Authorization Treatment Limitations**. The insurer also failed to provide sufficient information regarding the processes and standards used in the design and application of NQTLs for prior authorization of outpatient, in-network services. The initial analysis did not adequately demonstrate that these processes were comparable and no more stringent for MH/SUD benefits than for M/S benefits. The

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insurer identified five factors used in determining services subject to NQTLs but later added two more, creating uncertainty about which factors were actually used. CMS required the insurer to list all factors used, provide definitions, and offer quantitative measures where applicable. They also needed to provide a complete stringency assessment, including appeal data and decision timeliness, and include a reasoned discussion of findings.

Employer Action Steps

Overall, the Agencies noted that plans and insurers worked diligently with investigators to avoid determinations of noncompliance. It is also the intention of the Agencies to avoid issuing determinations of noncompliance, but rather work with plans and insurers to provide comparable MH/SUD benefits. Plan fiduciaries should carefully evaluate how their network affects access to MH/SUD benefits relative to M/S benefits since this is a focused priority of EBSA. The Agencies intend to issue additional guidance in the future to provide more information on MHPAEA's requirements. But, until then, plan sponsors should also continue to monitor plans that include benefit exclusions or limitations to ensure compliance with MHPAEA. Here are a few action steps to consider:

- Review and compare prior authorization requirements for MH/SUD and M/S benefits to identify any disparities.
- Conduct a thorough assessment of the processes, strategies, and standards used to apply NQTLs to MH/SUD and M/S benefits.
- Review plans for MH/SUD benefit limitations and exclusions. Be prepared to rpovide specific evidence and detailed explanations to support assertions about compliance with MHPAEA. Include data, case studies, or examples that clearly demonstrate how NQTLs are applied comparably to MH/SUD and M/S benefits.

The intent of this article is to provide general information on employee benefit issues. It should not be construed as legal advice and, as with any interpretation of law, plan sponsors should seek proper legal advice for application of these rules to their plans.

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