U.S. Department of Labor

Employee Benefits Security Administration
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VIA U.S. MAIL and EMAIL:
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May 18, 2022

The Board of Trustees of the MDA Health Plan Trust, Plan Administrator
MDA Health Plan Trust
Attn: Craig Start, President
3657 Okemos Road, Suite 100
Okemos, MI 48864

Re: MDA Health Plan Trust ("Plan") – Initial Determination Letter
NQTL – Prior Authorization
Case No. 43-011330

The Secretary has concluded that the Plan is not in compliance with the Mental Health Parity and Addiction Equity Act ("MHPAEA"). You have 45 days to specify the actions you will take to bring the Plan into compliance with MHPAEA and, if the corrective actions include applying a non-quantitative treatment limitation ("NQTL") to medical/surgical ("M/S") and mental health or substance use disorder ("MH/SUD") benefits, to provide additional comparative analyses demonstrating compliance. These materials are due by July 3, 2022.

Dear Plan Administrator:

Pursuant to his authority under ERISA § 712(a)(8), the Secretary of Labor ("Secretary") requested that the Plan submit comparative analyses and supporting documentation for specific NQTLs that it applies to MH/SUD benefits and identify all NQTLs for which the Plan determined a comparative analysis was required and had documented such analysis. Having reviewed the responses you provided on August 17, 2021, October 18, 2021, and November 30, 2021, and your supplemental emails on August 17, 2021 and October 11, 2021, the Secretary has determined that the Plan is not in compliance with MHPAEA's requirements.

ERISA § 712(a)(8)(A) requires plans and issuers to "perform and document comparative analyses of the design and application of NQTLs and, beginning 45 days after December 27, 2020, make available to the Secretary, upon request, the comparative analyses" and certain additional information. 29 U.S.C. § 1185a(a)(8)(A). Plans and issuers may not impose an NQTL on MH/SUD benefits unless, "under the terms of the plan, as written and in operation, any processes, strategies, evidentiary standards, or other factors" used in applying the NQTL to MH/SUD benefits in a given benefits classification are "comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the limitation with respect to medical/surgical benefits in the classification." 29 C.F.R. §2590.712(c)(4). Further, ERISA § 712(a)(8)(A) requires plans and issuers to "perform and

document comparative analyses of the design and application" of any such NQTLs sufficient to demonstrate compliance with MHPAEA's requirements. 29 U.S.C. §1185a(a)(8)(A).

Failure to Prepare Sufficient Comparative Analyses for NQTL of Prior Authorization

On July 29, 2021, the Secretary requested, *inter alia*, the Plan's comparative analysis relating to the following NQTL: "Prior authorization requirements for the following benefit classifications: (1) in-network outpatient; (2) out-of-network outpatient; (3) in-network in-patient; and (4) out-of-network in-patient (including, but not limited to, prior authorization requirements applicable to Applied Behavioral Analysis ("ABA"))."

On September 24, 2021, and November 12, 2021, the Secretary issued letters ("Insufficiency Letters") finding that the Plan's comparative analysis was missing information required by ERISA Section 712(a)(8)(A). The Insufficiency Letters identified specific deficiencies with the Plan's response and requested additional information. After reviewing the materials the Plan provided in response to the initial request and Insufficiency Letters, the Secretary finds that the Plan is not in compliance with ERISA Section 712(a)(8)(A), because the materials provided are still missing substantive content required by ERISA Section 712(a)(8)(A)(iii)-(v). The Plan's response was deficient in the following ways:

Failure to Define Factors and Evidentiary Standards

ERISA § 712(a)(8)(A)(iii) requires that the Plan make available "[t]he evidentiary standards used for the factors" to determine that the NQTL will apply to MH/SUD benefits and M/S benefits, "when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs..." In the comparative analysis provided on November 30, 2021, in an Excel spreadsheet ("Excel Comparative Analysis"), the Plan identified the following factors used to design and apply the Plan's prior authorization NQTL list and penalties:

1. Promoting evidence-based care.
2. Promoting and encouraging a dialogue between the health insurer and physician to ensure tailored patient-focused treatment that promote adherence.
3. Ensuring the safety and effectiveness of the treatment.
4. Promoting appropriate use of prescription drugs to avoid potentially dangerous side effects.
5. Minimizes over-utilization and unnecessary services.
6. Assisting to control rising health care costs.
7. 65% of physicians report that at least 15-30% of care is unnecessary.
8. The Institute of Medicine estimates that 10-30% of health care spending is wasted each year on excessive testing and treatment.
9. Between $200 and $800 billion is wasted annually on excessive testing and treatment.
10. Appropriate level of care based on clinical criteria.

