

MHPAEA Comparative Analysis Report to Congress

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PREFACE

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) was signed into law in 2008 to prevent group health plans (plans) and health insurance issuers (issuers) that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. The law, as amended, generally requires that plans and issuers offering group or individual health insurance coverage ensure that any financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) that apply to MH/SUD benefits are no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits in a benefits classification.¹ In addition, MHPAEA prohibits separate treatment limitations that apply only to MH/SUD benefits. MHPAEA builds on the Mental Health Parity Act of 1996, which prohibits less favorable aggregate lifetime and annual dollar limits for mental health benefits than for medical/surgical benefits in large group health plans.² These protections are vital for America's workers, health insurance consumers, and their families and caregivers.

When MHPAEA was amended by the Consolidated Appropriations Act, 2021 (CAA),³ a provision was added that requires plans and issuers to perform and document comparative

¹ Pub. L. 110-343, Oct. 3, 2008, as amended by the Patient Protection and Affordable Care Act, Pub. L. 111-148, Mar. 23, 2010, and the Consolidated Appropriations Act, 2021, Pub. L. 116-260, Dec. 27, 2020. Additionally, requirements related to mental health parity were included in the 21st Century Cures Act (Cures Act), Pub. L. 114-255, Dec. 13, 2016, as amended by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Support Act), Pub. L. 115-271, Oct. 24, 2018.

² Pub. L. 104-204, Sept. 26, 1996.

³ Pub. L. 116-260, Dec. 27, 2020.

analyses of the design and application of their non-quantitative treatment limitations (NQTLs)⁴ to demonstrate parity and provide those analyses to the Secretaries of the Departments of the Treasury (Treasury), Health and Human Services (HHS), and Labor (DOL) or to an applicable state authority upon request.⁵ This provision also requires the Secretaries to report to Congress annually on the results of these NQTL comparative analyses reviews conducted by the Secretaries.⁶ This report is intended to satisfy the CAA reporting obligation for the second year of implementation.⁷

Previous Reports to Congress⁸ have highlighted DOL's parity implementation, enforcement, and outreach efforts. In 2012 and 2014, the MHPAEA Reports to Congress provided an overview of the interim final regulations, final regulations, and related guidance. They also described how DOL worked to help the regulated community comply with MHPAEA and how DOL helped families and individuals understand the law and benefit from it. In 2016 and 2018, the Reports to Congress detailed DOL's enforcement efforts. The 2018 Report to Congress specifically explained not only how DOL planned to continue to identify and correct MHPAEA non-compliance, but also its strategy to minimize the likelihood of future violations.

⁴ NQTLs are generally plan provisions that impose non-numerical limits on the scope or duration of benefits (such as prior authorization requirements, step therapy, and provider reimbursement rates). For example, a treatment limitation that provides that a plan or issuer will refuse to pay for a higher-cost therapy until it is shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols) is an NQTL because the limitation is not expressed numerically but limits the scope or duration of treatment.

⁵ Internal Revenue Code (Code) Section 9812(a)(8); ERISA Section 712(a)(8) and Public Health Service Act (PHS Act) Section 2726(a)(8).

⁶ *Id.* Section 712(f) of ERISA also requires that the DOL send to Congress a biennial report on MHPAEA implementation. In addition, the Secretaries were required to send Congress, over a 6-year period, an annual report on complaints and investigations concerning compliance with the requirements of MHPAEA. *See* Section 13003 of the Cures Act, as amended by the Support Act.

⁷ This report fulfills the Secretaries' reporting obligations under Code Section 9812(a)(8)(B)(iv)(I), ERISA Section 712(a)(8)(B)(iv)(I), and PHS Act Section 2726(a)(8)(B)(iv)(I), as added by the CAA. Pub. L. 116-260, div. BB, title II, Section 203(a)(2).

⁸ The Departments' previous Reports to Congress are available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

The 2020 Report to Congress detailed DOL’s intent to use the information gathered from partnerships across the Administration to develop a roadmap for compliance so that health plan participants and beneficiaries can realize the full benefits of MHPAEA.

In January 2022, DOL, HHS, and Treasury published the first report since the enactment of the CAA: the 2022 MHPAEA Report to Congress, also referred to in this document as the January 2022 Report.⁹ The report highlighted the Departments’ emphasis on greater MHPAEA enforcement, including the CAA-mandated process of requesting and reviewing NQTL comparative analyses from plans and issuers. Along with detailed descriptions of the Departments’ enforcement efforts, findings, and results, the report indicated that plans and issuers failed to provide NQTL comparative analyses that contained sufficient information to demonstrate compliance with MHPAEA. In fact, the report noted that every comparative analysis reviewed was in some way insufficient when it was initially submitted to DOL’s Employee Benefits Security Administration (EBSA) or to HHS’s Centers for Medicare & Medicaid Services (CMS). The January 2022 Report outlined common themes in deficient NQTL comparative analyses and described EBSA’s and CMS’ efforts to help plans and issuers come into compliance.

This report focuses on the Departments’ enforcement efforts regarding NQTLs during the second year of implementation of the CAA amendments to MHPAEA (the Reporting Period).¹⁰

⁹ The January 2022 Report satisfied both the reporting requirement under Section 712(f) of ERISA that DOL provide a biennial report to Congress on MHPAEA compliance and the requirement under the CAA that the Departments provide an annual report to Congress on NQTL comparative analyses. *See* 2022 MHPAEA Report to Congress. <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>.

¹⁰ For EBSA, the Reporting Period is November 1, 2021, through July 31, 2022. For CMS, the Reporting Period is December 1, 2021, through September 1, 2022. EBSA’s reporting period for future reports will be from August 1 through July 31 of the following year. For the next Report to Congress, CMS’ reporting period will be September 2,

This report also looks broadly at the 18-month period since plans and issuers were first required to make their comparative analyses available on request.¹¹ In addition to a discussion of common deficiencies in NQTL comparative analyses submitted by plans and issuers during the Reporting Period, this report includes, as required by the CAA, the identity of each plan and issuer that received a final determination of non-compliance.¹² Finally, this report also highlights certain information that was provided by plans and issuers in response to the Departments' NQTL comparative analyses requests that either addressed an aspect of an identified deficiency or satisfied EBSA's or CMS' inquiry into the NQTL altogether.

2022, through July 31, 2023. CMS intends to align the CMS reporting period with EBSA's reporting period in subsequent years.

¹¹ ERISA Section 712(a)(8)(A), PHS Act Section 2726(a)(8)(A), and Code Section 9812(a)(8)(A), as added by Pub. L. 116-260, div. BB, title II, §203(a)(2), require plans and issuers to perform and document comparative analyses and make them available to the Secretaries or applicable state authorities, upon request, beginning 45 days after the date of enactment of the CAA.

¹² ERISA Section 712(a)(8)(B)(iv)(I), PHS Act Section 2726(a)(8)(B)(iv)(I), and Code Section 9812(a)(8)(B)(iv)(I), as added by Pub. L. 116-260, div. BB, title II, §203(a)(2), require the Secretaries to submit to Congress, and make publicly available, a yearly "summary of the comparative analyses requested . . . , including the identity of each group health plan or health insurance issuer. . . that is determined to be not in compliance after the final determination by the Secretary described in clause (iii)(I)(bb)[.]"

FAST FACTS

EBSA enforces Title I of ERISA, including the group health plan provisions added by MHPAEA, with respect to approximately 2.5 million private employment-based group health plans, which cover an estimated 133 million participants and beneficiaries in 2020. CMS enforces applicable provisions of Title XXVII of the PHS Act, including the provisions added by MHPAEA, with respect to approximately 90,000 non-federal governmental group health plans nationwide and 41 issuers in the three states where it was the direct enforcer of MHPAEA with respect to issuers¹³ during the Reporting Period. The following is an overview of the key enforcement actions taken by EBSA and CMS under section 203 of Title II of Division BB of the CAA, which are explained more fully in Sections I and II of this report.

- Between February 2021 and July 2022, EBSA issued **182 letters** requesting comparative analyses for **over 450 NQTLs** (or **over 270 unique NQTLs**¹⁴) across **102 investigations**.
 - This includes **25 letters** requesting comparative analyses for **69 NQTLs** (**57 unique NQTLs**) during the Reporting Period (November 1, 2021, through July 31, 2022 for DOL).
- Between February 2021 and September 2022, CMS issued **26 letters** requesting comparative analyses for **44 NQTLs** from **24 plans and issuers**.

¹³ CMS was responsible for enforcement of MHPAEA with respect to issuers in Missouri, Texas, and Wyoming during the Reporting Period.

¹⁴ This count of “unique” NQTLs only includes NQTLs that EBSA has identified under a plan or health coverage that the plan or issuer has defined using different factors or evidentiary standards than other NQTLs, regardless of whether it is applied to different classifications, or to different plans (in cases where a request was made to a health insurance issuer). If each NQTL is counted separately by benefit classification, plan, and product, the number of NQTLs for which EBSA requested a comparative analysis would be over 1,350 (over 200 requested during the Reporting Period). *See* Footnote 49 for further explanation of “unique” NQTLs.

- This includes **11 letters** requesting comparative analyses for **23 NQTLs (21 unique NQTLs)** from **11 plans and issuers** during the Reporting Period (December 1, 2021 through September 1, 2022 for CMS).

The Departments observed that many comparative analyses remained deficient, even after multiple insufficiency letters.

- Between February 2021 and July 2022, EBSA issued **138 insufficiency letters for over 290 NQTLs**, requesting additional information and identifying specific deficiencies.
 - EBSA issued **52 insufficiency letters for over 100 NQTLs** during the Reporting Period.
- Between February 2021 and September 1, 2022, CMS issued **35 insufficiency letters for 44 NQTLs**, requesting additional information and identifying specific deficiencies.
 - CMS issued **18 insufficiency letters** covering **23 NQTLs** between December 2021 and July 2022.

During the Reporting Period, the Departments issued numerous initial and final determinations of non-compliance with MHPAEA.

- Between February 2021 and July 2022, EBSA issued **53 initial determination letters** finding MHPAEA violations related to **76 NQTLs (56 unique NQTLs)**.
 - This includes **22 initial determination letters** for **26 NQTLs (20 unique NQTLs)** with MHPAEA violations during the Reporting Period.

- Between February 2021 and July 2022, EBSA issued **3 final determination letters**, all issued during the Reporting Period, finding that 3 plans violated ERISA section 712 for **3 NQTLs**.
- Between February 2021 and September 2022, CMS issued **15 initial determination letters** finding MHPAEA violations related to **15 NQTLs**.
 - This includes **two NQTLs** that were impermissible separate treatment limitations applicable only to MH/SUD benefits, and **13 NQTLs** for which comparative analyses were insufficient.
- Between the date of the last annual report and September 1, 2022, CMS issued **5 final determination letters** finding that **7 NQTLs** on MH/SUD benefits were not in parity with the NQTLs as applied to medical/surgical benefits, as described in more detail in Section II.D of this Report.

However, the Departments also saw promising results from some plans and issuers. For example, due to EBSA's enforcement efforts:

- **32 plans and issuers** sent corrective action plans in response to initial determination letters during the Reporting Period. These plans covered **36 NQTLs (24 unique NQTLs)**.
- Between February 2021 and July 2022, **104 plans (and their service providers) and issuers** agreed to make prospective changes to their plans addressing **135 NQTLs (71 unique NQTLs)**. These changes affected access to MH/SUD benefits for **over 4 million participants and their beneficiaries across over 39,000 plans**.

Similarly, due to CMS' enforcement efforts:

- **2 plans and 7 issuers** sent corrective action plans in response to initial determination letters during the Reporting Period. These plans covered **15 NQTLs**.

As described in detail later in this report, corrective action plan results can have life-changing effects on participants, beneficiaries, and enrollees. For example, due to EBSA's and CMS' efforts:

- A plan that covers **over 22,000 participants** removed an exclusion for treatment provided through opioid treatment programs (OTPs), a vital form of treatment for opioid use disorder.
- **Over 4,000 participants** are now able to directly access MH/SUD benefits after a plan stopped using its Employee Assistance Program as a gatekeeper.
- A service provider made a widespread correction to remove an exclusion of applied behavior analysis (ABA) therapy for treatment of autism spectrum disorder (ASD), affecting approximately 1,000 plans covering **over 1 million participants**.
- An issuer removed continued stay and discharge criteria that had applied only to MH/SUD benefits for inpatient, out-of-network services.
- Two issuers initiated annual processes to review and update comparative analyses for their plans to help ensure continuous compliance with MHPAEA requirements.

INTRODUCTION

Mental health is crucial to the overall health and well-being of every person, and access to quality MH/SUD care is as essential for health as access to quality medical/surgical care. Currently, the United States is experiencing a mental health and substance use disorder crisis, exacerbated by the COVID-19 pandemic.¹⁵ The crisis is impacting children and adults nationwide and across demographics, with marginalized and underserved communities affected disproportionately.

Even before the COVID-19 pandemic, the rate of mental health disorders was high. In 2019, over 20 percent of adults in America — nearly 50 million people — are estimated to have experienced a mental illness.¹⁶ About 4.8 percent of adults in America — an estimated 12 million people — reported having serious thoughts of suicide, according to 2019 data, with one death by suicide every eleven minutes.¹⁷

Frontline health care workers in America who have been impacted directly by the COVID-19 pandemic continue to face mental health challenges. In the fall of 2021, 34 percent of nurses surveyed rated their emotional health as “not at all emotionally healthy” or “not

¹⁵ Department of Health and Human Services. (2023). SAMHSA Announces National Survey on Drug Use and Health (NSDUH) Results Detailing Mental Illness and Substance Use Levels in 2021. Retrieved from <https://www.hhs.gov/about/news/2023/01/04/samhsa-announces-national-survey-drug-use-health-results-detailing-mental-illness-substance-use-levels-2021.html>.

¹⁶ Substance Abuse and Mental Health Services Administration. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, available at <https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHHFRPDFWHTML/2019NSDUHFFR090120.htm>.

¹⁷ *Id.*

emotionally healthy.”¹⁸ In 2021, nearly a quarter of physicians surveyed said they were clinically depressed, and close to two-thirds said they were colloquially depressed (defined as feeling down, blue, sad).¹⁹ In January 2022, 28 percent of teachers and principals surveyed reported symptoms of depression, higher than the overall rate for working adults.²⁰

Young people are experiencing mental health crises too. Even before the pandemic, over 15 percent of children ages 12 to 17 reported experiencing at least one major depressive episode, and 10.6 percent — over 2.5 million — experienced severe major depression.²¹ Meanwhile, suicidal behavior among children has sharply increased over the past decade. Known suicide attempts in children ages 10 to 12 leapt from 1,058 in 2010 to 5,606 in 2020, and in 2021, 22 percent of high school students seriously considered attempting suicide during the previous year.²² Suicide rates among Black or African American children below age 13 have been increasing rapidly, with Black or African American children in this age range nearly twice as likely to die by suicide than White children as of 2015.²³ In a survey of LGBTQ youth ages 13 to

¹⁸ American Nurses Foundation. (2022). Pulse on the Nation's Nurses COVID-19 Survey Series: Workplace Survey, June-July 2022. <https://www.nursingworld.org/~4a209f/globalassets/covid19/anf-2022-workforce-written-report-final.pdf>; American Nurses Foundation. (2022). Pulse on the Nation's Nurses COVID-19 Survey Series: Mental Health and Wellness <https://www.nursingworld.org/~4a22b6/globalassets/docs/ancc/magnet/anf-mh3-written-report-final-foundation-edits-2.pdf>.

¹⁹ Kane L. (2022). Physician Burnout & Depression Report 2022: Stress, Anxiety, and Anger. Medscape. <https://www.medscape.com/slideshow/2022-lifestyle-burnout-6014664>.

²⁰ Rand. Restoring Teacher and Principal Well-Being Is an Essential Step for Rebuilding Schools: Findings from the State of the American Teacher and State of the American Principal Surveys | RAND, available at https://www.rand.org/pubs/research_reports/RRA1108-4.html.

²¹ Mental Health America. (2022). Youth Ranking 2022. <https://mhanational.org/issues/2022/mental-health-america-youth-data>.

²² Sheridan D, Grusing S, Marshall R. (2022). Changes in Suicidal Ingestion Among Preadolescent Children from 2000 to 2020. JAMA Pediatrics. <https://jamanetwork.com/journals/jamapediatrics/article-abstract/2789948>; CDC, Youth Risk Behavior Survey, available at https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf.

²³ Bridge JA, Horowitz LM, Fontanella CA, et al. (2018). Age-Related Racial Disparity in Suicide Rates Among US Youths From 2001 Through 2015. JAMA Pediatrics. <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2680952>.

24, 45 percent seriously considered attempting suicide in the past year,²⁴ and nearly half of the multiracial LGBTQ youth surveyed seriously considered suicide.²⁵

Young people have also experienced a sharp rise in eating disorders throughout the pandemic. Emergency department visits for teenage girls with eating disorders doubled in January 2022 compared to 2019.²⁶ The age at which children begin experiencing eating disorders has been trending younger, with children as young as 9 years old seeking treatment.²⁷ Eating disorders, overall, are among the deadliest mental illnesses, alongside substance use disorders.²⁸

More than 16 percent of people aged 12 and older in the U.S. met the applicable DSM-5 criteria for having a substance use disorder in 2021.²⁹ More than 107,000 people died from drug overdoses in 2021, a striking increase from the over 71,000 overdose deaths in 2019.³⁰ During the first year of the COVID-19 pandemic, the overdose death rate was highest for American Indian and Alaska Native people and Black or African American people — about 30 percentage

²⁴ The Trevor Project. (2022). 2022 National Survey on LGBTQ Youth Mental Health. <https://www.thetrevorproject.org/survey-2022/>.

²⁵ The Trevor Project. (2022). The Mental Health and Well-Being of Multiracial LGBTQ Youth. <https://www.thetrevorproject.org/research-briefs/the-mental-health-and-well-being-of-multiracial-lgbtq-youth-aug-2022/>.

²⁶ Radhakrishnan L, Leeb R, Bitsko R, Carey K, Gates A, Holland K, Hartnett K, Kite-Powell A, DeVies J, Smith A, van Santen K, Crossen S, Sheppard M, Wotiz S, Lane R, Njai R, Johnson A, Winn A, Kirking H, Rodgers L, Thomas C, Soetebier K, Adjemian J, Anderson K. (2022). Pediatric Emergency Department Visits Associated with Mental Health Conditions Before and During the COVID-19 Pandemic — United States, January 2019–January 2022. *MMWR Morb Mortal Wkly Rep* 2022; 71(8);319-324. <https://www.cdc.gov/mmwr/volumes/71/wr/mm7108e2.htm>.

²⁷ Murray S, Blashill A, Calzo J. (2022). Prevalence of Disordered Eating and Associations With Sex, Pubertal Maturation, and Weight in Children in the US. *JAMA Pediatrics*. <https://jamanetwork.com/journals/jamapediatrics/article-abstract/2794847>.

²⁸ Chesney E, Goodwin G, Fazel S. (2014). Risks of All-Cause and Suicide Mortality in Mental Disorders: A Meta-Review. *World Psychiatry*. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4102288/>.

²⁹ Department of Health and Human Services (2023). SAMHSA Announces National Survey on Drug Use and Health (NSDUH) Results Detailing Mental Illness and Substance Use Levels in 2021. Retrieved from <https://www.hhs.gov/about/news/2023/01/04/samhsa-announces-national-survey-drug-use-health-results-detailing-mental-illness-substance-use-levels-2021.html>.