In the Priority Health, Mental Health Parity NQTL – Prior Authorization document, provided on November 30, 2021, the Plan provided a list of factors that included only factors #1-3 and #5-6 above. Further, the Plan provided a list of reasons that health spending has increased in the last four decades that included only factors #7-9 above. Although these items were listed as factors in determining that prior authorization will apply to MH/SUD and M/S benefits, the information provided did not:

1. Define the factors.[1]
2. Explain how each factor was applied in practice (including how it was weighted) to determine which benefits were subject to prior authorization requirements.[2]
3. Clarify whether any of the factors were applied quantitatively, and if applicable, how threshold amounts were defined and determined.[3]
4. Provide sufficient evidence demonstrating application of the factors in practice.[4]

The Excel Comparative Analysis also identified the following evidentiary standards used for the factors to design and apply the prior authorization NQTL:

1. Inpatient and outpatient costs as a percentage of medical cost ratio ("MCR").
2. Average costs per admission and per outpatient treatment episode.
3. Medical policies.
4. InterQual Criteria.
5. Milliman National Benchmark Data for Commercial Well Managed Plans.

Although these items were listed as evidentiary standards, the information provided did not:

1. Define the evidentiary standards, including identifying which evidentiary standard was used for which factor/s, if there is any correlation.[5]
2. Explain how the evidentiary standards were applied quantitatively, if applicable, or provide any supporting data, data analyses, testing and/or audits of those quantitative measurements (i.e., compliance with thresholds, etc.).[6] For example, the inpatient and outpatient costs as a percentage of MCR are identified as an evidentiary standard. However, the percentage of MCR that would trigger a benefit being subject to prior authorization requirements was not identified. Similarly, the quantitative average costs per admission or outpatient treatment episode that would trigger a benefit to be subject to prior authorization requirements were not identified.

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[1] See ERISA § 712(a)(8)(A)(iii).
[2] See Frequently Asked Questions about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act of 2021 Part 45 (Q2, No. 3).
[3] *Id.* (Q2, No. 4).
[4] See ERISA § 712(a)(8)(A)(iii)-(iv).
[5] See ERISA § 712(a)(8)(A)(iii).
[6] See Frequently Asked Questions about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act of 2021 Part 45 (Q2, No. 4).

Failure to Demonstrate Comparable Application of Processes, Strategies, Evidentiary Standards, and Other Factors and Failure to Include Sufficient Results of the Analyses that Support the Specific Findings and Conclusions Reached

ERISA §712(a)(8)(A)(iv) requires that the Plan 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." Additionally, ERISA § 712(a)(8)(A)(v) requires the Plan to also provide "[t]he specific findings and conclusions reached…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."

As noted above, the Plan did not explain how it applied the named factors or evidentiary standards to benefits within the inpatient and outpatient benefit classification in order to determine which benefits would be subject to prior authorization. Because the application of the factors was not explained, the Plan's response was also lacking any comparison of the stringency of how the factors were applied in practice.

The following documents were provided to demonstrate the Plan's application of the prior authorization NQTL in practice:

1. A one-page document summarizing outpatient ABA approval rates.
2. A one-page chart reviewing prior authorization approval and denial rates.
3. Two pie charts demonstrating 2021 appeals decisions.
4. A nine-page appeal and grievance report.[7]

Additionally, the Excel Comparative Analysis listed the following items as support:

1. MER reports.[8]
2. Total cost of care.
3. Utilization management reporting.
4. Behavioral health utilization reporting.
5. Denial rates M/S and MH/SUD.
6. Interrater reliability for application of clinical criteria.
7. Denial rates for acute inpatient vs. psychiatric hospital.
8. Denial rates for outpatient M/S and MH/SUD benefits.

[7] No in-operation comparative analysis of the initial duration of treatment authorized on prior authorization reviews was presented, though it was requested in the Department's November 12, 2021, letter.
[8] The Plan did not explain the meaning of the acronym MER in its responses.