³⁰ National Vital Statistics System. Provisional Drug Overdose Death Counts. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm.

points higher and 16 percentage points higher, respectively, than the rate for White people.³¹

Hispanic and Latino people saw the lowest overdose death rates, though that rate still increased in 2020.³²

The ongoing overdose epidemic has been devastating Americans and their families and caregivers since 2017. In 2021, an estimated 9.2 million people in the United States age 12 or older misused heroin or prescription pain relievers.³³ Nearly 75 percent of drug overdose deaths in 2020 involved an opioid³⁴ — most often illegal fentanyl, a synthetic opioid that is 50 to 100 times stronger than morphine.³⁵

The number of alcohol-induced deaths in the U.S., which had been increasing gradually each year since 2000, rose sharply during the first year of the COVID-19 pandemic.³⁶ After annual increases of 7 percent or less between 2000 and 2018, the overall age-adjusted rate³⁷ of alcohol-induced deaths increased 26 percent from 2019 to 2020. This steep uptick was consistent

³¹ Friedman, Joseph R, Hansen, Helena (2022) Research Letter: Evaluation of Increases in Drug Overdose Mortality Rates in the US by Race and Ethnicity Before and During the COVID-19 Pandemic. JAMA Psychiatry. <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2789697>.

³² *Id.*

³³ SAMHSA (2023). Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health.

<https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf>.

³⁴ CDC Data Overview. The Drug Overdose Epidemic: Behind the Numbers.

<https://www.cdc.gov/opioids/data/index.html>, and Hedegaard H, Miniño AM, Spencer MR, Warner M. Drug Overdose Deaths in the United States, 1999-2020. National Center for Health Statistics, December 2021.

³⁵ Fentanyl. U.S. Drug Enforcement Administration.

<https://www.dea.gov/factsheets/fentanyl>.

³⁶ Spencer MR, Curtin SC, Garnett MF. (2022). Alcohol-induced death rates in the United States, 2019-2020. NCHS Data Brief, No. 448. National Center for Health Statistics. <https://www.cdc.gov/nchs/products/databriefs/db448.htm>.

³⁷ See National Library of Medicine, Age-Adjustment, available at

https://www.nlm.nih.gov/nichsr/stats_tutorial/section2/mod5_age.html (“Sometimes, health statistics are used to compare how healthy two different groups of people are, or how healthy a certain group is during two different time periods. Since older people are more likely to get ill, and younger people are more likely to injure themselves, age adjustment can make studies more accurate. Age is another confounding variable: something that impacts the people being studied but is not related to the health event being studied. To be able to better compare groups while adjusting for age, we use a process called direct standardization. When we use direct standardization, we assume both groups have the same number of people. Then we calculate the expected number of deaths and death rates in both groups. By doing this, the two populations can be directly compared, independent of the age distribution of each group.”).

for both males and females despite differing trends in their respective rates of alcohol-induced death since 2000. Rates of alcohol-induced deaths for males were stable from 2000 to 2009, increased 30 percent from 2009 to 2018, and increased 26 percent from 2019 to 2020. Meanwhile, rates of alcohol-induced deaths for females increased each year over the entire period, with the largest annual increase (27 percent) occurring between 2019 and 2020.

As with medical and surgical conditions, mental health conditions and substance use disorders can be managed with timely and affordable access to quality care. Mental health conditions and substance use disorders that are left untreated can have devastating effects not only on the individuals experiencing them, but also on their families, friends, caregivers, communities, students, patients, clients, and the behavioral health workforce.

Far too many Americans do not seek MH/SUD care because of discrimination, stigmatization, local in-network provider shortages, cost, geography, and other barriers. Over half of adults with a mental illness reported that they have not received treatment for it. Nearly a quarter said they were unable to obtain treatment.³⁸ The barriers are particularly problematic for young adults ages 18-34, who are more likely to have poorer overall mental health than older adults.³⁹ Even more striking, of the estimated 43.7 million people needing substance use disorder treatment in 2021, only 3 million (6.8 percent) received treatment at a specialty substance use disorder treatment facility and only 4.1 million (9.4 percent) received “any treatment,” which

³⁸ See Mental Health America. (2022). Adult Prevalence of Mental Illness (AMI) 2022 (“Individuals seeking treatment but still not receiving needed services face the same barriers that contribute to the number of individuals not receiving treatment: (1) No insurance or limited coverage of services. (2) Shortfall in psychiatrists, and an overall undersized mental health workforce. (3) Lack of available treatment types (inpatient treatment, individual therapy, intensive community services). (4) Disconnect between primary care systems and behavioral health systems. (5) Insufficient finances to cover costs including copays, uncovered treatment types, or when providers do not take insurance.”), available at <https://mhanational.org/issues/2022/mental-health-america-adult-data#one>.

³⁹ National Alliance on Mental Illness. (2021). Mood Disorder Survey Report. <https://nami.org/NAMI/media/NAMI-Media/Research/NAMI-Mood-Disorder-Survey-White-Paper.pdf>.

includes having participated in a mutual aid group, such as Alcoholics Anonymous, Narcotics Anonymous, or SMART Recovery, and receiving services in a hospital or through primary care.⁴⁰ Moreover, only about 19 percent of the estimated 5.6 million people with opioid use disorder in 2021 received medications to treat their condition, despite the fact that this care can save lives.⁴¹ The intent behind MHPAEA is to provide people covered by group health plans or group or individual health insurance that include MH/SUD benefits access to treatment for covered mental health condition (such as anxiety or post-traumatic stress disorder) or substance use disorder that is comparable to treatment for covered medical/surgical conditions (such as diabetes or heart disease).⁴²

MHPAEA enforcement is essential for obtaining parity between MH/SUD benefits and medical/surgical benefits. MHPAEA generally aims to help ensure that financial requirements and treatment limitations on MH/SUD benefits are not more restrictive than those that apply to substantially all medical/surgical benefits. Some of the treatment limitations on MH/SUD benefits include exclusions of specific treatments for covered mental health conditions or substance use disorders, disparate ways of determining reimbursement rates for MH/SUD providers than for medical/surgical providers, plan practices that may serve as barriers that

⁴⁰ Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health, available at <https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHNNR122322/2021NSDUHNNR122322.htm>.

⁴¹ Center for Behavioral Health Statistics and Quality (2022), Results from the 2021 National Survey on Drug Use and Health: Detailed Tables, Substance Abuse and Mental Health Services Administration, available at <https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables>.

⁴² In a floor statement, Representative Patrick Kennedy (D-RI), one of the chief architects of MHPAEA, made the case for its passage on the grounds that “access to mental health services is one of the most important and most neglected civil rights issues facing the Nation. For too long, persons living with mental disorders have suffered from discriminatory treatment at all levels of society.” 153 Cong. Rec. S1864-5 (daily ed. Feb. 12 2007). *Cf.* H. Rept. 110-374, Part 3 - Paul Wellstone Mental Health and Addiction Equity Act of 2007, available at <https://www.congress.gov/congressional-report/110th-congress/house-report/374>. (“The purpose of H.R. 1424, the ‘Paul Wellstone Mental Health and Addiction Equity Act of 2007’ is to have fairness and equity in the coverage of mental health and substance-related disorders vis-a-vis coverage for medical and surgical disorders.”)

prevent MH/SUD providers from joining a plan's network, and stricter prior authorization or medical necessity reviews for MH/SUD coverage. Reforming or removing those limitations in accordance with MHPAEA ensures that participants, beneficiaries, and enrollees have equitable access to MH/SUD benefits as compared to medical/surgical benefits.

Under the Biden-Harris Administration, DOL has taken numerous steps to promote mental health awareness, increase access to MH/SUD services, and decrease the stigmatization associated with MH/SUD care. Then-Secretary Walsh participated in events nationwide to meet and learn from America's workers with mental health conditions and substance use disorders and share his own personal story of substance use and recovery. DOL has subsequently launched its Mental Health at Work Initiative, which is aimed at raising awareness of mental health issues and promoting the creation of workplaces that prioritize mental health. EBSA has also taken steps to raise awareness, and has hosted national and regional compliance activities centered on mental health conditions and substance use disorders, with a particular focus on outreach to underserved populations and providing education and materials in languages other than English. The Office of Disability Employment Policy has created resources for employers on how to build and sustain a mental health-friendly workplace, as well as resources for workers and job seekers with mental health conditions.⁴³ Similarly, the Employment and Training Administration (ETA) has continued to improve and add resources to the Recovery-Ready Workplace (RRW) Resource Hub. Launched in September 2022 with support from an interagency workgroup the RRW Resource Hub provides information and resources for employers seeking to respond more effectively to substance misuse in the workforce and to hire people in recovery from substance

⁴³ See The Campaign for Disability Employment, available at <https://www.dol.gov/agencies/odep/initiatives/campaign-for-disability-employment>.

use disorder. On March 30, 2023, ETA also hosted a webinar on RRW Policies through its Workforce GPS initiative. Additionally, multiple DOL components are taking part in initial planning discussions hosted by the Office of National Drug Control Policy (ONDCP) to identify strategies for implementing RRW policies in federal workplaces. In May 2022, the Wage and Hour Division released guidance highlighting provisions of the Family and Medical Leave Act (FMLA) that entitle workers to take time off to care for their own or for a family member's mental health condition, as well as certain job and health coverage protections afforded under FMLA.⁴⁴ The Occupational Safety and Health Administration has also taken numerous steps, including releasing a poster for workplaces on suicide prevention and launching a suicide prevention website focused on the construction industry.⁴⁵ Finally, several DOL agencies have provided training to their employees on a variety of mental health issues.

DOL officials also have reached out to multiple advocacy organizations for people with mental health conditions and substance use disorders, with an emphasis on groups advocating for underserved communities, to learn more about the groups' work and discuss avenues for collaboration. DOL officials and staff have met with a number of groups, including disability advocacy leaders, advocates for children and adults living with eating disorders, members of the transgender community, Black or African Americans, survivors of violence and trauma, advocates for maternal mental health, and grieving families, to understand both the specific

⁴⁴ See US Department of Labor Publishes Updated Family and Medical Leave Act Guidance on Mental Health, Job-Protected Leave for Workers, Employers, available at <https://www.dol.gov/newsroom/releases/whd/whd20220525>.

⁴⁵ See Suicide Prevention: 5 Things You Should Know, available at <https://www.osha.gov/sites/default/files/publications/OSHA4180.pdf>.

impact that the COVID-19 pandemic has had on mental health as well as the ongoing, broader mental health challenges facing vulnerable populations.⁴⁶

DOL has also met with several trade associations and other groups representing workers in occupations with high rates of MH/SUD issues, including pilots, physicians, nurses, dentists, and attorneys.⁴⁷ These meetings have deepened DOL's understanding of the barriers to treatment workers face, helped to inform DOL's MHPAEA enforcement approach, and connected advocacy groups to government resources across and outside of DOL.

DOL leaders have participated in multiple webinars and in-person and virtual speaking opportunities to promote MHPAEA compliance, destigmatize mental health care, and raise awareness of mental health needs and treatment opportunities. These engagements included a webinar on mental health coverage in employer-sponsored health plans, meeting with insurance industry executives on the importance of MHPAEA compliance, visits to mental health programs at nonprofits and health care facilities, and speeches on mental health to migrant workers and employees in the construction industry. A few examples of these meetings include:

- In May 2022, then-Secretary Walsh, alongside HHS Secretary Becerra, met with industry leaders from groups representing employers, their service providers, and health insurance issuers. The Secretaries impressed upon the attendees the importance and urgency of fully complying with MHPAEA. The Secretaries also paid a visit to Capital Clubhouse, a

⁴⁶ See, e.g., Secretary Walsh Joins Health, Employee Wellness Experts to Discuss Promote Good Mental Health Practices in the Workplace, available at <https://www.dol.gov/newsroom/releases/odep/odep20221013>.

⁴⁷ See, e.g., Secretary Walsh Hears Nurses Discuss Experiences Amid Pandemic, Concerns about Staffing, Job Quality During National Nurses Week, available at <https://www.dol.gov/newsroom/releases/osec/osec20220509>.

Washington, D.C.-based non-profit organization that helps people with mental health conditions reenter the workforce.

- Also in May 2022, in honor of Mental Health Awareness Month, EBSA's then-Acting Assistant Secretary Ali Khawar and Office of Disability Employment Policy Assistant Secretary Taryn Williams co-hosted a public webinar on the importance of mental health benefits in the workplace.
- Later in May 2022, then-Secretary Walsh delivered virtual remarks on mental health to the Justice for Migrant Women Summit and the Associated General Contractors of California. In D.C., he visited The George Washington University's Hospital and Behavioral Health Department to discuss ways to strengthen professional pathways to mental health care and hear about workers' experiences with behavioral health service delivery and staff support amid the pandemic.

Similarly, HHS has made advancing mental health and substance use disorder policies across the full continuum of prevention, treatment, and long-term recovery support services a priority across the Department. HHS Secretary Becerra elevated behavioral health to one of five Agency Priority Goals across HHS and revived the Behavioral Health Coordinating Council (BHCC), an internal coalition of HHS's top behavioral health experts working to advance policies that extend beyond individual agency boundaries. The BHCC identified five cross-cutting areas — overdose prevention, suicide prevention and crisis care, children and youth, integration with primary care, and data and evaluation — and works systematically to advance coordinated policies across agencies and programs. HHS has also established the Secretary's Behavioral Health Implementation Council, which allows for regular monthly engagement of

HHS agency principal leadership and expedited clearance of high priority behavioral health policy across operating divisions.

In November 2021, HHS issued a new overdose prevention strategy highlighting an evidence-based approach to tackle the worst overdose epidemic in history, including a first-time focus on harm reduction and long-term recovery supports, in addition to prevention and treatment.⁴⁸ The strategy accompanied the highest level of substance use disorder funding support in history through the American Rescue Plan, among other sources of appropriations, and built on policy advancements to make permanent tele-behavioral health for prescribing medications for opioid use disorder (undertaken during the COVID-19 public health emergency), revising guidelines for prescribing buprenorphine for opioid use disorder, and allowing for grant funds to be used for purchase of fentanyl test strips as a harm reduction strategy. In April 2021, HHS released new buprenorphine practice guidelines. The *Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder*⁴⁹ exempt eligible providers from federal certification requirements that are part of the process for obtaining a waiver to treat up to 30 patients with buprenorphine. A December 2022 HHS study reported that the *Practice Guidelines* were associated with accelerated growth of waived clinicians. An estimated additional 5,830 providers were certified to treat up to 30 patients, corresponding to an increase in potential treatment capacity of about 174,900 patients.⁵⁰ Additionally, access was further increased by section 1262 of the Consolidated Appropriations Act of 2023, which removed the

⁴⁸ <https://www.hhs.gov/overdose-prevention/>.

⁴⁹ <https://www.federalregister.gov/documents/2021/04/28/2021-08961/practice-guidelines-for-the-administration-of-buprenorphine-for-treating-opioid-use-disorder>.

⁵⁰ <https://aspe.hhs.gov/reports/early-changes-after-2021-hhs-buprenorphine-practice-guidelines>.

requirement for practitioners to submit a request for a waiver (a Notice of Intent) to prescribe buprenorphine for the treatment of opioid use disorder.

Following President Biden's State of the Union, on March 2, 2022, Secretary Becerra kicked off a National Tour to Strengthen Mental Health to draw attention to the mental health challenges that have been exacerbated by the COVID-19 pandemic, including substance use, youth mental health, and suicide.⁵¹ Since beginning the tour, Secretary Becerra and HHS leaders have been traveling across the country to hear directly from Americans about the mental health challenges they face and engage with local leaders to strengthen the mental health and crisis care system in our communities. This tour is part of HHS' ongoing efforts to support the Biden-Harris Administration's whole-of-government strategy to transform mental health services for all Americans — a key part of the President's Unity Agenda that is reflected in the President's Fiscal Year 2023 budget.⁵² The efforts were further reinforced by the release of President Biden's inaugural National Drug Control Strategy (*Strategy*) on April 21, 2022. With saving lives as its North Star, the *Strategy* calls for immediate actions that will save lives in the short term and outlines long-term solutions to reduce drug use and its associated harms, including overdose. The *Strategy* guides Executive Branch efforts to accomplish these goals. It details actions to be taken to prevent substance use and expand and improve treatment, sets forth steps to develop the nation's harm reduction and recovery support services infrastructure, and calls for efforts to eliminate barriers to recovery and full participation in society for the millions of Americans with substance use disorder.

⁵¹ <https://www.hhs.gov/overdose-prevention/>.

⁵² <https://www.hhs.gov/about/news/2022/05/03/fact-sheet-celebrating-mental-health-awareness-month-2022.html>.

HHS has made major advancements over the last year to address rising suicide rates in certain groups including older adults and children⁵³ and access to behavioral health services for those in crisis, including implementing the 988 Suicide & Crisis Lifeline, a 3-digit nationwide number that people experiencing a mental health or substance use related crisis can call, chat, or text for help,⁵⁴ and establishing a new state option for Medicaid coverage of qualifying community-based mobile crisis intervention services for individuals experiencing a behavioral health crisis. Recognizing youth in crisis, HHS issued hundreds of millions in funding for behavioral health, issued new mental health parity guidance for youth and their parents,⁵⁵ and established new guidance to integrate mental health services in schools and early childhood programs. In September 2022, HHS issued the Roadmap for Behavioral Health for Integration, a brief describing HHS' commitment to advancing those action items in the next year that better integrate behavioral health into health care.⁵⁶ Importantly, for Medicare Advantage, Medicaid, and qualified health plans, CMS has been developing regulatory proposals focused on ensuring network adequacy and minimum wait times for behavioral health care.⁵⁷ Additionally, in April 2022, the Substance Abuse and Mental Health Services Administration (SAMHSA), working with DOL, published a trio of resources on parity for MH/SUD benefits, aiming to inform

⁵³ <https://www.cdc.gov/nchs/hsr/topics/suicide.htm>.

⁵⁴ <https://www.samhsa.gov/find-help/988>.

⁵⁵ <https://www.samhsa.gov/newsroom/press-announcements/20220427/hhs-new-mental-health-substance-use-disorder-benefit-resources>.

⁵⁶ <https://aspe.hhs.gov/reports/hhs-roadmap-behavioral-health-integration>.

⁵⁷ See, e.g., Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024; Final Rule, 88 FR at 25872-80 (April 27, 2023).

patients,⁵⁸ families and caregivers,⁵⁹ and policymakers⁶⁰ about the protections and requirements enshrined in federal law.

Parity enforcement is one of the key components in ensuring behavioral health access for participants and beneficiaries in group health plans and for consumers across insurance markets. EBSA and CMS together have made MH/SUD parity and compliance with MHPAEA a top enforcement priority. The scope of EBSA's efforts to enforce MHPAEA's NQTL requirements is significant and consistent with its commitment to removing illegal barriers blocking access to MH/SUD benefits. EBSA has primary enforcement jurisdiction over MHPAEA for approximately 2.5 million private, employment-based group health plans covering roughly 133 million Americans. EBSA relies on its approximately 322 investigators to review pension and welfare benefit plans for compliance with ERISA, including the group health plan provisions added by Congress in MHPAEA. EBSA is currently devoting nearly 25 percent of its enforcement program to work focusing on MHPAEA NQTLs. During the Reporting Period, EBSA continued to expand staffing dedicated to MHPAEA enforcement, including an increase of over 30 investigators and technical experts. EBSA also:

- increased staff specialization, including by shifting personnel to full-time work on the NQTL Task Force discussed below;
- developed new investigative tools for MHPAEA investigations; and

⁵⁸ SAMHSA (2022). Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits. Retrieved from https://store.samhsa.gov/product/know-your-rights-parity-for-mental-health-substance-use-disorder-benefits/pep21-05-00-003?referer=from_search_result.

⁵⁹ SAMHSA (2022). Understanding Parity: A Guide to Resources for Families and Caregivers. Retrieved from <https://store.samhsa.gov/product/understanding-parity-guide-to-resources-for-families-caregivers/pep21-05-00-002>.

⁶⁰ SAMHSA (2022). The Essential Aspects of Parity: A Training Tool for Policymakers. Retrieved from <https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001>.

- hired and consulted with subject matter experts on MH/SUD diagnoses, common treatment modalities and related review processes, and certain types of NQTLs.

Shortly after enactment of the CAA, EBSA established a dedicated MHPAEA NQTL Task Force that continues to coordinate EBSA's NQTL enforcement activity. The Task Force is composed of experienced investigators, health policy experts, technical experts from EBSA's regional and national offices, and attorneys from DOL's Office of the Solicitor. During the second year of implementation, the Task Force worked closely with EBSA leadership at the regional and national levels to oversee all aspects of NQTL enforcement, from the issuance of initial NQTL comparative analysis requests to the review of findings.

Ongoing training of new and existing staff has been critical to EBSA's increased enforcement activities. During the Reporting Period, the Task Force delivered 24 training sessions to groups ranging in size from 7 employees to over 200 investigators, managers, benefits advisors, and attorneys from the Office of the Solicitor. EBSA's regional offices conducted more than 60 NQTL-specific training sessions tailored to staff needs.

Yet even with the recent increase in staffing and resources devoted to MHPAEA NQTL enforcement, DOL's enforcement resources—both in EBSA and for the necessary legal support provided by the Office of the Solicitor—are limited compared to the vast universe that it regulates. EBSA regulates an estimated 2.5 million health plans, 747,000 private pension plans, and 673,000 other welfare plans, for a total of 3.9 million ERISA-covered plans covering 152 million participants and beneficiaries. EBSA has 1 investigator for every 7,700 health plans (and roughly 1 investigator for every 12,200 plans, once retirement plans and other welfare plans, which are also under EBSA's jurisdiction, are considered).

Similarly, CMS has increased its enforcement activities in the individual and fully insured group markets in the three states⁶¹ where it is the direct enforcer of MHPAEA with respect to issuers. CMS also has direct enforcement authority with respect to MHPAEA, over non-federal governmental group health plans (which include state and local government employee plans) in all states and has also increased its MHPAEA enforcement activities involving non-federal governmental group health plans. For example, since February 2021, CMS has requested comparative analyses for 44 NQTLs across 24 plans and issuers, including 23 new reviews in 2022. In FY 2022, CMS closed 4 self-funded non-federal governmental plan investigations related to MHPAEA. To provide consumers more resources for reporting potential MHPAEA violations, starting in 2022, consumers were also able to directly submit MHPAEA complaints through the No Surprises Help Desk.⁶²

CMS oversees approximately 90,000 non-federal governmental group health plans and, in the three states where CMS is the direct enforcer of MHPAEA, CMS oversees 41 health insurance issuers offering coverage in the individual and fully-insured group markets. CMS currently has 15 investigators who review plan and issuer compliance with MHPAEA and other applicable PHS Act provisions.

⁶¹ In the 2022 plan year, CMS was responsible for enforcement of MHPAEA with respect to issuers in Missouri, Texas, and Wyoming.

⁶² The No Surprises Help Desk is available at 1-800-985-3059 or via webform located at <https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing>.

MHPAEA ENFORCEMENT EFFORTS

I. EBSA’S MHPAEA ENFORCEMENT ACTIVITY UNDER THE CAA

EBSA has undertaken unprecedented enforcement action since the enactment of the CAA by requesting comparative analyses for hundreds of NQTLs and obtaining corrections for NQTL issues that have resulted in removal of barriers to coverage of MH/SUD treatment for millions of participants and the reversal of denials of claims for MH/SUD benefits.

A. EBSA’s NQTL Enforcement Priorities

This section of the report covers nine months of activity between November 1, 2021, and July 31, 2022.⁶³ During the Reporting Period, EBSA continued to prioritize the review of NQTLs using the enforcement tools added in ERISA Section 712(a)(8) by the CAA.

The January 2022 Report to Congress detailed four areas of NQTL enforcement priority. Subsequently, EBSA added two areas of priority for this Reporting Period based on EBSA’s CAA implementation experience during the first reporting period. The six priority areas are:

1. Prior authorization requirements for in-network and out-of-network inpatient services;
2. Concurrent care review for in-network and out-of-network inpatient and outpatient services;

⁶³ The January 2022 Report to Congress also covered nine months of activity – between February 10, 2021, and October 31, 2021. The time for the Secretaries to issue their reports was set by statute; subsequent reports will be due yearly instead of every nine months.

3. Standards for provider admission to participate in a network, including reimbursement rates;
4. Out-of-network reimbursement rates (methods for determining usual, customary, and reasonable charges);
5. Impermissible exclusions of key treatments for mental health conditions and substance use disorders (**NEW** since the January 2022 Report); and
6. Adequacy standards for MH/SUD provider networks (**NEW** since the January 2022 Report).

In its enforcement efforts, EBSA has placed increased priority on NQTLs related to network adequacy, particularly provider network composition and participation standards, which includes reviewing how plans set their provider reimbursement rates and their efforts to monitor the adequacy of provider networks. Provider and patient advocacy groups have voiced concerns about patients having difficulties finding in-network MH/SUD providers, which is a major barrier to accessing MH/SUD benefits. At this time, EBSA is pursuing over 20 network admission standards investigations related to NQTLs impacting network adequacy.

B. EBSA's Approach to Implementing Its NQTL Enforcement Priorities

For all NQTL areas, including these priorities, EBSA develops investigative leads through careful review of plan documents and examination of plan operations among EBSA's open health case inventory. EBSA also gathers leads from other sources, such as state and federal regulatory partners, media reports, private litigation, participant or beneficiary complaints, professional associations, and patient advocacy groups.

This approach is consistent with EBSA’s strategy of leveraging its limited investigative resources based on specific leads to target potential violations that, if corrected, will have the greatest impact on the MH/SUD benefits for participants and beneficiaries.

EBSA is prioritizing potential violations that stem from the actions of service providers that affect not just one plan, but hundreds or thousands of plans. When EBSA finds NQTL violations in a plan, it examines the role that each of the plan’s service providers have in the design and administration of each NQTL to ascertain whether any of the service providers play a similar role serving other plans that also use the same impermissible NQTL.

During the Reporting Period, EBSA expanded an initiative targeting service providers that administer many plans for possible impermissible exclusions⁶⁴ of key MH/SUD treatments. Under this approach, EBSA directly contacts service providers before contacting the plans they serve in order to:

- Clarify whether the service provider administers plans that have these exclusions, and determine which plans are affected.
- Gather information on whether the service provider has or the plans it serves have conducted a comparative analysis that demonstrates compliance for the NQTL.

Depending on the circumstances, this may require EBSA to issue requests for NQTL comparative analyses from some or all of the service provider’s plan clients.

- Work with the service provider to correct impermissible exclusions.

⁶⁴ Examples include exclusions of ABA therapy to treat autism spectrum disorder, medication-assisted treatment and medications for treating opioid use disorder, urine drug testing (if part of treatment for a mental health condition or substance use disorder), and nutritional counseling to treat mental health conditions such as eating disorders.

Under this approach, correction first requires that the service provider change its impermissible practices, then ensures that the service provider notifies and works with all its plan clients to make necessary changes at the plan level, including amendments to plan terms, notices to participants, and payment of wrongly denied claims.

During the Reporting Period, EBSA worked with over 20 service providers using this strategic approach. In many cases, the service provider agreed to remove potentially impermissible exclusions applied to many plans, without requiring EBSA to issue requests for comparative analyses to the service provider or its plan clients. These service providers collectively cover thousands of plans and millions of participants. They include some of the largest service providers administering plans across the country, as well as regional service providers.

In the current Reporting Period, EBSA is expanding this service provider approach by sending request letters or subpoenas to three more service providers, including some of the largest in the country. As it performed its investigative work, EBSA has encountered more total exclusions of key treatments for MH/SUD conditions than expected, such as ABA therapy to treat ASD, medication-assisted treatment (MAT) and medications for opioid use disorder (MOUD), and nutritional counseling for eating disorders. In response, the request letters will ask the service providers to specifically disclose whether they apply these exclusions or any other potentially impermissible exclusion. If they do, EBSA will seek the service provider's justification, if any, for why the exclusion is in parity and when appropriate, demand that they stop engaging in prohibited practices.

C. EBSA's Enforcement Results Under the CAA and Their Impact

1. Results During the Reporting Period

EBSA achieved corrections at all the various stages of its NQTL review process. The stages include asking initial questions about an NQTL, issuing an initial request for comparative analysis, and issuing an initial determination of non-compliance. Appropriate correction depends on the NQTL and may include one or more of the following:

- 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; or
- Notice to participants and beneficiaries of an opportunity to submit previously unsubmitted claims that will now be accepted for processing.

During the Reporting Period, EBSA issued the following:

- 25 initial letters requesting comparative analyses for 69 NQTLs (57 “unique” NQTLs⁶⁵),
- 52 insufficiency letters covering over 100 NQTLs,⁶⁶
- 22 initial determination letters finding that plans and issuers had violated

MHPAEA’s requirements for 26 NQTLs (20 unique NQTLs), and

- 3 final determination letters finding MHPAEA violations for 3 NQTLs

(3 unique NQTLs).⁶⁷

However, these statistics do not tell the whole story. EBSA often obtained corrections without having to go through the entire review and determination process set forth in the CAA.

Indeed, **the majority of corrections obtained by EBSA were accomplished without the need to issue determinations of non-compliance**, as plans and issuers corrected potential MHPAEA

⁶⁵ This count of “unique” NQTLs includes only NQTLs that EBSA has identified with respect to a specific plan or issuer that has defined the NQTL using different factors or evidentiary standards than other NQTLs. For example, if a plan applies an identical pre-authorization requirement NQTL to four different benefit classifications, or to four different options in the same plan, EBSA counts the NQTL as just one “unique” NQTL, even though it is technically four separate NQTLs. When a comparative analysis request is sent to an issuer with identical NQTLs that apply to many fully insured plans, EBSA similarly counts the NQTL as one unique NQTL, even though there are technically many separate NQTLs for the different plans. When EBSA learns in the course of its investigations that NQTLs previously thought to be identical are administered differently with respect to different classifications, plans, or products, EBSA changes the characterization accordingly. If EBSA took a different approach and instead counted each NQTL separately by benefit classification, plan, and product, irrespective of whether the NQTLs are administered in the same way in these different contexts, then the number of NQTLs for which EBSA requested a comparative analysis during the Reporting Period would be over 200.

⁶⁶ The insufficiency letters and initial and final determination letters noted here and issued during the Reporting Period addressed NQTLs where EBSA’s review was ongoing during the Reporting Period, irrespective of the reporting year during which EBSA initially requested the comparative analyses.

⁶⁷ This report describes these final determinations in more detail in Section I.D.5.

violations in response to EBSA's comparative analysis requests or subsequent insufficiency letters.⁶⁸

2. Results Since the CAA was Enacted

EBSA's efforts and the corrections obtained during the Reporting Period are a continuation of the EBSA enforcement activities outlined in the January 2022 Report. Because investigations into NQTLs are resource-intensive and time consuming, reviews that began during the initial reporting period were not all completed during that period. Instead, many of those reviews concluded during this Reporting Period, and some current reviews will be included in future Reports to Congress.

For these reasons, the full picture of EBSA's enforcement efforts under the CAA is not apparent by looking at this single 9-month Reporting Period in isolation. By looking at EBSA's efforts over the last 18 months,⁶⁹ the full breadth of EBSA's MHPAEA enforcement under the CAA comes into focus. Since February 2021, EBSA has issued:

- 182 initial letters requesting comparative analyses for over 450 NQTLs (over 270 unique NQTLs),

⁶⁸ While many plans and issuers made corrections to avoid being identified in this Report as failing to comply with MHPAEA, EBSA believes that the protections of MHPAEA would be greatly strengthened with the enactment of many of the legislative recommendations noted in the January 2022 Report.

⁶⁹ Under the CAA, plans and issuers were required to have comparative analyses available upon request starting February 10, 2021. EBSA requested the first comparative analysis on April 9, 2021, shortly after the Departments issued guidance in FAQs About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 (Apr. 2, 2021), available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf> and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/MHPAEA-FAQs-Part-45.pdf>. However, even before the enactment of the CAA, plans and issuers were obligated to ensure that they met the NQTL requirements, both as written and in operation, and should have analyzed the comparability and stringency of their practices as a means of ensuring compliance with MHPAEA and its implementing regulations.

- 138 insufficiency letters, covering over 290 NQTLs,
- 53 initial determination letters finding that plans and issuers had violated MHPAEA’s requirements for 76 NQTLs (56 unique NQTLs), and
- 3 final determination letters finding MHPAEA violations for 3 NQTLs (3 unique NQTLs).

EBSA’s efforts during the Reporting Period, as well as its efforts described in the January 2022 Report, cumulatively resulted in 104 plans (and their service providers) and issuers agreeing to make prospective changes to their plans addressing 135 NQTLs across 46 investigations. These corrections directly benefit over 4 million participants in more than 39,000 plans and are the result of EBSA’s exercise of the enforcement and disclosure provisions under ERISA Section 712(a)(8), as added by the CAA.

3. Current Status of Reviews of Unique NQTLs Noted in January 2022 Report

In the period covered by the January 2022 Report, EBSA issued comparative analysis requests for 217 unique NQTLs.⁷⁰ EBSA continues to work to bring these plans and issuers into compliance. Due to the complex nature of these cases, a MHPAEA investigation can take a year or more, depending on a variety of factors, including whether EBSA receives all the necessary information from a plan or issuer to make a determination of compliance or has to engage experts or refer the matter to another DOL agency to litigate the issue.⁷¹ Although the process of

⁷⁰ The January 2022 Report identifies 216 unique NQTLs requested between April 2021 and October 31, 2021. After publication of the January 2022 Report, EBSA identified one NQTL that should have been noted as unique but was erroneously omitted from the count of unique NQTLs. The revised number is 217 unique NQTLs.

⁷¹ See 2018 MHPAEA Report to Congress, pages 9-11, available at <https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-2018-pathway-to-full-parity.pdf>.

gathering additional information and bringing plans into compliance has been challenging and labor intensive, EBSA was able to issue initial determinations for 36 unique NQTLs during the 9-month period⁷² covered by that report.

As of July 31, 2022, EBSA continues to work with the plans and issuers to resolve insufficiencies and gather supplemental information so that it can assess MHPAEA compliance for approximately 127 of those 217 unique NQTLs. For the approximately 90 unique NQTLs remaining, EBSA is either:

- in the process of obtaining proof of correction from a plan or issuer that has agreed to correct, or is reviewing corrective action plans from the plan or issuer; or
- no longer pursuing the NQTL issue through the ERISA Section 712(a)(8)(B) process for various reasons, including because the plan terminated, the NQTL was removed before the comparative analysis was requested, additional information resolved the concern, or proof of full correction was obtained.⁷³

4. Examples of the Impact of EBSA's Enforcement Results under the CAA

EBSA's successes have had a real impact on individual lives by ensuring access to needed MH/SUD benefits and obtaining payment for previously denied MH/SUD service claims. But as noted above, statistics alone cannot tell the full story of the significance of EBSA's work to enforce parity between MH/SUD benefits and medical/surgical benefits. The following

⁷² The January 2022 Report covered activity from February through October 31, 2021.

⁷³ If EBSA is no longer pursuing an NQTL through the ERISA Section 712(a)(8)(B)/CAA process, but if an NQTL issue is not fully resolved, EBSA will continue to determine NQTL compliance and seek full correction of any NQTL violations through its normal investigative process.

examples illustrate EBSA's impact on participants and beneficiaries who are seeking MH/SUD treatment across the country. The examples include EBSA's enforcement activity during the Reporting Period and ongoing enforcement efforts that began before the Reporting Period.

a. Examples of Corrections to NQTLs Imposed on Various MH/SUD Benefits

Example #1 – Removal of Exclusion for MH/SUD Residential Treatment Facilities and Reprocessing of Claims

Residential treatment facilities generally provide MH/SUD services in a structured living environment for people who need support in their recovery but do not need inpatient treatment. These facilities have the goal of preparing people to live on their own and move into the community at lower levels of care.⁷⁴ Residential treatment can be an important part of the continuum of care for MH/SUD conditions.

Issue: A self-funded plan covering over 800 participants excluded MH/SUD benefits at residential treatment facilities but covered benefits at medical/surgical residential treatment facilities, such as skilled nursing facilities and stroke rehabilitation programs. The plan did not have an explanation for the difference in coverage or a comparative analysis that addressed this exclusion when EBSA requested it.

Action: EBSA's Atlanta Regional Office issued an initial determination letter citing the plan for imposing an impermissible NQTL.

⁷⁴ <https://aspe.hhs.gov/reports/state-residential-treatment-behavioral-health-conditions>.

Result: The plan removed the exclusion and reprocessed previously denied MH/SUD residential treatment claims. MH/SUD residential treatment will be covered by the plan going forward.

Example #2 – Ending the Use of an EAP as a Gatekeeper for MH/SUD Services

Employee Assistance Programs (EAPs) are employment-based programs that may offer free and confidential assessments, short-term counseling, referrals, and follow-up services when an employee has a personal or work-related problem. These types of programs can promote employees' emotional well-being and help employees with issues such as substance use, stress, grief, family issues, and psychological disorders. However, EBSA has found that some plans have erected barriers to access MH/SUD benefits under the group health plan by requiring participants to use EAPs before a participant can access MH/SUD benefits, when there is no comparable requirement to access medical/surgical benefits under the group health plan.

Issue: When participants of a multiple employer welfare arrangement plan sought MH/SUD benefits by calling the phone number on their plan membership card, they were connected directly to the plan's EAP provider. The EAP call operators acted as gatekeepers, using prescreening questions to decide whether to direct participants to EAP counselors or to refer them to the plan's network provider for MH/SUD services. The plan did not use the EAP or any other comparable program or entity as a gatekeeper for any medical/surgical benefits.

Action: EBSA's Los Angeles Regional Office issued an initial determination of non-compliance to the plan, citing the practice of using the EAP as a gatekeeper for accessing MH/SUD benefits as an impermissible NQTL.

Result: The plan ended the practice of using the EAP as a gatekeeper for MH/SUD benefits. It removed the NQTL from plan documents and issued new membership cards with amended information allowing participants to contact MH/SUD providers directly without going through the EAP. This correction affected over 4,000 participants who will now be able to directly access MH/SUD benefits through the plan’s network provider for MH/SUD services.

Example #3 – Removal of Exclusion of Coverage for MH/SUD Telehealth Benefits

During the COVID-19 public health emergency, health care providers expanded the use of telehealth to deliver both MH/SUD services and medical/surgical services. The availability of MH/SUD services via telehealth is critical to ensuring that patients receive timely treatments, especially given the increased demand for MH/SUD services as a result of the public health emergency.⁷⁵ While many plans and issuers have expanded the availability of telehealth services, EBSA is concerned about plans that have reduced or limited coverage of telehealth services in ways that disproportionately affect access to MH/SUD benefits.

Issue: A self-funded plan excluded MH/SUD benefits provided via telephone, email, or internet. The plan did not have any similar restrictions on medical/surgical benefits.

Action: EBSA’s Cincinnati Regional Office issued an initial determination of non-compliance to the plan, citing the exclusion as an impermissible NQTL.

⁷⁵ <https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/#:~:text=Telehealth%20has%20played%20a%20particularly,for%20these%20services%20via%20telehealth.>

Result: The plan removed the impermissible NQTL and notified participants of the change in plan terms. Approximately 2,000 participants now have access to MH/SUD telehealth benefits as a result of the correction.

Example #4 – Removal of Prior Authorization Requirement on Certain MH/SUD

Services

Prior authorization is a requirement that the issuer or plan must determine that a health care item or service is medically necessary before the issuer or plan will provide benefits for the item or service.

Issue: A service provider that is both an issuer and a third-party administrator for self-funded plans, covering over 24,000 participants, applied prior authorization to some outpatient MH/SUD benefits and some outpatient medical/surgical benefits. EBSA's San Francisco Regional Office identified deficiencies and inconsistencies when reviewing the comparative analysis prepared by the service provider for its fully insured products and on behalf of its self-funded client plans.

The service provider classified the following intermediate levels of care as outpatient services: skilled nursing care, home health services, intensive outpatient services, partial hospitalization, and partial residential treatment. After evaluating outpatient medical/surgical services using named factors, the service provider removed the prior authorization requirement for intermediate outpatient services for medical/surgical conditions but did not change the prior authorization requirement for outpatient MH/SUD services, including intermediate care for mental health conditions and substance use disorders. The service provider acknowledged that it had not evaluated outpatient MH/SUD benefits using the identified factors. The comparative

analysis was deficient because it did not adequately demonstrate how the factors used to determine whether prior authorization was required were comparably applied.

Action: EBSA's San Francisco Regional Office sent an insufficiency letter identifying these deficiencies and raising related questions.

Result: The service provider acknowledged that it had not applied the factors comparably, submitted a corrective action plan, and changed its claims processing system to remove the prior authorization requirement for intensive outpatient MH/SUD benefits.

The San Francisco Regional Office is working with the service provider and reviewing claims activity to determine the extent to which the service provider's application of the NQTL adversely impacted any participants and beneficiaries of its fully insured plan clients and the self-funded plans it administers.

b. Examples of Corrections to NQTLs Specific to SUD Benefits

As outlined in the introduction to this Report, the opioid epidemic is affecting millions of people in the U.S. every day, and access to SUD treatment can be both lifesaving and life-changing. Accordingly, removing impermissible limits on access to SUD treatments is an urgent enforcement priority.⁷⁶ EBSA's work to ensure parity between SUD benefits and medical/surgical benefits has helped people across the country not only receive the treatment they need but also rebuild their lives.

⁷⁶ <https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf>.

Example #5 – Removal of Exclusion for Treatment Provided by Opioid Treatment Programs and Reprocessing of Claims

Issue: A large self-funded plan covering over 22,000 participants excluded treatment for opioid use disorder with methadone (which must be provided through an opioid treatment program) but covered methadone to treat medical/surgical conditions. The plan did not have a comparative analysis that addressed the exclusion of methadone for the treatment of opioid use disorder when EBSA requested it.

Action: EBSA's New York Regional Office issued an initial determination letter citing the plan for imposing an impermissible NQTL.

Result: The plan took corrective action by removing the impermissible exclusion and reprocessing and paying all claims that had been wrongfully denied because of the exclusion. EBSA's New York Regional Office is also working directly with the plan's service provider to seek widespread correction affecting other plan clients of the service provider that may have the same treatment exclusion.

Example #6 – Removal of Exclusion of Drug Testing for MH/SUD Conditions and Reprocessing of Claims

Issue: As described in Example #4 in the January 2022 Report, a service provider to many self-funded Taft-Hartley health plans had been processing claims in a discriminatory manner that resulted in the denial of coverage for drug testing related to MH/SUD treatment, but not for drug testing related to medical/surgical treatment.

Action: EBSA issued requests for comparative analyses to many of the service provider's plan clients.

Result: The service provider and its plan clients reprocessed claims as a result of EBSA's inquiries. Many plans were not aware of how the service provider was processing drug testing claims related to MH/SUD treatment. EBSA's Kansas City Regional Office worked directly with the service provider to identify the specific claims for each plan client that were wrongfully denied so that the service provider could reprocess and pay those denied claims. During the Reporting Period, the service provider reprocessed over 3,000 previously denied claims totaling nearly \$2 million, resulting in payments of over \$1 million to plan participants, beneficiaries, and providers.⁷⁷ Additionally, the service provider, along with 31 plans covering a total of 73,067 participants and 99,910 dependents, adopted new internal procedures for handling drug testing claims to ensure that all drug testing claims are paid according to plan terms and are not improperly denied.

Example #7 – Removal of Exclusion for Inpatient Substance Use Disorder Treatment
Unless the Participant Completes the Entire Course of Treatment

Issue: A self-funded plan covering over 4,000 participants had a provision in its plan documents excluding coverage for inpatient substance use disorder treatment unless the participant completed the entire course of treatment. The plan did not have any similar limitations for inpatient medical/surgical benefits.

⁷⁷ The remaining approximate \$900,000 in claims was reprocessed and written off as network discounts for which participants and beneficiaries would not be billed.

Action: EBSA’s Chicago Regional Office issued an insufficiency letter because the plan’s comparative analysis was deficient. The comparative analysis failed to demonstrate how the NQTL was applied in parity.

Result: After receiving the insufficiency letter, the plan removed this impermissible requirement.

c. Examples of NQTLs Imposed on ABA Therapy to Treat ASD

ASD is a developmental disability caused by differences in the brain.⁷⁸ The Centers for Disease Control and Prevention estimates that, among 8-year-old children, 1 in 44 have been identified with ASD,⁷⁹ which lasts throughout a person’s life and can affect their behavior, communication, interactions, and learning.⁸⁰ Early diagnosis is important because it allows for early intervention, including support and services that enable children with ASD to reach their full potential.⁸¹

Treatments for ASD are focused on each individual person because ASD affects each person differently. The primary focus of ASD treatment is to reduce symptoms that interfere with daily life. While there are many approaches, many treatments use both behavioral and developmental approaches. A primary treatment modality for ASD is ABA therapy, which encourages desired behaviors and discourages undesired behaviors. It is generally delivered by a behavioral specialist and often involves recurring sessions.⁸²

⁷⁸ <https://www.cdc.gov/ncbddd/autism/facts.html>.

⁷⁹ <https://www.cdc.gov/ncbddd/autism/addm.html>.

⁸⁰ <https://www.cdc.gov/ncbddd/autism/facts.html>.

⁸¹ <https://www.cdc.gov/ncbddd/autism/screening.html>.

⁸² <https://www.cdc.gov/ncbddd/autism/treatment.html>.

EBSA is committed to ensuring that participants and beneficiaries with ASD in ERISA-covered plans can access treatment to improve their lives, including ABA therapy, as this treatment can have a huge impact on the lives of people with ASD, especially children.^{83, 84}

Example #8 – Removal of ABA Therapy Exclusion at an Early Stage of EBSA’s Inquiry

Issue: A self-funded plan covering more than 2,500 participants excluded benefits for ABA therapy to treat ASD despite generally providing benefits for ASD.

Action: EBSA’s Dallas Regional Office asked the plan about this exclusion in preparation for issuing a request for the plan’s comparative analysis.

Result: As a result of EBSA’s questions and before EBSA issued a request for the comparative analysis, the plan removed the ABA therapy exclusion. EBSA’s Dallas Regional Office is working with the plan to determine the extent to which claims were affected by the exclusion.

⁸³ Foxx, R. M. (2008). Applied behavior analysis treatment of autism: The state of the art. *Child and Adolescent Psychiatric Clinics of North America*, 17, 821-834, available at <https://www.sciencedirect.com/science/article/abs/pii/S1056499308000412>. (“The only interventions that have been shown to produce comprehensive, lasting results in autism have been based on the principles of ABA”); Orinstein, Helt, Tyson, Barton, Eigsti, Naigles, and Fein (2015) *Intervention History of Children and Adolescents with High-Functioning Autism and Optimal Outcomes*, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4487510/> (“ABA is generally considered the autism intervention supported by the most evidence.”); Centers for Disease Control and Prevention, *Treatment and Intervention Services for Autism Spectrum Disorder*, available at <https://www.cdc.gov/ncbddd/autism/treatment.html#Behavioral> (“Behavioral approaches have the most evidence for treating symptoms of ASD.”).

⁸⁴ J Smith-Young (2020) “Managing the Wait”: Parents' Experiences in Accessing Diagnostic and Treatment Services for Children and Adolescents Diagnosed With Autism Spectrum Disorder, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6987484/> (“‘Managing the Wait’ was identified as the core category central to parents’ experience of this process. This process was found to be impacted by socioeconomic status, parents’ skills and capacity to advocate on their child’s behalf, and severity of their child’s ASD.”); Aylward, Diana Gal-Szabo, Taraman (2021) *Racial, Ethnic, and Sociodemographic Disparities in Diagnosis of Children with Autism Spectrum Disorder*, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8500365/> (“[P]arents often have to wait an average of 3 years between their first concerns and their child receiving an ASD diagnosis. The average age of diagnosis remains between 4 and 7 years, with this delay being more pronounced with children from lower-income, ethnic/racial minority, and rural backgrounds.”).

Example #9 – Removal of ABA Therapy Exclusion and Prevention of a New Treatment

Plan Requirement on ABA Therapy

Issue: A self-funded plan covering around 1,000 participants excluded benefits for ABA therapy to treat ASD while generally providing other benefits for ASD. The plan did not have an explanation or comparative analysis for this limitation.⁸⁵

Action: EBSA’s Los Angeles Regional Office issued an initial determination of non-compliance citing the plan for the potentially impermissible NQTL. The initial determination letter also noted that the plan must provide a corrective action plan, including a comparative analysis if the corrective action involved imposing or continuing to impose an NQTL on the benefits in question.

Result: The plan removed the ABA therapy exclusion and issued a Summary of Material Modification reflecting this change to all participants and beneficiaries. The plan’s corrective action plan did not include a comparative analysis or reference to any NQTLs the plan would impose on ABA therapy.

However, in following up with the plan to confirm that the plan was receiving and covering ABA therapy claims following the removal of the exclusion, EBSA learned that the plan was postponing the processing of ABA therapy claims by placing them in “pending” status while the plan was in the process of imposing a new limitation on ABA therapy claims. The

⁸⁵ This plan and investigation were unrelated to the service provider or client plans mentioned in Example #2 earlier in this report.

plan's new policy required the review of provider notes and a treatment plan for ABA therapy claims.

EBSA requested the plan's comparative analysis for the new review requirement. Instead of providing a comparative analysis, the plan removed the new review requirement for ABA therapy claims and processed pending claims.

5. Significant Work Remains to Fulfill MHPAEA's Promise

While EBSA's efforts have improved parity for many affected plan participants and beneficiaries, more work remains to ensure MHPAEA's promise of parity between medical/surgical and MH/SUD benefits for Americans covered by group health plans. EBSA has made an unprecedented effort to increase MHPAEA enforcement, relying on the supplemental funds temporarily provided by the CAA, and EBSA is determined to ensure MHPAEA compliance.⁸⁶

A major component of EBSA's work to ensure parity involves utilizing the CAA provisions that require plans to perform and document their comparative analyses and submit them for review upon request. Comparative analyses submitted by plans and issuers should give EBSA a sound basis for determining whether plans and issuers are complying with MHPAEA's NQTL provisions. In actual practice, however, the comparative analyses that plans and issuers are performing and providing to the Secretary for review commonly fall far short of MHPAEA's requirements, as outlined in the section below.

⁸⁶ Section 118 of the No Surprises Act, as enacted in the CAA, appropriated \$500 million in implementation funding to the Departments to carry out the provisions of, and the amendments made by, Title I (No Surprises Act) and Title II (Transparency), Division BB of the CAA. This implementation fund is available until expended through FY 2024.

EBSA is increasingly concerned that some plans and issuers are most focused on the task of documenting a parity analysis and avoiding obvious red flags, rather than truly working to ensure parity in their MH/SUD benefits and coverage. Some plans and issuers provide the minimum information necessary to avoid an insufficiency finding, but do not provide all of the relevant information necessary to determine the plan's compliance with the substantive requirements of MHPAEA. The net result is that EBSA is forced to expend significant investigative resources to identify and obtain the information necessary to determine compliance, including information on how plans and issuers are applying NQTLs in practice, which is a critical and necessary component of the analysis.

Fulfilling the promise of parity under MHPAEA will require years of sustained effort and engaged cooperation from plans and issuers. EBSA is fully committed to working to ensure parity in access to MH/SUD benefits. However, to be fully successful, EBSA will need enactment of many of the legislative recommendations noted in the January 2022 Report and increased funding for its NQTL enforcement efforts.⁸⁷

⁸⁷ Authority to enforce group health plan requirements directly against employment-based plans' administrative service providers was a focus of the legislative recommendations in the January 2022 Report. Since the release of the January 2022 Report, Treasury has received questions regarding the tax for failure to meet certain group health plan requirements, including MHPAEA, under Code Section 4980D. The statute provides that the party liable for any applicable tax under Code Section 4980D is the employer or, in certain circumstances, the plan itself. However, Treasury acknowledges that it is rare for employers to self-administer their group health plans and is of the view that enforcement directed at administrative service providers would be more effective.

D. Statutory Reporting Requirements

1. Summary of Requests and Identification of Non-Compliant Plans and Issuers⁸⁸

During the Reporting Period, EBSA issued 25 letters requesting comparative analyses for 69 NQTLs (57 unique NQTLs). EBSA sent 18 letters to plans and seven letters to issuers. In total between April 9, 2021, and July 31, 2022, and across 101 investigations, EBSA issued 182 letters to plans and issuers requesting comparative analyses for over 450 NQTLs (over 270 unique NQTLs).

The following table summarizes the different types of NQTLs for which EBSA requested analyses during the Reporting Period.⁸⁹

Type of NQTL Covered by New Requests in Reporting Period	Number of Comparative Analysis Requests Issued
Prior authorization, precertification, or prior notification	17
Exclusion of ABA, intensive behavioral, rehabilitative/habilitative, or cognitive therapy to treat MH/SUD conditions	9
Network admission standards, including reimbursement rates and network adequacy	9
Concurrent care review	7
Out-of-network reimbursement rates and out-of-network provider requirements	5
Limitations based on likelihood of improvement or progress	4

⁸⁸ This summary fulfills the Secretary's reporting obligations under ERISA Section 712(a)(8)(B)(iv)(I), 29 U.S.C. Section 1185a(a)(8)(B)(iv)(I), which requires the Secretary to submit a yearly "summary of the comparative analyses requested . . . , including the identity of each group health plan or health insurance issuer, with respect to certain health insurance coverage that is determined to be not in compliance after the final determination by the Secretary described in clause (iii)(I)(bb)[.]"

⁸⁹ See the January 2022 MHPAEA Report to Congress for a table summarizing the types of NQTLs for which EBSA requested comparative analyses between April 2021 and October 31, 2021.

Type of NQTL Covered by New Requests in Reporting Period	Number of Comparative Analysis Requests Issued
Exclusion of MAT for SUDs	3
Exclusion of speech therapy to treat MH conditions	2
Exclusion of nutritional or dietary counseling for MH conditions	2
EAP referral/exhaustion requirements	2
Fail-first requirements	2
Treatment plan requirements	2
Other	5
Total	69

Although EBSA requested many more analyses than the minimum amount required by the CAA, EBSA requested fewer comparative analyses during the Reporting Period than in the previous year because of the large number of reviews of NQTLs that were ongoing from the prior reporting period. EBSA’s new requests for comparative analyses reflect its strategic focus on exclusions of key MH/SUD treatments, with a primary focus on exclusions applied by service providers that administer many plans. The new requests also reflect EBSA’s ongoing attention to the NQTLs listed as focus areas in FAQs Part 45.⁹⁰

ERISA Section 712(a)(8)(B)(iv)(I), as added by Section 203 of title II of Division BB of the CAA, requires that this report include “the identity of each group health plan or health insurance issuer, with respect to certain health insurance coverage that is determined not to be in compliance after the final determination by the Secretary....”

⁹⁰ FAQs Part 45, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf> and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/MHPAEA-FAQs-Part-45.pdf>.

During the Reporting Period, EBSA issued final determinations of non-compliance, which are described in more detail in Section I.D.5, to the following plans:

- **International Brotherhood of Electrical Workers (IBEW) Local Union No. 126 Health and Welfare Plan**
 - EIN/Plan Number 23-6395223/501
 - 2,025 participants as of December 31, 2021
 - Final determination issued on April 13, 2022
- **North Shore Healthcare LLC Health Care Plan**
 - EIN/Plan Number 47-5124382/501
 - 951 participants as of November 30, 2021
 - Final determination issued on May 23, 2022
- **Pipefitters Union Local No. 537 Health and Welfare Fund**
 - EIN/Plan Number 04-2167074/501
 - 2,776 participants as of February 28, 2021
 - Final determination issued on July 7, 2022

2. *EBSA's Conclusions Regarding Sufficiency of Responses*⁹¹

Comparative analyses are an opportunity for plans and issuers to think carefully and deeply about how they apply NQTLs to MH/SUD benefits as compared to medical/surgical benefits, either through a longstanding practice or a new limitation. EBSA expects comparative analyses to include descriptions of the ways plans and issuers have worked to avoid NQTL practices that, by design or in application, are more stringently applied to MH/SUD benefits than to medical/surgical benefits.

However, in its second year of CAA implementation, EBSA has not seen a marked improvement in the sufficiency of the initial comparative analyses received. The same deficiencies and trends noted in the January 2022 Report⁹² are still commonly reflected in comparative analyses reviewed during the Reporting Period.

During the Reporting Period, none of the comparative analyses initially submitted were sufficient to demonstrate compliance. Most comparative analyses were missing multiple content elements required by the statute. EBSA is of the view that several factors contribute to this result. For example, EBSA did not make requests at random, but rather requested comparative analyses based on plan provisions that appeared problematic or raised red flags. In addition, many plans

⁹¹ This summary fulfills the Secretary's reporting obligations under ERISA Section 712(a)(8)(B)(iv)(II), 29 U.S.C. Section 1185a(a)(8)(B)(iv)(II), which requires the Secretary to submit his "conclusions as to whether each group health plan or health insurance issuer submitted sufficient information for the Secretary to review the comparative analyses requested... for compliance with this section[.]"

⁹² See Section II.b.2.b. on pages 16-18 of the January 2022 Report for the following common themes in deficiencies:

- 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,
- Nonresponsive 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.

and issuers appear to have attempted to use the comparative analysis process to justify longstanding practices and policies that were put in place either prior to the MHPAEA's effective date or otherwise without consideration of MHPAEA compliance. In EBSA's experience, plans that did not prepare a comparative analysis in advance of a request often provided insufficient analyses and documentation.

Similarly, since MHPAEA's requirements apply to NQTLs both as written, and *in operation*, EBSA often cannot assess compliance without requesting and evaluating data and/or other supporting information on the operation of the processes, strategies, evidentiary standards and other factors, which may or may not appear compliant as written. EBSA is hopeful that much of this noncompliance will diminish in time as plans and issuers continue to make good faith efforts to come into compliance with MHPAEA's requirements and to diligently work towards parity.

If EBSA found that a comparative analysis was missing information required by the statute and that information was necessary to determine compliance with MHPAEA's NQTL provisions, EBSA issued an insufficiency letter notifying the plan or issuer of the deficiency. The insufficiency letters listed specific additional information or supporting documentation the plan or issuer should provide to supplement its submission or to fix a deficiency in its comparative analysis.

The main challenges that EBSA faced during the Reporting Period were that, despite the requirement in the CAA for all plans to have prepared an NQTL analysis by February 10, 2021, many plans and issuers were still unprepared to submit their comparative analyses upon request, and when comparative analyses were provided, the comparative analyses often failed to:

- Adequately explain how factors were applied when determining which benefits would be subject to the NQTL. Deficient explanations of the application of a factor were compounded by inadequate definitions of factors and inadequate explanations of how sources were used in selecting, defining, or applying factors.
- Demonstrate how or if the factors were comparably applied to MH/SUD benefits and to medical/surgical benefits.
- Adequately explain how an NQTL was applied in operation, describing processes generally and evaluating differences in application to MH/SUD and medical/surgical benefits without sufficient detail.
- Demonstrate that, in operation, the NQTL was comparably applied to both MH/SUD and medical/surgical benefits.

Additionally, plans and issuers that were initially unprepared ultimately submitted comparative analyses that often lacked data showing what happened when the NQTL was applied in operation. When operational data were included, plans and issuers often failed to explain numerical inputs, underlying methodologies, or calculations behind summary data that were presented as evidence of a comparable application. Many plans and issuers also failed to explain apparent differences in access to MH/SUD and medical/surgical benefits, instead focusing only on similarities.

EBSA has been responding to deficient comparative analyses by making extraordinary efforts to give plans and issuers opportunities to supplement their responses and cure deficiencies. Because the CAA process was new, EBSA intentionally chose not to move to

determinations of non-compliance for deficient comparative analyses at the earliest possible moment. Instead, EBSA engaged plans and issuers in repeated exchanges – asking follow-up questions, seeking additional evidence, performing further assessments, and affording opportunities for explanation – without making a final determination of noncompliance and triggering the CAA’s requirement for plans and issuers to notify participants and beneficiaries of a MHPAEA violation.

These dialogues generally resulted in plans and issuers producing information that brought them closer to having a comparative analysis meeting the requirements of the CAA, but the process was and continues to be time-consuming and resource-intensive. Each insufficiency letter is unique to the plan or issuer and NQTL, and each letter includes multiple follow-up questions or addresses problems related to the comparative analysis and supporting documents submitted. Of the 22 initial determination letters that EBSA issued during the Reporting Period, 14 cited plans or issuers for non-compliance due to not having a comparative analysis or for failure to cure apparent deficiencies in their comparative analysis after multiple opportunities to provide additional information. All three final determination letters referenced above included this same citation.

Because EBSA often requires additional information to determine operational compliance, EBSA is increasingly conducting full investigations to determine if the plan or issuer is complying with MHPAEA’s NQTL obligations.

These investigations are time-consuming. They often involve multiple rounds of interviews, depositions, document requests, data requests, and subpoenas to gather basic information from multiple sources needed to determine compliance. The overwhelming majority

of these investigations remain outstanding. However, EBSA will not close its investigations without considering whether other MHPAEA violations, in addition to the failure to prepare a complete comparative analysis, exist and are negatively impacting participants and beneficiaries.

More than 2 years have elapsed since the CAA NQTL comparative analysis requirements took effect, and CAA requirements and the corresponding review processes are no longer new. In following years, EBSA expects more complete comparative analyses from the start of the review process. If comparative analyses are insufficient, EBSA will expect them to be cured more quickly and may not provide the numerous opportunities to further supplement a submission that it has in the prior years before issuing a final determination of non-compliance.

Despite these ongoing challenges, EBSA has noted a handful of instances during the Reporting Period in which a few plans and issuers provided more detailed responses to insufficiency letters, which were promising improvements since the initial reporting period. In many cases, additional information cured an aspect of an identified deficiency. In some instances, depending on the facts and circumstances, the additional information provided was sufficiently detailed to satisfy EBSA's inquiry into the NQTL altogether. Data showing the effect of an NQTL's application were particularly important and sometimes operated as a "green flag" signaling that an NQTL in question did not appear to apply more stringently to MH/SUD benefits relative to medical/surgical benefits. This approach aligns with EBSA's aim to strategically focus its limited enforcement resources on NQTLs with a negative impact on access to MH/SUD benefits as compared to medical/surgical benefits.

EBSA hopes to see continued improvements in the details provided in responses going forward. See Appendix A for a more detailed explanation of the deficiencies listed above and

Appendix B for examples of how some plans and issuers provided additional information that cured deficiencies.

3. *EBSA’s Conclusions Regarding Compliance with Disclosure Requirements*⁹³

a. Initial Determinations by the Numbers

Since February 2021, through its review of comparative analyses and information gathered through the insufficiency letter process as well as through independent investigations, EBSA obtained sufficient information to make initial determinations of non-compliance for 53 plans and issuers in connection with 76 NQTLs (56 unique NQTLs). Of these determinations, EBSA issued 22 initial determination letters in connection with 26 NQTLs (20 unique NQTLs) during the Reporting Period.

These initial determination letters involved the following NQTLs that were not applied in parity for MH/SUD benefits. EBSA’s review of the other NQTLs and comparative analyses is ongoing.

Type of NQTL	Number of Initial Determinations of Non-Compliance Issued	
	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	19	9

⁹³ This summary fulfills the Secretary’s reporting obligations under ERISA Section 712(a)(8)(B)(iv)(III) – “for each group health plan or health insurance issuer that did submit sufficient information for the Secretary to review the comparative analyses requested under clause (i), the Secretary’s conclusions as to whether and why the plan or issuer is in compliance with the disclosure requirements under this section[.]”

Type of NQTL	Number of Initial Determinations of Non-Compliance Issued	
	Total Issued Since February 2021	Issued During the Reporting Period
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
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

b. EBSA's Enforcement Efforts Have Led to Improvements in Access to MH/SUD Benefits

Many plans and issuers changed their practices and/or removed NQTLs as a result of EBSA's request and review process. During the Reporting Period, EBSA received corrective action plans from 32 plans and issuers in response to initial determination letters. These corrective action plans addressed 36 NQTLs (24 unique NQTLs). Some of those corrections are complete, and some are pending as EBSA awaits proof of completion.

As a result of EBSA's efforts since February 2021, a total of 104 plans (and their service providers) and issuers have indicated that they are in the process of or have already completed making prospective changes to their plans for 135 NQTLs (71 unique NQTLs). That number includes 59 plans and issuers that received EBSA's requests for comparative analyses but did not receive an initial determination of non-compliance. During the Reporting Period, 99 plans and issuers were in the process of or have completed corrections addressing 130 NQTLs. These corrections affected access to MH/SUD benefits for over 4 million participants and beneficiaries across over 39,000 plans.⁹⁴

⁹⁴ While part of EBSA's strategic approach to NQTLs is to identify and focus on service providers that are in a position to enact widespread change for an entire line of business and potentially many affected plans that they serve, EBSA does not limit itself to large service provider investigations and continues to enforce against plans where a careful review of plan documents and examination of plan operations indicates a request for comparative analysis is warranted.

4. *Specifications Regarding Sufficiency of Responses*⁹⁵

Since February 2021, EBSA has issued a total of 138 letters noting that the plans and issuers have failed to provide sufficient information in response to requests for comparative analyses covering over 290 NQTLs. These 138 letters followed EBSA's initial sending of 182 letters requesting comparative analyses from plans and issuers since February 2021.

As stated earlier, some plan or issuer responses were deficient because they did not have a comparative analysis available to provide upon request. Additionally, there were many instances when a comparative analysis was provided, but the analysis itself was deficient. EBSA's specifications regarding the sufficiency of responses, which draw from the statutory requirements of ERISA Section 712(a)(8) and the guidance issued by the Departments in FAQs Part 45, are detailed above in Section II.D.2. (*EBSA's Conclusions Regarding Sufficiency of Responses*) and in the attached Appendix A.

5. *EBSA's Specifications Regarding Compliance*⁹⁶

EBSA issued three final determinations of non-compliance during the Reporting Period. Following these determinations, these plans were required to notify all individuals enrolled in the plans that the coverage was determined to be not in compliance with MHPAEA within 7 days of the date of the final determination letter. The following is a summary of each instance, including

⁹⁵ This summary is intended to comply with the Secretary's reporting obligations under ERISA Section 712(a)(8)(B)(iv)(IV) – “the Secretary's specifications described in clause (ii) for each group health plan or health insurance issuer that the Secretary determined did not submit sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section[.]”

⁹⁶ This summary is intended to comply with the Secretary's reporting obligations under ERISA Section 712(a)(8)(B)(iv)(V) – “the Secretary's specifications described in clause (iii) of the actions each group health plan or health insurance issuer that the Secretary determined is not in compliance with this section must take to be in compliance with this section, including the reason why the Secretary determined the plan or issuer is not in compliance.”

the reason EBSA determined the plan was not in compliance and the corrective action required to come into compliance.

- a. International Brotherhood of Electrical Workers (IBEW) Local Union No. 126 Health and Welfare Plan, EIN/Plan Number 23-6395223/501

On August 5, 2021, EBSA's Philadelphia Regional Office requested that this self-funded plan, which, at the time of the request, covered 2,025 participants, provide its comparative analysis for precertification in the inpatient and outpatient benefit classifications. The plan's written documents required precertification for all outpatient MH/SUD benefits but only some outpatient medical/surgical benefits.

EBSA issued an initial determination on September 2, 2021, citing the plan for failure to produce a comparative analysis and for imposing an impermissible NQTL. The initial determination letter also required the plan to provide a comparative analysis demonstrating compliance if it planned to continue to impose precertification requirements on MH/SUD benefits and medical/surgical benefits in the outpatient and inpatient classifications.

Within 45 calendar days of the initial determination, the plan submitted a corrective action plan that included amending its Summary Plan Description to narrow the scope of the precertification requirement, which it planned to continue imposing on both MH/SUD benefits and medical/surgical benefits. However, the plan did not submit a comparative analysis for the precertification requirement at that time.

The plan submitted a comparative analysis on March 14, 2022. The comparative analysis failed to identify and define all factors used to apply the precertification requirement to benefits,

failed to demonstrate comparable application of the NQTL in operation, and failed to demonstrate comparable application of the factors in operation.

EBSA issued a final determination of non-compliance on April 13, 2022, citing the plan for failure to comply with ERISA Section 712(a)(8), and the plan provided the statutorily required violation notice to participants and beneficiaries. To come into compliance, the plan must demonstrate that the precertification NQTL complies with MHPAEA's parity requirements, or it must change its precertification practices to align with parity. EBSA's investigation of the plan's operations and the impact of the violation on access to MH/SUD benefits is ongoing.

b. North Shore Healthcare LLC Health Care Plan, EIN/Plan Number 47-5124382/501

On August 30, 2021, EBSA's Chicago Regional Office requested that this self-funded plan, which, at the time of the request, covered almost 1,000 participants, provide its comparative analysis on prior authorization for benefits in the outpatient classifications. The plan did not provide a comparative analysis in response to this initial request, nor to a subsequent request, by the stated deadlines.

EBSA issued an initial determination of non-compliance on January 20, 2022, citing the plan for failure to produce a comparative analysis.

The plan provided a comparative analysis on March 7, 2022. The analysis was deficient because it did not identify all outpatient benefits subject to prior authorization, did not identify or define factors used to apply the prior authorization requirement to benefits or sources or evidentiary standards for those factors, and did not demonstrate comparable application of the factors in operation.

EBSA issued a final determination letter on May 23, 2022, citing the plan for failure to comply with ERISA Section 712(a)(8). The plan provided the statutorily required violation notice to participants and beneficiaries on May 29, 2022. To come into compliance, the plan must demonstrate that the prior authorization NQTL complies with MHPAEA's parity requirements, or it must change its prior authorization requirement to be in parity. EBSA's investigation of the plan's operations and the impact of the violation on access to MH/SUD benefits is ongoing.

- c. Pipefitters Union Local No. 537 Health and Welfare Fund, EIN/Plan Number 04-2167074/501

On May 11, 2021, EBSA's Boston Regional Office requested that this self-funded plan, which, at the time of the request, covered over 2,700 participants, provide its comparative analysis on prior authorization for benefits in the inpatient classifications. The plan's written provisions imposed a more stringent penalty for lack of prior authorization for MH/SUD benefits than for medical/surgical benefits.⁹⁷

The plan's comparative analysis contained information generated separately by its medical/surgical claims processor and by its MH/SUD claims processor, which were unrelated entities. Each service provider named different factors used in the design of the NQTL for medical/surgical claims than for MH/SUD claims, and the comparative analysis did not compare or contrast the factors, strategies, evidentiary standards, and processes described by each service provider.

⁹⁷ See 26 CFR 54.9812-1(c)(4)(iii) Ex. 3; 29 CFR 2590.712(c)(4)(iii) Ex. 3; and 45 CFR 146.136(c)(4)(iii) Ex. 3 (plan imposing a more stringent penalty for failure to preauthorize MH/SUD benefits violates MHPAEA).

EBSA issued an initial determination on December 14, 2021, citing the plan for violating ERISA Section 712(a)(3) by imposing a more stringent penalty on participants for failing to obtain prior authorization for MH/SUD inpatient benefits than for participants who fail to obtain prior authorization for medical/surgical inpatient benefits and for violating ERISA Section 712(a)(8) by failing to provide a sufficient comparative analysis.

The plan provided a corrective action plan on February 1, 2022 and indicated that it would amend its terms to remove the more stringent penalty for lack of prior authorization for MH/SUD benefits. However, the plan did not provide a date as of which it would complete its corrections.

EBSA issued a final determination on July 7, 2022. The plan issued the statutorily required violation notice to participants and beneficiaries on July 15, 2022. To come into compliance, the plan must demonstrate that the prior authorization NQTL complies with MHPAEA's parity requirements, or it must change its prior authorization practices and written provisions to align with parity. EBSA's investigation of the plan's operations and the impact of the violation on access to MH/SUD benefits is ongoing.

II. CMS' MHPAEA ENFORCEMENT ACTIVITY UNDER THE CAA

CMS, on behalf of HHS, carries out enforcement responsibilities under Title XXVII of the PHS Act, including MHPAEA enforcement. CMS is responsible for enforcement of MHPAEA for issuers in states that do not have authority to enforce or fail to substantially enforce MHPAEA (referred to as direct enforcement states) and for non-federal governmental group health plans in all states.^{98,99} CMS requested 21 comparative analyses from 6 non-federal governmental group health plan sponsors and 5 issuers in direct enforcement states between March 25, 2022, and June 6, 2022.¹⁰⁰

After CMS reviewed the comparative analysis from each of the plan sponsors and issuers, CMS identified areas of noncompliance and issued an initial determination of non-compliance to each plan sponsor and issuer. The plan sponsors and issuers were required to provide a corrective action plan and an additional comparative analysis that demonstrated compliance within 45 calendar days of the date of the initial determination letter.¹⁰¹ CMS was available to provide information and technical assistance to plan sponsors and issuers regarding corrective action plan submissions upon request. Plan sponsors and issuers are generally expected to:

⁹⁸ CMS is responsible for enforcement of MHPAEA with respect to non-federal governmental group health plans in all 50 states, the District of Columbia, and the territories. In the 2022 plan year, CMS was also the direct enforcer of MHPAEA for issuers in Missouri, Texas, and Wyoming. In addition, six states (Alabama, Florida, Louisiana, Montana, Oklahoma, and Wisconsin) have entered into collaborative enforcement agreements with CMS that include MHPAEA enforcement. These latter states perform state regulatory and oversight functions with respect to MHPAEA; however, if the state finds a potential violation and is unable to obtain compliance by an issuer, the state will refer the matter to CMS for possible enforcement action.

⁹⁹ For this Reporting Period, sponsors of self-funded non-federal governmental group health plans could elect to exempt those plans from (opt out of) certain requirements of Title XXVII of the PHS Act, including MHPAEA and the NQTL comparative analysis requirements. *See* former PHS Act Section 2722(a)(2). Also see 45 CFR 146.180. The Consolidated Appropriations Act, 2023 amended PHS Act Section 2722(a)(2) such that sponsors of self-funded non-federal governmental plans generally can no longer opt out of MHPAEA.

¹⁰⁰ Multiple NQTL comparative analyses were requested from some plan sponsors and issuers, resulting in 21 total comparative analysis reviews.

¹⁰¹ *See* PHS Act Section 2726(a)(8)(B)(iii)(I)(aa).

- provide sufficient information for CMS to assess compliance with the NQTL requirements under MHPAEA (for example, a sufficiently reasoned discussion and supporting evidence to substantiate findings and conclusions related to MHPAEA compliance);
- correct the identified instances of non-compliance (for example, remove separate treatment limitations applied only to MH/SUD benefits and not to medical/surgical benefits from coverage policies); and
- perform a self-audit to identify consumers who were affected by the instances of non-compliance in order to re-adjudicate claims and denials where necessary.

If the initial corrective action plans submitted by the plan sponsors and issuers do not sufficiently address or correct the identified instances of non-compliance, the final determination letter from CMS will provide an updated corrective action plan directing the plan sponsor or issuer on the necessary next steps to come into compliance.

The Reporting Period included requests for comparative analyses for plan years starting in 2021 and 2022, covering the time period between December 1, 2021, and September 1, 2022. Plan Year 2021 reviews that were in progress at the time of the publication of the January 2022 Report resulted in final determination letters for 11 reviews. As detailed in Section II.C, four reviews resulted in a final determination of no findings of non-compliance, and seven reviews resulted in final determinations of non-compliance.¹⁰² Because investigations into NQTLs are

¹⁰² At the time of the drafting of this Report to Congress, a final compliance determination has not yet been made in five of the reviews initiated by CMS for Plan Year 2021 or the 21 reviews initiated by CMS for Plan Year 2022. Plans and issuers are working with CMS to provide more information about identified NQTLs, complete corrective action plans, and submit revised comparative analyses. Results of these reviews will be included in future Reports to Congress.

resource-intensive and time-consuming, five Plan Year 2021 reviews are still ongoing. CMS continues to assess the remaining responses from plan sponsors and issuers for these five Plan Year 2021 reviews and will include these reviews in future Reports to Congress.

In its second year of implementation of MHPAEA’s NQTL provisions that were added or amended by the CAA, CMS has not seen a marked improvement in the sufficiency of the initial NQTL comparative analyses provided by plan sponsors and issuers. The deficiency reasons and trends noted in the January 2022 Report were still commonly reflected in comparative analyses reviewed during the Reporting Period. For Plan Year 2022, of the 21 comparative analyses submitted in response to CMS’ initial requests,¹⁰³ all were found to be insufficient after the initial review. Reviews that began for Plan Year 2022 are ongoing and will be included in future Reports to Congress.

A. CMS’ NQTL Enforcement Priorities

During the Reporting Period, CMS requested a total of 21 comparative analyses for 7 NQTLs for Plan Year 2022. CMS prioritized reviews of NQTLs as follows:

- Prior authorization treatment limitations were the focus of 13 of the 21 comparative analyses requested. These reviews included inpatient/in-network, inpatient/out-of-network, outpatient/in-network, and outpatient/out-of-network benefit classifications.

¹⁰³ Since the release of the January 2022 Report to Congress, an initial determination of sufficiency has been made in two of the reviews initiated by CMS in Plan Year 2021, and they are included in the metrics within this report. This brings the total number of sufficiency reviews from 21 to 23 for this annual Report to Congress.

- Concurrent review treatment limitations were the focus of 7 of the 21 comparative analyses requested. These reviews included outpatient/in-network, and outpatient/out-of-network benefit classifications.

CMS also requested an NQTL comparative analysis for exclusions of specific treatments for certain conditions in the prescription drug classification. This was a newly emphasized NQTL review that focused on a benefit classification for which an NQTL analysis had not yet been requested in prior reviews.

B. CMS' Approach to Implementing Its NQTL Enforcement Priorities

To maximize CMS' resources for MHPAEA enforcement, the agency based its NQTL comparative analyses requests on previous MHPAEA non-compliance indications in market conduct examinations, form reviews, non-federal governmental group health plan investigations, and complaints received from interested parties related to coverage for ASD services. CMS then supplemented its risk-based requests with a random selection of issuers in direct enforcement states.

After sending the initial comparative analysis request, CMS held entrance conferences with each plan sponsor and/or issuer to discuss the review process and the elements of a sufficient comparative analysis submission. This was a new step established for Plan Year 2022 to offer plan sponsors and issuers additional assistance, discuss expectations, and address any questions about the review early in the process. In addition to entrance conferences, CMS met with plan sponsors and issuers to discuss initial determinations of insufficiency, initial determinations of non-compliance, and final determinations of non-compliance, where applicable. CMS was also available to provide technical assistance throughout the entire review

process. This included clarifying the review process or determinations with plan sponsors or issuers.

C. CMS' Enforcement Results Under the CAA and Their Impact

Plan sponsors and issuers completed various corrective actions based on CMS' initial and final determinations of non-compliance.

Plan sponsors and issuers that received a final determination of non-compliance were also required to notify all individuals enrolled in the plan that the coverage was determined to be not in compliance with MHPAEA within seven days of the date of the final determination letter.¹⁰⁴ This requirement ensures impacted consumers are informed of their plan's non-compliance.

1. Examples of Corrective Actions Taken for Insufficient Comparative Analyses

In many of the instances of non-compliance, the plan sponsor or issuer provided an insufficient comparative analysis, insufficient supporting documentation, or insufficient supplemental information in response to CMS' comparative analysis request. As a result of CMS' determinations, plan sponsors and issuers provided additional information and documentation to support their comparative analyses. This resulted in a more thorough, in-depth comparative analyses of the processes, strategies, evidentiary standards, and other factors used in the design and application of NQTLs to MH/SUD benefits and medical/surgical benefits in the same benefits classification, as written and in operation. Examples of corrective actions taken as

¹⁰⁴ See PHS Act Section 2726(a)(8)(B)(iii)(I)(bb).

a result of CMS' initial and final determinations of non-compliance related to insufficient comparative analyses include –

- An issuer provided the sources and evidentiary standards used to measure and determine applicability of the factors identified in the NQTL cost-benefit analysis.
- An issuer provided copies of its medical coverage policies and access to external guidelines used in the application of the relevant NQTL.
- An issuer provided supporting documentation demonstrating the timeframes for decisions involved in the design and application of the relevant NQTL.
- An issuer provided additional documentation demonstrating which factors applied to each MH/SUD benefit and medical/surgical benefit subject to the relevant NQTL. As a result, the issuer more thoroughly analyzed whether these factors were applied comparably and no more stringently to the MH/SUD benefits than to medical/surgical benefits and also demonstrated how the factors were used in the design and application of the relevant NQTL.
- Multiple plan sponsors and issuers compiled and analyzed additional supporting documentation, including operational data metrics, to demonstrate the relative stringency in the application of the relevant NQTL to MH/SUD benefits and medical/surgical benefits. Operational data metrics provided for reviewing a prior authorization NQTL included denial rates comparing medical/surgical and MH/SUD prior authorization or concurrent review approval and denial rates, including denial reasons, appeal and decision overturn rates, decision timeliness rates, and average length of stay or units

approved. The plan sponsors and issuers also performed and provided a corresponding narrative analysis regarding the comparability and relative stringency of the NQTL as demonstrated by the operational data metrics.. Analyzing these metrics allows plan sponsors and issuers to assess the comparability and stringency of the application of NQTLs between MH/SUD benefits and medical/surgical benefits in operation and help to demonstrate compliance in their comparative analyses.

- A plan sponsor informed CMS that it had limited historical information on the design and application of the relevant NQTL and, therefore, its comparative analysis was determined to be insufficient. Although the plan is no longer in effect, the plan sponsor stated it will use the results of CMS’ review to “promote continued learning internally and NQTL design considerations in the future application” of the relevant NQTL in future plans.

2. Examples of Corrective Actions Taken for Impermissible Treatment Limitations

In instances where a plan or issuer was found to have an impermissible separate treatment limitation applied to MH/SUD benefits that was not applied to medical/surgical benefits, plan sponsors and issuers took corrective action to not only remove this limitation, but also to ensure steps were taken to identify and remediate any member impact. Examples are described below.

Example #1 – Self-Auditing MH/SUD Treatment Facility Coverage Claims

Issue: One plan sponsor was found to have applied an impermissible separate treatment limitation for MH/SUD benefits, 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 MH/SUD benefit. There was no similar requirement applied to medical/surgical benefits.

Result: The plan sponsor completed a self-audit to identify claims impacted by the impermissible separate treatment limitation. No claims identified during the self-audit were denied, and therefore, no re-adjudication of claims was needed. There also was no need to eliminate the NQTL in future plan years as the plan was terminated.

Example #2 – Removing MH/SUD Progress and Improvement Requirements

Issue: As noted in the January 2022 Report, one of the comparative analyses revealed an issuer applied impermissible separate treatment limitations in the form of MH/SUD continued stay criteria requiring evident progress for continued care coverage. It also revealed the issuer applied MH/SUD discharge criteria resulting in loss of coverage if no significant improvement in condition occurred or if the member left treatment against medical advice. There were no similar criteria applied to medical/surgical benefits.

Result: The initial corrective action plan for this review required the issuer to revise its continued stay and discharge criteria, as well as provide supporting documentation demonstrating that the more stringent limitations on MH/SUD benefits were removed and no longer in effect in the continued stay and discharge criteria in use for the plan. In addition, because the impermissible separate treatment limitations may have resulted in member impact, the issuer was also required to conduct a self-audit to identify and re-adjudicate claims impacted by the criteria. It was found that no claims were denied due to the impermissible treatment limitations, and therefore no re-adjudication of claims was needed. The issuer provided documentation of the new guidelines used for its continued stay and discharge criteria. The

updated criteria did not contain the previously identified impermissible separate treatment limitation (e.g., there was no requirement for evident progress or improvement in the condition).

However, after submission of the January 2022 Report, it came to CMS' attention that the issuer's website still included references to the continued-stay and discharge criteria that it had stated were no longer in use. Therefore, in addition to the initial corrective actions included in the January 2022 Report, CMS directed the issuer to revise external facing websites to remove references to the criteria to avoid misrepresentation to members and providers of evidentiary standards used in the application of the NQTL. CMS performed an informal review of the issuer's website and confirmed the references to the continued stay and discharge criteria have been removed.

D. Statutory Reporting Requirements

1. CMS' Summary of Requests and Identification of Non-Compliant Plans and Issuers¹⁰⁵

During the Reporting Period, CMS requested a total of 21 comparative analyses across 7 NQTLs for Plan Year 2022. The following is a comprehensive list of the NQTLs for which CMS requested a comparative analysis organized by benefit category.

NQTL	Number of Comparative Analyses Requested
Concurrent review	7
Concurrent review treatment limitations for outpatient, in-network services	6

¹⁰⁵ This summary fulfills the Secretary's reporting obligations under PHS Act section 2726(a)(8)(B)(iv)(I) – "A summary of the comparative analyses requested under clause (i), including the identity of each group health plan or health insurance issuer, with respect to particular health insurance coverage that is determined to be not in compliance after the final determination by the Secretary described in clause (iii)(I)(bb)."

NQTL	Number of Comparative Analyses Requested
Concurrent review treatment limitations for outpatient, out-of-network services	1
Prior authorization	13
Prior authorization treatment limitations for inpatient, in-network services	3
Prior authorization treatment limitations for inpatient, out-of-network services	1
Prior authorization treatment limitations for outpatient, in-network services	7
Prior authorization treatment limitations for outpatient, out-of-network services	2
Prescription drug exclusions of specific treatments for certain conditions	1
Prescription drug exclusions of specific treatments for certain conditions	1
Total:	21

A number of reviews were in progress for Plan Year 2021 at the time of publication of the January 2022 Report. Four reviews resulted in final determinations of no findings of non-compliance, and seven reviews resulted in final determinations of non-compliance for Plan Year 2021.¹⁰⁶ CMS is reviewing the comparative analyses, corrective action plans, and other information received, as well as engaging with plan sponsors and issuers to obtain additional information to assess compliance of the remaining five Plan Year 2021 reviews. The results of these reviews will be included in future Reports to Congress.

¹⁰⁶ At the time of this report, a final compliance determination has not yet been made in 5 of the reviews initiated by CMS for Plan Year 2021 or the 21 reviews initiated by CMS for Plan Year 2022. Results of these reviews will be included in future Reports to Congress.

2. CMS' Findings Regarding Compliance with Requirements of PHS Act Section 2726(a)

After reviewing initial comparative analysis submissions, CMS sent plan sponsors and issuers requests for additional information needed to complete the reviews. CMS was available to plan sponsors and issuers to respond to questions and provide additional assistance, including communicating via email and holding meetings with plan sponsors and issuers. CMS provided one opportunity for the submission of additional information before making an initial compliance determination. Since the publication of the January 2022 Report, CMS sent letters requesting additional information and received supplemental responses for 21 reviews for Plan Year 2022 and two reviews for Plan Year 2021.¹⁰⁷ CMS is currently reviewing plan sponsors' and issuers' initial and supplemental submissions in order to make initial determinations about compliance.

a. Examples of Corrective Actions

At the time of this Report, an initial compliance determination has not yet been made in two of the reviews initiated by CMS for Plan Year 2021 and 21 reviews for Plan Year 2022. Results of these reviews will be included in future Reports to Congress.

For any instances of non-compliance found in Plan Year 2021, CMS sent an initial determination letter to the plan sponsor or issuer describing each instance of non-compliance. The initial determination letters also requested that the plan sponsor or issuer submit a corrective action plan within 45 calendar days of the date of the letter. CMS requested that the corrective action plan include actions taken or in progress to correct the instances of non-compliance

¹⁰⁷ Since the release of the January 2022 Report to Congress, an initial determination of sufficiency has been made in two of the reviews initiated by CMS in Plan Year 2021 and they are included in the metrics within this report. This brings the total number of sufficiency reviews by CMS from 21 to 23 for this annual Report to Congress.

described in the letter, a timeline for completion, supporting documentation confirming that corrective actions are in progress or completed, and a revised NQTL comparative analysis demonstrating compliance based on the corrective actions identified in the corrective action plan.

As a result of CMS' initial determination letters, plan sponsors and issuers implemented changes to correct instances of non-compliance and more proactively and thoroughly assess compliance with MHPAEA. Examples of these changes are described below.

Example #1 – Increased Analysis of Operational Comparability and Stringency

As discussed in Section II.D.2 above, many of the initial submissions lacked a sufficient analysis and supporting documentation to demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply an NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, those applied to medical/surgical benefits, as written or in operation.

After receiving CMS' initial determination letter, plan sponsors and issuers routinely took action to compile and analyze additional supporting documentation demonstrating the relative stringency of the application of the relevant NQTL. In order to demonstrate that written processes were comparable and no more stringently applied to MH/SUD benefits as compared to medical/surgical benefits, plan sponsors and issuers analyzed and provided CMS with operational data metrics as part of corrective actions in response to identified instances of non-compliance. For example, for the review of a prior authorization NQTL, operational data metrics analyzed to assess compliance with parity requirements included denial rates comparing medical/surgical and MH/SUD prior authorization decisions, appeal rates, and decision timeliness rates. This analysis allowed for plan sponsors, issuers, and CMS to assess the

comparability and stringency of the application of NQTLs in operation and to demonstrate compliance with supporting evidence.

Example #2 – Additional Supporting Documentation Provided to Demonstrate Comparability and Stringency of Factors, as Applied and in Operation

Plan sponsors and issuers often provided a list of identifying factors used in the design and application of an NQTL, but they do not include an in-depth analysis or supporting documentation demonstrating the factors were comparable and no more stringently applied to MH/SUD benefits than to medical/surgical benefits in operation.

In one example, after receiving CMS' initial determination letter, an issuer provided additional supporting documentation to demonstrate which factors were applicable to each MH/SUD benefit and medical/surgical benefit subject to a prior authorization requirement. With this information, the issuer and CMS could more thoroughly analyze whether factors were being applied comparably and no more stringently to MH/SUD benefits as compared to medical/surgical benefits, as well as analyze how the factors are used in the design and application of the prior authorization NQTL.

b. Identification of Plans and Issuers that were Issued a Final Determination of Non-Compliance and Description of Findings¹⁰⁸

CMS is required to identify the non-federal governmental plans and health insurance issuers that were issued a final determination of non-compliance.¹⁰⁹ CMS determined that the below listed plans and issuers reviewed during Plan Year 2021 were not in compliance with MHPAEA. A description of findings resulting in a final determination of non-compliance is also included.

CMS requires that plan sponsors and issuers that receive a final determination of non-compliance provide proof that the required corrective actions have been completed and follows up to ensure that such corrective actions are taken.

Plan/Issuer	NQTL(s)
Blue Cross Blue Shield of Texas – Texas	Prior authorization treatment limitations for outpatient, out-of-network services
Colorado University Graduate Medical Education – Colorado	Treatment certification requirements for inpatient, in-network services
Humana Health Plan of Texas – Texas	Provider network participation requirements for inpatient, in-network providers; Provider network participation requirements for outpatient, in-network providers

¹⁰⁸ This summary is intended to comply with the Secretary’s reporting obligations under PHS Act section 2726(a)(8)(B)(iv)(V) – the Secretary’s specifications described in clause (iii) of the actions each group health plan or health insurance issuer that the Secretary determined is not in compliance with this section must take to be in compliance with this section, including the reason why the Secretary determined the plan or issuer is not in compliance.

¹⁰⁹ PHS Act section 2726(a)(8)(B)(iv)(I).

Plan/Issuer	NQTL(s)
Humana Insurance Company of Texas – Texas	Provider network participation requirements for inpatient, in-network providers; Provider network participation requirements for outpatient, in-network providers
SHA, LLC DBA FirstCare Health Plans – Texas	Concurrent review for outpatient, in-network benefits

All plan sponsors and issuers that received a final determination of non-compliance were required, within 7 days of the date of the final determination letter, to notify all individuals who were enrolled under the impacted plans that such coverage was determined to be out of compliance with MHPAEA.¹¹⁰ All plan sponsors and issuers subject to this requirement fulfilled this obligation in a timely manner.

In all cases in which a plan sponsor or issuer received a final determination of non-compliance, the plan sponsor or issuer did not provide sufficient information and supporting documentation in its comparative analyses. Without sufficient information and supporting documentation, CMS was unable to validate whether 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 medical/surgical benefits, as written and in operation. The following provides specific examples:

¹¹⁰ See PHS Act section 2726(a)(8)(B)(iii)(I)(bb).

Blue Cross Blue Shield of Texas – Texas (prior authorization treatment limitations for outpatient, out-of-network services)

The issuer did not provide a sufficient comparative analysis and supporting documentation regarding how each factor is identified and used in the design and application of the prior authorization NQTL with respect to outpatient, out-of-network services. Without this information, the issuer failed to demonstrate that the factors used in the design and application of the prior authorization NQTL to MH/SUD benefits were comparable to and applied no more stringently than the factors used in the design and application of the prior authorization NQTL to medical/surgical benefits.

The issuer provided a list of seven factors used in the design and application of the prior authorization NQTL. The seven factors included:

1. Level of care (LOC) or treatment requested is high intensity and/or high complexity and for which LOC guidelines are broadly recognized and accepted;
2. Treatment is at increased risk of misuse, overutilization, and/or fraud and abuse;
3. Treatment requested is provided at the least restrictive and most appropriate level of care;
4. Treatment requested is only appropriate for specific clinical diagnosis, conditions, and stages of care;
5. Diagnostic testing requested applies only to specific diagnoses and conditions;
6. Treatment requested is provided for or administered to vulnerable populations; and

7. Treatment is indicated for treatment-resistant conditions and is therefore not considered a first-line treatment for a condition.

The issuer's response to the initial determination letter provided a mapping document combining the seven factors into three broader categories: Appropriateness of Care, High Complexity, and Risk of Overutilization. "Risk of Overutilization" was both a factor (factor 2 from above) and a category, and the remaining six factors were split between "Appropriateness of Care," (which includes factors 3, 5, and 7 from the above list), and "High Complexity" (which includes factors 1, 4, and 6 from the above list).

The mapping document did not specify which of the original seven factors would prompt either "Appropriateness of Care" or "High Complexity" to be considered for prior authorization. The mapping document was also unclear about which factors were weighed more than others within the "Appropriateness of Care" and "High Complexity" categories. The issuer did not provide additional documentation to demonstrate how each of the seven factors were applied to the MH/SUD benefits and medical/surgical benefits, resulting in a prior authorization requirement. Therefore, the issuer still failed to provide sufficient information and supporting documentation on the sources, guidelines, or evidentiary standards for how the seven factors identified are used to trigger a prior authorization requirement.

The issuer also did not provide sufficient information on one of its factors and the accompanying evidentiary standards used in the development and application of the prior authorization NQTL. In its initial submission, the issuer stated that no quantitative measures were used in making a prior authorization recommendation. However, in its response to the initial determination letter, the issuer indicated that utilization data is analyzed for potential

statistical outliers as a source or evidentiary standard for the factor “Treatment is at increased risk of misuse, overutilization and/or fraud and abuse.” The issuer failed to provide sufficient information and supporting documents that described the extent to which the “Risk of Overutilization” factor is defined in a quantitative manner. The issuer also failed to provide information on the supporting evidentiary standards used to assess this factor.

Finally, the issuer did not provide sufficient information regarding additional factors used in the design and application of the prior authorization NQTL. The issuer stated in the comparative analysis that there are additional factors considered, such as “market conditions or populations,” that may result in state or market variation in prior authorization requirements. CMS requested information regarding how the “market conditions or populations” factors are identified and measured, including the data sources used. However, the information requested about the sources, evidentiary standards, or guidelines considered with respect to these additional factors were not provided.

As a result of CMS’ final determination of non-compliance, CMS specified the following corrective actions for the issuer to address the remaining instances of non-compliance:

- Provide a revised mapping document to demonstrate which of the seven identified factors are attributed to each service resulting in a prior authorization requirement, including information for how these factors are weighed in the design and application of the prior authorization NQTL for MH/SUD benefits and medical/surgical benefits;
- Provide precise definitions and supporting sources describing the extent to which the “Risk of Overutilization” factor is defined in a quantitative manner, as well as the supporting evidentiary standards used to assess this factor. This includes any quantitative

standards used to measure “statistical outliers” (including “potential” statistical outliers) when analyzing utilization data as a source or evidentiary standard for the factor “Treatment is at increased risk of misuse, overutilization and/or fraud and abuse;”

- Provide the definition of the “market conditions or populations” factors used in the development of the prior authorization list, including any associated hierarchical weight compared to any other factors used in the design of the prior authorization NQTL; and
- Provide the sources, evidentiary standards, and/or guidelines considered with respect to the “market conditions or populations” factors, used in the development of the prior authorization list.

These corrective actions have been completed. The issuer provided sufficient information in a revised comparative analysis to satisfactorily address the specified non-compliance issues, and no further concerns with regard to compliance with MHPAEA for the coverage under review were identified.

Colorado University Graduate Medical Education – Colorado (treatment certification requirements for inpatient, in-network services)

The plan sponsor did not provide a sufficient comparative analysis and supporting documentation to demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply a treatment certification requirement to MH/SUD benefits in the inpatient, in-network classification are comparable to and no more stringently applied than those applied to medical/surgical benefits in the same classification, as written or in operation. Examples of instances in which sufficient information was not provided include the following:

- Much of the historical information and supporting documentation required as part of a comparative analysis was no longer accessible or had not been documented. The statements within the comparative analysis were not definitive assertions of the processes, strategies, evidentiary standards, and other factors that were used in the design and application of the NQTL;
- The plan sponsor did not provide an exhaustive list of all factors used in the design and application of the NQTL;
- The plan sponsor did not provide a sufficient explanation or supporting documentation describing the process of determining which MH/SUD services and medical/surgical services are subject to the NQTL;
- The plan sponsor provided the name of one committee responsible for decisions pertaining to the design and application of the NQTL but did not provide the qualifications, including clinical specialties, of decision-makers; and
- The plan sponsor provided a general assertion of MHPAEA compliance between MH/SUD benefits and medical/surgical benefits without providing a sufficient comparative analysis or supporting documentation to support the assertion.

The plan sponsor terminated the plan on June 30, 2021. The plan sponsor completed a self-audit to identify claims impacted by the impermissible treatment limitation and identify whether re-adjudication was needed. No claims identified during the self-audit were denied. Therefore, no negative consumer impact occurred, and no re-adjudication of claims was needed. As such, the only action as a result of CMS' final determination of non-compliance was the

requirement to notify all individuals who were enrolled under the plan that such coverage was determined to be not in compliance with MHPAEA within 7 days of the date of the final determination letter. The plan sponsor completed and provided supporting documentation of this action in a timely manner. The plan sponsor stated it will use the results of CMS' review to "promote continued learning internally and NQTL design considerations in the future application" of MHPAEA requirements to future plans offered by the sponsor.

Humana Health Plan of Texas and Humana Health Insurance Company of Texas – Texas (provider network participation requirements for inpatient and outpatient, in-network providers)

The issuer did not provide a sufficient comparative analysis and supporting documentation regarding the processes, factors, and evidentiary standards used when applying the network participation requirements NQTL to MH/SUD in-network providers (inpatient and outpatient) and medical/surgical in-network providers (inpatient and outpatient). In addition, CMS found certain quantitative thresholds for the access and adequacy factors used in the design and application of the network participation requirements NQTL were not comparable and were more stringently applied to MH/SUD in-network providers compared to medical/surgical in-network providers.

In its initial submission, the issuer identified both access and adequacy as factors considered in the design and application of a network participation requirement NQTL. In a supplemental response, the issuer provided quantitative thresholds for the following access and adequacy factors used in the design and application of its network participation requirements NQTL: Geographic Access Standards, Access to Service/Waiting Time Standards, and

Availability Standards. However, the issuer did not demonstrate comparability as written and in operation regarding its access and adequacy factors used in the design and application of the network participation requirements NQTL for either inpatient, in-network providers or outpatient, in-network providers. As detailed further below, CMS identified several instances where a different standard was used for MH/SUD providers than for medical/surgical providers. CMS therefore found that the quantitative thresholds used in the application of the access and adequacy factors as part of the design and application of the network participation requirements NQTL were not comparable and were more stringently applied to MH/SUD benefits compared to medical/surgical benefits in the same benefit classification.

The issuer also failed to provide sufficient information and supporting documentation regarding the sources and evidentiary standards used to establish the quantitative thresholds for the issuer's identified standards. While the issuer provided information on the results of its network adequacy review as part of its supplemental response, it failed to provide a sufficient explanation of the process and factors used to develop the quantitative thresholds used in the application of the access and adequacy factors as part of the design and application of the provider participation requirements NQTL. Details regarding these standards and CMS' analysis of MHPAEA compliance are discussed below.

1. Geographic Access Standards

The issuer provided Geographic Access Standards (one factor considered in the design and application of the network participation requirement NQTL) in the form of time and distance requirements for different "specialty/provider type" categories. For MH/SUD provider types, the distance and time standards were 50 or 60 miles/60 minutes for urban areas and 90 miles/90

minutes for rural areas. This includes outpatient MH/SUD and inpatient MH/SUD providers. However, for medical/surgical provider types, the distance and time requirements were 30 miles/30 minutes for urban areas and 60 miles/60 minutes for rural areas. This includes primary care (i.e., outpatient) and general/acute hospital (i.e., inpatient) providers.

The issuer's comparative analysis did not provide a sufficient reasoned discussion demonstrating that the processes and evidentiary standards used in setting each geographic access standard and the accompanying quantitative thresholds for MH/SUD providers are comparable to, and applied no more stringently than, the processes and factors used to set the standards for medical/surgical providers. These standards and the application of these different quantitative thresholds could deny MH/SUD providers admission to the network based on analyses that there are sufficient numbers or "saturation" of MH/SUD providers using time and distance standards that are more restrictive than what is applied to medical/surgical providers in the same benefit classification. The use of these disparate thresholds can result in granting a medical/surgical provider's application to participate in the same network while at the same time denying a MD/SUD provider's application to participate in the same network. By using a non-comparable and more stringent threshold without demonstrating that the processes used in setting this threshold were comparable, as written and in operation, this NQTL is not comparable and is applied more stringently to MH/SUD benefits compared to medical/surgical benefits in the same benefit classification.

2. Availability Standards

The issuer provided Availability Standards in the form of provider-to-member ratios for different "provider specialty" categories. The provider-to-member ratio for a behavioral health

inpatient psychiatric facility is 1 provider to 45,000 members. Yet the highest provider to member ratio for medical/surgical provider types was “all other” specialists, with a ratio of 1 provider to 26,000 members. Some standards applied to medical/surgical provider types, went as low as 1 provider to 1,000 members. This standard and the application of these different quantitative thresholds could deny MH/SUD providers admission to the network based on analyses that there are sufficient numbers of MH/SUD providers using provider-to-member ratio standards that are more restrictive than what is applied to medical/surgical providers in the same benefit classification. The use of these disparate thresholds can result in granting medical/surgical providers’ applications to participate in the same network while at the same time denying MH/SUD providers’ applications to participate in the same network. The issuer’s comparative analysis did not provide a sufficient reasoned discussion showing that the processes and factors used in setting quantitative thresholds for MH/SUD provider types were comparable to, and applied no more stringently than, the processes and factors used to set the standards for medical/surgical provider types. By using a non-comparable and more stringent threshold, as written and in operation, this NQTL is not comparable and is applied more stringently to MH/SUD benefits as compared to medical/surgical benefits in the same benefit classification.

As a result of CMS’ final determination of non-compliance, CMS specified the following corrective actions for the issuer:

- Modify the geographic access standards for MH/SUD and inpatient MH/SUD providers to be comparable to and no more stringent than the standards for medical/surgical providers; and

- Modify the provider-to-member ratio availability standards for behavioral health inpatient psychiatric facility to be comparable to and no more stringent than the standards for medical/surgical providers.

These corrective actions have been completed.

SHA, LLC DBA FirstCare Health Plans – Texas (concurrent review for outpatient, in-network benefits)

The issuer did not provide a sufficient comparative analysis and supporting documentation regarding the sources and evidentiary standards used, as well as the decision timeframes involved, in the design and application of the concurrent review NQTL to MH/SUD in-network, outpatient providers and medical/surgical in-network, outpatient providers.

In its initial submission, the issuer indicated it used a cost-benefit analysis in determining whether to apply concurrent review to outpatient, in-network MH/SUD services and medical/surgical benefits. However, in its initial submission, the issuer did not provide sufficient information regarding how it measured each of the six factors considered in its cost-benefit analysis. For example, the issuer did not provide the parameters of any datasets, the sources used for decisions, or copies of clinical guidelines used in the design and application of the concurrent review NQTL to outpatient, in-network benefits.

The issuer provided an additional comparative analysis, as part of its supplemental response, which identified five different factors from those identified in the initial submission as the ones considered in determining whether to apply the concurrent review NQTL to MH/SUD and medical/surgical outpatient, in-network services. The issuer's supplemental response,

however, did not provide any sources used to measure the factors or share copies of clinical guidelines used in the design and application of the concurrent review NQTL for the factors the issuer identified in the initial submission or the factors identified in the additional comparative analysis provided as part of its supplemental response.

Furthermore, the issuer did not provide sufficient information regarding decision timeframes for concurrent review authorizations in its initial submission. CMS therefore requested further supporting documentation for the issuer's decision timeframes. In response, the issuer shared a policy that did not include supporting documentation for the decision timeframes used for concurrent review authorizations.

As a result of CMS' final determination of non-compliance, CMS specified the following corrective actions for the issuer:

- Provide the sources and/or evidentiary standards used to measure and determine applicability of the factors identified in the cost-benefit analysis as part of the design and application of the concurrent review NQTL;
- Provide copies of clinical guidelines, sources, and/or evidentiary standards used in the application of the NQTL to approve or deny a request for concurrent review; and
- Provide supporting documentation demonstrating the timeframes for decisions involved in the design and application of the NQTL under review.

These corrective actions have been completed.

CONCLUSION

The Departments are committed to the implementation and enforcement of MHPAEA and recognize their important role in ensuring parity between MH/SUD benefits and medical/surgical benefits so that individuals with mental health conditions and substance use disorders receive the full protections required by law. The Departments will continue to emphasize NQTL enforcement and will remain engaged with interested parties to identify potential violations and challenges in compliance. Over the next Reporting Period, the Departments will continue to:

- Provide compliance assistance to plans and issuers;
- Publish enforcement statistics that report closed investigations for each fiscal year; and
- Report on the full scope of their efforts to ensure understanding and compliance with MHPAEA in the biennial Report to Congress.

Additionally, DOL, in coordination with HHS and Treasury, will work to update the Self-Compliance Tool for the Mental Health Parity and Addition Equity Act to reflect the CAA and related guidance.

The Departments have also issued proposed rules to amend the MHPAEA regulatory requirements. The rules propose to revise existing definitions and add new definitions of key terms relevant to analyzing compliance with the rules for NQTLs and amend the existing NQTL standard to prevent plans and issuers from using them to place greater limits on access to MH/SUD benefits. Additionally, these proposed rules would set forth the required content elements of the NQTL comparative analyses and specify how plans and issuers must make these

comparative analyses available to the Departments, as well as to an applicable State authority, and participants and beneficiaries. Finally, HHS proposes regulatory amendments to implement the sunset provision for self-funded, non-Federal governmental plan elections to opt out of compliance with MHPAEA, adopted in the Consolidated Appropriations Act, 2023 (CAA, 2023).

In the interim, the Departments will continue to work with plans, plan sponsors, issuers, consumers, providers, states, and other interested parties to help the regulated community come into compliance with the NQTL comparative analysis requirements. For example, EBSA will continue to conduct robust outreach initiatives, including webcasts, in-person seminars, and nationwide compliance outreach events for the regulated community, as well as participant assistance and public awareness events that educate workers and other interested parties about rights and benefits safeguarded under MHPAEA. The Departments will also work to help families, caregivers, and individuals understand the law and benefit from it, as Congress intended.

This report demonstrates the Departments' firm commitment to ensuring parity between MH/SUD benefits and medical/surgical benefits. The Departments' findings regarding the design and application of NQTLs—as well as their findings from working with plans, plan sponsors, and issuers to correct non-compliance and minimize the risk of future violations—demonstrate the continued need for investigative and enforcement efforts. Despite the fact that none of the comparative analyses submitted by plans or issuers during the Reporting Period were initially sufficient to satisfy provisions of MHPAEA added by the CAA, 2021,¹¹¹ follow-up requests,

¹¹¹ Code Section 9812(a)(8), ERISA Section 712(a)(8), and PHS Section 2726(a)(8).

continued conversations, insufficiency letters, and the possibility of being named as non-compliant in this report eventually incentivized a significant proportion of plans, plan sponsors, and issuers to correct MHPAEA violations, including removing or revising non-compliant NQTLs.

The Departments' experience indicates that increased investigations and other activity by the Departments, including outreach to interested parties and compliance assistance, are essential to the goal of ensuring parity between MH/SUD benefits and medical/surgical benefits. The Departments also believe that the protections of MHPAEA would be greatly strengthened with the enactment of many of the legislative recommendations noted in the January 2022 Report.

APPENDIX A: COMMON DEFICIENCIES

A comparative analysis must demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply an NQTL to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to medical or surgical benefits in the benefits classification.

This Appendix contains additional detail on common deficiencies the Departments found in comparative analyses reviewed during the Reporting Period. The Departments expect the discussion in this section will clarify the level of detail required from plans and issuers in their comparative analyses.

A. EBSA's Conclusions Regarding Sufficiency

1. Plans and Issuers Still Unprepared, No Comparative Analysis

During the Reporting Period, EBSA found that many plans and issuers were unprepared to provide their comparative analyses. Some plans did not have a comparative analysis prepared and quickly created one after receiving EBSA's request. The CAA required plans and issuers to have completed their analyses by February 10, 2021.

EBSA reminds plans and issuers that the requirement to perform and document a comparative analysis is not dependent upon a request by EBSA. Under MHPAEA, as amended by the CAA, a comparative analysis is generally required for plans and issuers that cover both MH/SUD benefits and medical/surgical benefits and that impose NQTLs on MH/SUD benefits. EBSA also notes that an NQTL includes any provision or plan practice that is generally not

numerically expressed and limits the scope or duration of treatment; plans and issuers should evaluate any plan practice or term that operates in that manner. Even before enactment of the CAA, plans and issuers were obligated to ensure that they met the NQTL requirements, both in writing and in operation and should have previously adopted the practice of analyzing the comparability and stringency of their practices as a means of ensuring compliance with the regulations that existed prior to the CAA's amendments. Following the second anniversary of Congress' enactment of the CAA, EBSA expects that plans and issuers will increasingly begin to submit compliant analyses from the outset when the plan or issuer receives a request for a comparative analysis.

2. Deficiencies Noted in January 2022 Report Persist

The common deficiencies that were listed in the January 2022 Report continue to persist. That report listed several deficiencies:

- 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;
- failure to identify or define in sufficient detail the factors, sources, and evidentiary standards used in designing and applying the NQTL;
- 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.

The January 2022 Report also listed common themes in deficiencies:

- 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;
- nonresponsive comparative analysis;
- documents provided without adequate explanation;
- failure to identify the specific MH/SUD and medical/surgical benefits or MHPAEA benefit classification(s) to which an NQTL applies;
- 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; and
- failure to demonstrate compliance of an NQTL as applied.

To date, nearly all the initial comparative analyses EBSA has reviewed have not contained the specific information required under ERISA Section 712(a)(8)(A)(i)-(v) that is necessary to assess compliance.

3. Issues with Explanations of Factors

During the second year of implementation, EBSA found that relatively more plans and issuers identified specific factors used in the design or application of the NQTL, as compared to

the number of plans and issuers whose comparative analyses identified such factors during the first year. However, even when the comparative analyses identified specific factors, EBSA still found that most lacked a meaningful analysis of the NQTL's design and application.

a. Failure to Adequately Explain How Factors Were Applied When Determining Which Benefits Are Subject to the NQTL

Even when comparative analyses listed factors considered in the design of the NQTL, many did not explain how the plan or issuer applied each factor when determining which benefits would be subject to the NQTL. For example, many comparative analyses repeated the same list of factors, verbatim, for both the design of the NQTL for MH/SUD benefits and medical/surgical benefits. These lists were followed by conclusory statements that the plan or issuer was in compliance because "the factors are the same." Further explanation or support was not provided. Conclusions about the comparability of factors did not include a meaningful explanation of how the plan or issuer applied each factor or how evidentiary standards were used in applying the factors.

EBSA also found that many comparative analyses that listed more than one factor did not explain how the factors worked together when they were applied. For instance, the comparative analyses did not describe:

- the order in which the plan or issuer applied each factor;
- whether some factors rendered others inapplicable or less significant; or
- whether and how each factor was given more weight than the other factors.

EBSA found these comparative analyses deficient because they lacked the information required by ERISA Section 712(a)(8)(A)(iv) and (v).

b. Inadequate Definition of Factors

In many cases, a failure to adequately define each factor compounded the deficient explanation of how the factors were applied. Several plans or issuers defined factors in generic terms that did not provide enough information. The definition often failed to use specific evidentiary standards, thresholds, or sources that played a role when applying the factor to evaluate which benefits would be subject to the NQTL. EBSA cannot verify the comparability of factors that lack definitional specificity.

For example, plans or issuers often cited “risk of fraud, waste, or abuse” as a factor considered when deciding which benefits in the in-network, outpatient benefit classification would be subject to prior authorization. Many plans and issuers defined “risk of fraud, waste, or abuse” as any benefit identified by their fraud division. They did not explain:

- how the fraud division identified those benefits;
- what evidentiary standards or processes were used; or
- whether such considerations were applied in a similar fashion to evaluate both MH/SUD benefits and medical/surgical benefits.

Also, “high-cost service,” which corresponds to quantitative evidentiary standards and numeric thresholds, was another commonly cited factor. Many plans and issuers gave generic

definitions of “high-cost” that lacked specific numbers or formulas used to identify benefits as “high-cost.”

EBSA found these types of comparative analyses deficient because they lacked the information required by ERISA Section 712(a)(8)(A)(iii).

c. Inadequate Explanation of Sources for Factors

In many comparative analyses, the lack of explanation for how factors were applied and defined was exacerbated by the lack of explanation of how sources were used in that process. If plans and issuers identified sources, they often did not explain how those sources were used in the process of selecting, defining, or applying factors.

For example, in comparative analyses that addressed network admission standards, including reimbursement rates, many plans and issuers identified rates from specific sources, such as Medicare or FairHealth, as the starting point or benchmark used to set network provider rates. However, when setting their standard network provider rate schedules (sometimes referred to as “base rates”), almost all plans and issuers applied varying and opaque markups from the stated benchmark rates. Comparative analyses for these NQTLs generally lacked adequate explanation of how plans or issuers develop base rates from the source’s benchmark rates. This deficiency is particularly significant when base rates for MH/SUD benefits are lower (relative to the benchmark) than base rates for medical/surgical benefits, as was quite often the case.

Many plans and issuers use the base rate as the starting point for negotiations with network providers to arrive at contracted rates that are different from base rates. The comparative analyses for this type of NQTL also generally did not adequately explain whether and how the

negotiation processes are comparable or explain any constraints on the negotiating process or its results that ensured parity. This is significant when, for example, negotiated increases to base rates for MH/SUD benefits are less than the negotiated increases to base rates for medical/surgical benefits within a classification.

In another common scenario, plans and issuers named generic sources of factors without further description or explanation. Examples include generic references to such sources as “industry publications,” “medical journals,” “claims data,” and “internal analysis.” These comparative analyses lacked a clear description of each source, including how the plan or issuer used the source to support or inform the definition or application of a particular factor. In some cases, the comparative analyses listed factors and sources separately without indicating which source corresponded to which factor.

EBSA found these comparative analyses deficient because they lacked the information required by ERISA Section 712(a)(8)(A)(iii), (iv), and (v).

d. Failure to Demonstrate Comparable Application of Factors

While EBSA found that some comparative analyses identified factors and defined each factor with some explanation about its application, many still failed to demonstrate that the factors were applied in a comparable manner. EBSA received many incomplete responses when it sought documentation from plans and issuers showing how they applied a factor or documentation supporting their conclusions that factors were comparably applied to MH/SUD benefits and medical/surgical benefits.

Examples of such responses included:

- reiterations of unsupported conclusions;
- production of a large volume of documents, without analysis;
- data without any explanation of how it related to the factor or its application;
- detailed information about previously unnamed factors; and
- explanations about unrelated NQTLs.

EBSA questioned whether comparative analyses were accurate reflections of plans' and issuers' processes when they were unable to show that they had applied factors or were unable to answer basic questions about how they had applied factors. EBSA's review was regularly prolonged by these incomplete comparative analyses that raised many additional questions.

For example, some plans and issuers provided a list of the specific medical/surgical benefits and MH/SUD benefits subject to prior authorization within the benefit classification to demonstrate that a particular factor was comparably applied when deciding which benefits would be subject to prior authorization. The plans and issuers noted that the application of a factor was comparable because both MH/SUD benefits and medical/surgical benefits were subject to prior authorization. This type of response did not demonstrate:

- how each benefit subject to prior authorization met the definitional criteria for the factor;
- whether and how the plan or issuer had applied the factor to other benefits that were ultimately not subject to prior authorization; or

- whether the stated evidentiary standard (such as services costing more than a specified dollar threshold per service) was applied equally to all benefits in the classification.

In some instances, the comparative analyses containing these definitions concerned the application of a factor that resulted in a clearly greater limitation on access to MH/SUD benefits (for example, when all or almost all MH/SUD benefits in a classification were subject to prior authorization, but only a few medical/surgical benefits in the same classification were subject to prior authorization). In such cases, as the Departments have previously stated, it is “unlikely that a reasonable application of the NQTL requirement would result in all MH/SUD benefits being subject to an NQTL in the same classification in which less than all medical/surgical benefits are subject to the NQTL.”¹¹² Yet, the comparative analyses failed to effectively address the apparent disparities.

As another example, some plans or issuers submitted charts that listed benefits within a classification and indicated whether the benefit met the specific average cost threshold for a factor that would result in the application of concurrent care review to that benefit. When EBSA asked for supporting documentation to show what the plan or issuer had calculated as the average cost for each service to support how each benefit met or did not meet the threshold, some plans or issuers were unable to provide that information.

In some instances, EBSA found that plans or issuers included an explanation of how factors were applied, but the analysis portion of their response did not address apparent differences in application of factors between MH/SUD benefits and medical/surgical benefits. For instance, if a factor was defined differently or a different evidentiary standard was used in

¹¹² 78 FR 68240, 68245 (Nov. 13, 2013).

applying a factor to MH/SUD benefits than to medical/surgical benefits, EBSA expected the comparative analysis to include an explanation of such differences. Many comparative analyses focused primarily on similarities, glossing over or avoiding discussion of apparent differences. Some of these problematic comparative analyses were provided by plans that had separate service providers for MH/SUD benefits and medical/surgical benefits who did not coordinate with each other about comparability or parity. These plans gathered information from each service provider without comparing the material provided by the two service providers.

EBSA found these responses deficient because the plan or issuer failed to provide the information required by ERISA Section 712(a)(8)(A)(iv) and (v). Additionally, EBSA flagged many for more comprehensive investigations into plan operations to gather missing information needed to assess compliance.

4. Failure to Explain or Adequately Explain How the NQTL Was Applied in Operation

Many comparative analyses did not include a sufficiently detailed explanation of how the NQTL was applied in operation to the specified benefits within a classification. Without this information, a comparative analysis lacks the context needed to meaningfully address compliance.

For example, some plans and issuers described their concurrent care review processes generically, without any details at all. Vague statements that service providers such as claims processors gathered information, adhered to timelines, and consulted with medical experts as needed to adjudicate claims, are insufficient for a comparative analysis. Often, these plans recited conclusory statements that the NQTL was “applied the same” for MH/SUD benefits and medical/surgical benefits or seemed to copy and paste the same text as the explanation for how

the application of the NQTL was identical. Such analyses lacked the detail required to support a finding that the processes, strategies, evidentiary standards, and other factors used in applying the NQTL were comparable and no more stringently applied in operation.

NQTLs such as concurrent care review and prior authorization often involve specific review systems that are complex and vary based on claim or service type. In some cases, these NQTLs impose administrative burdens upon participants and beneficiaries (and their authorized representatives) seeking MH/SUD care that appear more restrictive than those imposed in connection with medical/surgical care. If plans and issuers use such review systems – including multiple or variable levels of medical consultation, peer review, or reviewer types with differing levels of authority to approve or deny claims – the comparative analyses should describe such processes in detail and note procedural variations unique to each stage of review and specific benefit type.

EBSA found such responses deficient because they lacked the information required by ERISA Section 712(a)(8)(A)(i) and (iv).

5. Failure to Demonstrate Comparable Application of the NQTL

Plans and issuers can provide different types of information to demonstrate that an NQTL is not more stringently applied to MH/SUD benefits than to medical/surgical benefits. The appropriate and relevant information necessary to demonstrate comparable application depends on the type of NQTL, how it is applied, and other details unique to each plan's and each NQTL's design.

EBSA observed three common ways that plans and issuers fell short when attempting to demonstrate comparable application of an NQTL in operation.

a. Lack of Data Showing Results When the NQTL Was Applied in Operation

Many comparative analyses lacked any specific information showing consideration of how the NQTLs would actually apply in operation. For example, some prior authorization NQTL comparative analyses described how prior authorization was designed to work but did not provide any information on how prior authorization requirements were applied to MH/SUD benefits as compared to medical/surgical benefits. They also did not explain significant disparities in the application of prior authorization requirements between medical/surgical and MH/SUD benefits. The Departments have highlighted that plans and issuers should be prepared to provide samples of covered and denied MH/SUD and medical/surgical benefit claims and have also made clear that the precise information needed to support an NQTL analysis will vary depending on the type of NQTL.

In many insufficiency letters addressing a prior authorization NQTL, EBSA sought the following types of information, broken out by MH/SUD and medical/surgical benefits within a classification, in order to assess how an NQTL was applied in operation:

- the number of pre-service claims received,
- the number and rate of pre-service denials,
- turnaround times for processing pre-service claims,
- number and rate of pre-service claims involving peer review, and

- outcome of pre-service claims involving peer review.

In several instances, the nature of the NQTL required such information to be further itemized by benefit type in order to meaningfully show how the NQTL was applied in operation. Without information to show what a plan is doing in practice, EBSA had difficulty assessing compliance.

b. Failure to Explain Numerical Inputs, Underlying Methodologies, or Calculations
Behind Summary Data Presented as Evidence of Comparable Application

Many plans provided rudimentary data in an effort to demonstrate comparable application between medical/surgical benefits and MH/SUD benefits. However, this data lacked meaning because the plan or issuer did not provide a description of its source, how the source was selected, and information about underlying calculations. Without such a foundational description, the utility of such data was limited.

For example, to demonstrate that prior authorization was comparably applied, some plans provided a summary chart listing the exact same denial rate for MH/SUD benefits and medical/surgical benefits within a broad classification, such as a cumulative denial rate across all outpatient services. However, there was no explanation for how that rate was calculated. Such plans did not note whether the denial rate took into account all outpatient benefits or just benefits subject to prior authorization, whether the denial rate was for pre-service claims or post-service claims or both, or whether the denial rate included claims denied for reasons unrelated to prior authorization. If the underlying data used to calculate denial rates is not appropriate or consistent in scope, the resulting rates do not demonstrate compliance in operation.

c. Failure to Explain Apparent Differences in Access to MH/SUD Benefits as Compared to Medical/Surgical Benefits

When an NQTL's application results in apparent disparate limitations on MH/SUD benefits as compared to medical/surgical benefits, EBSA expects plans and issuers to explain and analyze the disparity as part of their reasoned discussion of their findings and conclusions. Yet, as noted above, many comparative analyses focused only on similarities, ignoring apparent differences presented within the information provided.

For example, in addressing the network admission standard NQTL, many plans and issuers cited the importance of considering the access standards they set and efforts to maintain an adequate network of providers. However, many comparative analyses did not adequately address apparent differences in access standards for medical/surgical providers as opposed to MH/SUD providers, such as different time and distance standards or provider-to-member ratios.

Plans and issuers provided their own network access standards as the metrics they used to monitor network adequacy, but those standards often allowed for longer travel times and travel distances for participants to reach a smaller number of MH/SUD providers as compared to medical/surgical providers. As justification, some plans and issuers simply pointed to external entities that are not required to comply with MHPAEA as the sources from which they derived the different standards. Such responses are not adequate to address the differences.

Many comparative analyses addressing network admission standards also described how plans or issuers monitored the adequacy of their provider network for medical/surgical services, including a detailed assessment of whether and how access standards were met, broken out by providers of each medical/surgical specialty. However, the comparative analyses showed that

monitoring efforts for the adequacy of the provider network for MH/SUD services were less detailed than for medical/surgical services, without explaining how the difference could be squared with the requirement of parity.

These comparative analyses also failed to explain why, in operation, plans and issuers consistently failed to ensure they met access standards for MH/SUD benefits, while appearing to ensure that they consistently met access standards for medical/surgical benefits. The plans and issuers often made special efforts to correct problems with medical/surgical networks without making comparable efforts when MH/SUD networks fell short.

B. CMS' Conclusions Regarding Sufficiency¹¹³

After submitting an initial request for a comparative analysis to a plan sponsor or issuer, CMS held entrance conferences with each plan sponsor and/or issuer to discuss the NQTL comparative analysis review process and the elements of a sufficient comparative analysis submission. After receiving a submission, CMS reviewed it to determine whether sufficient information was provided for CMS to assess compliance. If the information was insufficient, CMS sent a letter to the plan sponsor or issuer detailing the additional information needed to perform the NQTL review.

In every review for which CMS determined the plan sponsor's or issuer's initial submission was insufficient during the Review Period,¹¹⁴ the initial comparative analysis was

¹¹³ This summary fulfills the Secretary's reporting obligations under PHS Act section 2726(a)(8)(B)(iv)(II) – "the Secretary's conclusions as to whether each group health plan or health insurance issuer submitted sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section."

¹¹⁴ Since the release of the January 2022 MHPAEA Report to Congress, an initial determination of sufficiency has been made in two of the reviews initiated by CMS in Plan Year 2021 and they are included in the metrics within this

insufficient in one or more areas. The following are the most common reasons the initial comparative analysis submissions were determined to be insufficient.

1. Supporting Policies and Procedures Not Included

The PHS Act requires that plan sponsors and issuers provide “any other source or evidence relied upon to design and apply NQTLs to mental health or substance use disorder benefits and medical or surgical benefits” in their comparative analyses.¹¹⁵ However, in some instances, the plan sponsor or issuer only provided narrative explanations with no supporting policies and procedures. In other instances, the comparative analysis submission included some supporting documentation, but additional supporting documentation was needed for CMS to perform a review and confirm the NQTL’s compliance with MHPAEA. For example, a concurrent review policy and procedure was provided as supporting documentation for a concurrent review NQTL, but that document also referenced additional policies and procedures used to apply the concurrent review NQTL, and those related policies and procedures were not provided.

CMS noted this type of insufficiency in 23 reviews.

2. Insufficient Information Regarding Qualifications of NQTL Decision-Makers

The PHS Act requires plan sponsors and issuers to provide “[t]he factors used to determine that the NQTLs will apply to [MH/SUD benefits] and medical or surgical benefits.”¹¹⁶ The qualifications of decision-makers are another factor that CMS considers as part of its review

summary. This brings the total number of sufficiency reviews by CMS from 21 to 23 for this annual Report to Congress.

¹¹⁵ PHS Act Section 2726(a)(8)(A)(iii).

¹¹⁶ PHS Act Section 2726(a)(8)(A)(ii).

if the application of the NQTL turns on specific decisions in administration of benefits. In many instances, plan sponsors and issuers did not provide information describing the qualifications of any decision-makers or experts involved in the design and application of the NQTL. In several instances, certain committees were identified as decision-makers involved in the design and application of the NQTL, but the information provided by the plan sponsor or issuer did not specify the qualifications, including clinical specialties, of the individuals on the committee.

By failing to provide such supporting information, these comparative analyses did not provide sufficient information for CMS to determine whether the development and application of NQTLs, such as the requirement to impose prior authorization for certain MH/SUD benefits, would be evaluated and determined by individuals who are qualified or trained in a MH/SUD clinical specialty area and whether the NQTL is applied, as written and in operation, to MH/SUD benefits in a manner that is comparable to and no more restrictive than its application to medical/surgical benefits. Information describing the qualifications of any decision-makers or experts involved in the design and application of the NQTL is necessary to provide a complete comparative analysis that will enable the determination of compliance with MHPAEA.

CMS noted this type of insufficiency in 23 reviews.

3. Insufficient Information Regarding Factors

The PHS Act requires plan sponsors and issuers to provide “[t]he factors used to determine that the NQTLs will apply to [MH/SUD benefits] and medical or surgical benefits.”¹¹⁷ However, in many instances, the plan sponsor or issuer provided insufficient information

¹¹⁷ PHS Act Section 2726(a)(8)(A)(ii).

regarding factors, including definitions, explanations for how factors were measured and applied, and any applicable quantitative thresholds used in the design and application of the NQTL.

For example, one issuer explained it considered a numerical factor when determining which MH/SUD and medical/surgical services would be subject to a prior authorization requirement. However, the issuer did not share information on the definitions, data, processes, or evidentiary standards used to develop and apply the factor. As part of its review, CMS examined whether quantitative thresholds were used in the design and application of the NQTL, and whether there was any variability between MH/SUD and medical/surgical benefit thresholds. However, the missing additional information about the quantitative thresholds, including the precise definitions, data, and information necessary to assess their development and application, stood in the way of verifying the comparability and stringency of this numerical factor in operation.

CMS noted this type of insufficiency in 23 reviews.

4. Insufficient Documentation of Sources, Evidentiary Standards, and Guidelines

The PHS Act requires plan sponsors and issuers to provide “[t]he evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.”¹¹⁸ In all instances, the initial comparative analysis submission did not include sufficient information and supporting documentation related to the sources, evidentiary standards, or guidelines considered in the

¹¹⁸ PHS Act Section 2726(a)(8)(A)(iii).

design or application of the NQTL. No comparative analysis that CMS received included copies of all evidentiary standards used.

For example, multiple plan sponsors and issuers claimed to use internal coverage policies or clinical guidelines or external guidelines, such as Milliman Care Guidelines or the American Society of Addiction Medicine Criteria, as evidentiary standards in the application of a prior authorization or concurrent review NQTL to determine whether to approve or deny coverage. However, plans and issuers did not provide all of these policies and guidelines to CMS as part of their comparative analyses. Copies of these professionally recognized treatment guidelines are needed for this Review when they are identified by an Issuer/Plan Sponsor as sources relied upon to design and apply the NQTL. For example, the publication information and year is needed to confirm the exact source used by the Issuer or Plan Sponsor to determine whether MH/SUD services and M/S services are subject to an NQTL, such as a prior authorization requirement. This includes identifying the exact version and edition used for each source when determining, for example, whether a prior authorization request should be approved or denied for the applicable plan year(s). Additionally, exact copies allow CMS to review whether there are any variations in how the Issuer or Plan Sponsor has applied guidelines, such as including an additional requirement not contained within the clinical guideline.

CMS noted this insufficiency in 23 reviews.

5. Insufficient Discussion of Comparability and Stringency of NQTL

The PHS Act requires issuers and plan sponsors to provide “[t]he comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are

comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification,”¹¹⁹ as well as “[t]he specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance with this section.”¹²⁰ In many instances, the comparative analysis did not include a sufficient reasoned discussion of the plan sponsor’s or issuer’s conclusions as to the comparability and stringency of the processes, strategies, evidentiary standards, and other factors used to apply the NQTL between MH/SUD benefits and medical/surgical benefits, as written and in operation. In addition, when supporting documentation of comparability and stringency analyses was provided, it was unclear whether the data metrics provided were specific to the benefit classification under review, the NQTL under review (e.g., concurrent review as opposed to all utilization management), or separate processes utilized to apply the NQTL (standard vs. urgent review processes).

CMS noted this insufficiency in 23 reviews.

6. Insufficient Information Regarding Application Variations

The PHS Act requires issuers and plan sponsors to provide “[t]he comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary

¹¹⁹ PHS Act Section 2726(a)(8)(A)(iv).

¹²⁰ PHS Act Section 2726(a)(8)(A)(v).

standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.”¹²¹ In most instances, the comparative analysis did not include sufficient information regarding any variations in the application of any guideline or standard between MH/SUD benefits and medical/surgical benefits.

For example, an issuer identified three factors – indicators of fraud, safety, and high cost growth – used in the design of prior authorization requirements for MH/SUD benefits and medical/surgical benefits. The issuer further explained that all three factors are not necessary to select a MH/SUD benefit or medical/surgical benefit for the prior authorization requirement. However, the issuer did not provide sufficient information in the comparative analysis to explain what instances require fewer than all three factors, nor whether any variations in the use of these factors is comparable for MH/SUD benefits or medical/surgical benefits.

CMS noted this insufficiency in 22 reviews.

7. Failure to Identify the Benefits to Which an NQTL Applied

The PHS Act requires issuers and plan sponsors to provide “The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.”¹²² In many instances, the comparative analysis did not include specific identification or breakdown of the MH/SUD benefits and medical/surgical benefits to which the NQTL under review applied within each benefit classification. In some instances in which a list of benefits subject to the NQTL was provided, plan sponsors and issuers

¹²¹ PHS Act Section 2726(a)(8)(A)(iv).

¹²² PHS Act Section 2726(a)(8)(A)(i).

had to clarify whether certain benefits were classified as MH/SUD benefits or medical/surgical benefits. In other instances, plan sponsors and issuers provided a list of certain MH/SUD and medical/surgical benefits subject to the NQTL, but also provided documentation stating that the list was not comprehensive as to all benefits subject to the NQTL.

CMS noted this insufficiency in 20 reviews.

8. Insufficient Information and Documentation Regarding TPA Involvement

In most instances, the comparative analysis did not include sufficient information regarding any third-party administrator (TPA) involvement in the design and application of the NQTL. If a TPA was involved, sufficient supporting documentation was not included.¹²³ For example, it was unclear whether certain TPAs referenced in a comparative analysis had continued involvement in the design and application of the NQTL or if the TPA involvement was historical.

CMS noted this insufficiency in 23 reviews.

9. Missing Information on Comparative Analysis

In some instances, the comparative analysis did not include the date of the analyses and the title and/or position of the person or persons who performed or participated in the comparative analyses.¹²⁴

CMS noted this insufficiency in 15 reviews.

¹²³ FAQs Part 45, Q4, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf> and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/MHPAEA-FAQs-Part-45.pdf>.

¹²⁴ FAQs Part 45 (Apr. 2, 2021), Q2, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf> and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/MHPAEA-FAQs-Part-45.pdf>.

10. Summary of Common Trends Identified in Initial Submissions

CMS consistently requested clarification following its initial review of the comparative analyses submitted because the comparative analysis did not provide all required documentation or supporting rationale for its assertions. For example, one comparative analysis listed factors used in the design and application of the NQTL, but it did not identify which factor(s) were applied to each MH/SUD service and medical/surgical service or the rationale for determining whether a factor is applicable. Some of the information that plan sponsors and issuers must make available¹²⁵ – but is commonly missing from the comparative analysis – included:

- a sufficient reasoned discussion and all supporting documentation to support conclusions related to the comparability and relative stringency of the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits as compared to medical/surgical benefits, as written and in operation;
- sufficient information regarding TPA involvement in the design and application of the NQTL;
- copies of coverage policies for MH/SUD and medical/surgical services subject to the NQTL; and
- copies of sources, evidentiary standards, or guidelines used in the design and application of the NQTL.

¹²⁵ Consistent with the requirements of the PHS Act section 2726(a)(8)(A) and as delineated in FAQs Part 45 (April 2, 2021), Q2, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf> and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/MHPAEA-FAQs-Part-45.pdf>.

APPENDIX B: CURING DEFICIENCIES IN COMPARATIVE ANALYSES

As discussed above, persistent areas of deficiency in comparative analyses were found in the explanations of the factors used in applying the NQTLs. While EBSA continues to work with plans and issuers through the insufficiency process to gather this missing information, EBSA has found that some recent responses contain more detail addressing these concerns than has previously been the case. In many cases, the additional information cured an aspect of an identified deficiency. In some instances, depending on the facts and circumstances, the additional information provided was sufficiently detailed to satisfy EBSA's inquiry into the NQTL altogether.

This Appendix provides examples of how some plans and issuers cured deficiencies identified in insufficiency letters by providing detailed additional information.

Example #1 – Detailed Explanations Addressing Disparities, with Data and Supporting Documentation

Issue: A self-funded multiple employer welfare arrangement plan imposed a prior authorization requirement for inpatient facility-based care. The plan's initial comparative analysis contained many deficiencies, including failure to define factors, identify sources, explain how each factor was applied, and demonstrate comparable application of the NQTL in operation.

Action: EBSA's Chicago Regional Office issued two insufficiency letters identifying specific information needed to assess compliance.

Response: In response to the insufficiency letters, the plan provided:

- detailed information about how and why it defined each factor;
- information explaining how it applied each factor when deciding which benefits would be subject to prior authorization;
- comparison data showing how the NQTL applied to benefits in the inpatient classification; and
- quotes or references to sections of specific journal articles that the plan named as sources.

The plan provided a full and detailed explanation of how and why specific journal articles supported use of each factor the plan used in the design of the NQTL.

The comparison data initially suggested a significant disparity in the approval and denial rates for medical/surgical care received at in-network, inpatient facilities, such as skilled nursing facilities, as compared to approval and denial rates for MH/SUD care at in-network inpatient facilities, such as residential treatment centers. In response to further questions about the apparent disparity, the plan provided multiple reasons to conclude that the disparity was more apparent than real and did not reflect a substantive MHPAEA violation. Most importantly, the plan supported those reasons with additional data and documentation.

Result: EBSA did not cite a violation and is no longer seeking additional information about this specific NQTL.

Example #2 – Detailed Explanations Addressing Disparities, with Data and Supporting Documentation

Issue: An issuer that provides fully insured group health coverage products to ERISA-covered plan clients produced comparative analyses addressing prior authorization and concurrent care review for the fully-insured group health plans offered by its clients. The initial comparative analysis identified a formula-based numerical factor that the issuer applied quantitatively as one of the factors it considered when deciding which benefits would be subject to prior authorization and concurrent care review.

Benefits with numerical calculations over a certain threshold were subject to prior authorization, and benefits below that threshold were not subject to prior authorization. The issuer did not provide the formula for how this factor was defined or calculated, and it did not identify the sources and inputs used to calculate the factor. The issuer also failed to provide information to demonstrate the factor's comparable application.

Action: EBSA's Boston Regional Office requested supporting documentation and details about the factor.

Response: In response, the issuer provided:

- the mathematical formula it used to calculate the factor;
- the numerical threshold it used when applying the factor to the benefits; and

- a table showing the specific numerical results that it calculated when applying the factor's formula to each MH/SUD benefit and medical/surgical benefit in the benefit classification.

The supporting documentation identified which benefits met the specified numerical threshold and which did not. The list of those matching the threshold matched the list of benefits subject to the NQTL.

Result: Although EBSA continues to have substantive concerns about the specific NQTL, both as written and applied, the specificity of the issuer's response helped advance the inquiry and is an example of improvement in the level of detail and supporting documentation received during this Reporting Period.