However, sufficient supporting analyses were not presented (such as descriptions of the contents of these reports, an explanation of how these materials support a demonstration of comparable application of the NQTL, the reports themselves, or an explanation of the methodology or underlying data used to generate each report).
In addition, the Plan failed to explain and compare how it applies the NQTL of prior authorization in practice with respect to different types of prior authorization reviews. For example, page 5 of 8 of Priority Health's Authorization Quick Reference List, produced on November 30, 2021, has a table showing which benefits are subject to prior authorization for which products and whether the benefit is considered MH/SUD vs. M/S. This table indicates that for inpatient services, "some elective procedures do not require health plan review..., but do require an auth for claims payment" and "[o]ther elective procedures require health plan review and specific criteria must be met..." The Plan appears to apply a more stringent review process to some but not all inpatient services, and this more stringent review involves evaluation against specific criteria. However, the Plan did not identify which inpatient benefits required the more stringent prior authorization review, describe or compare the different review processes, or explain how and what factors it applied when deciding which benefits would be subject to the more stringent type of prior authorization review. Additionally, it is not evident whether the Plan adopted the processes and requirements noted on Priority Health's Authorization Quick Reference List in practice, as page 1 of 8 of Priority Health's Authorization Quick Reference List indicates that the table applies to fully-funded plans, but application to self-funded plans might vary based on plan design.

In addition, the Plan failed to explain or compare any differences in the penalty it applied to claims for which prior authorization was required but not obtained. It appears that the Plan may apply a $250 penalty or total denial of a claim if prior authorization was required but not obtained for MH/SUD benefits. Specifically, the Summary Plan Descriptions ("SPDs") state that if required prior authorization is not obtained, the benefit administrator will review the claim and if it is determined that the care received was medically/clinically necessary and appropriate, the care will be covered and a penalty may be applied. The Insufficiency Letter dated November 12, 2021, requested all data analyses, testing and/or audit results demonstrating the application of penalties for failing to obtain prior authorization for ABA treatments for Autism. However, the Plan's response did not explain whether the prior authorization penalty language in the SPD was applicable to ABA and the chart of ABA therapy prior authorization approval and denial percentages did not demonstrate whether a $250 penalty applied. As such, the Plan failed to explain whether ABA therapy (for the treatment of Autism) or any other MH/SUD benefits were subject to a penalty for lack of prior authorization. Further, if a penalty applies, the Plan failed to demonstrate how this prior authorization penalty is comparable, and no more stringent, than the penalties for outpatient M/S benefits subject to prior authorization.

Further, page 2 of the amended comparative analysis summary report provides "The report is a comparative analysis summary which substantiates that Priority Health's processes, strategies, evidentiary standards, and other factors are comparable and no more stringently applied to MH/SUD benefits than to med/surg benefits." While the comparative analysis and supporting documents include similar conclusory statements regarding comparability and relative stringency, there was insufficient explanation of how the Plan reached its conclusions as to the

comparability of the processes, strategies, evidentiary standards, factors, and sources. The comparative analysis lacks the required supporting analysis.

Accordingly, the Secretary finds that the Plan is in violation of ERISA Section 712(a)(8)(A) because substantive required content related to the definitions and application of factors and evidentiary standards is missing and because the Plan's response lacked a comparative analysis sufficient to demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply prior authorization requirements to MH/SUD benefits, as written and in operation, are comparable to, and applied no more stringently than, those applied to M/S benefits.

What Happens Next

The Plan must specify, within 45 days, the actions it will take to come into compliance with regard to the violation noted above (corrective action plan) and provide a sufficient comparative analysis containing all the information required by ERISA Section 712(a)(8)(A)(iii)-(v) reflecting such compliance to the extent compliance includes continuing to impose the NQTL on both M/S and MH/SUD benefits. 29 U.S.C. § 1185a(a)(8)(B)(iii)(I)(aa). Accordingly, within 45 days, please provide us with details on the actions taken (or planned) to fully correct the violations noted above. Your corrective action may include the amendment and distribution of updated Plan documents or policies, changes to Plan operations, the date(s) each corrective action is expected to be completed or is completed, and if the corrective actions include continuing to impose an NQTL on M/S and MH/SUD benefits, a comparative analysis demonstrating that the Plan will be in compliance with the corrections.

Please submit the above-listed items by July 3, 2022. You can send the documents electronically to: wilkinson.meghann@dol.gov.

If, after the 45-day corrective action period, the Secretary makes a final determination that the Plan is still not in compliance, the Secretary will give you written notice of that determination and the Plan will have seven (7) days thereafter to notify all enrolled participants and beneficiaries covered under the Plan that the Secretary has determined the Plan is not complying with MHPAEA. ERISA § 712(a)(8)(B)(iii)(I)(bb), 29 U.S.C. § 1185a(a)(8)(B)(iii)(I)(bb). Please note that the timelines for the 45-day corrective action period and the notice requirement to enrollees are set by statute.

You should be aware that the Secretary is required by statute to make public in an annual report to Congress the identity of any plan or issuer for which the Secretary makes a final determination of non-compliance with MHPAEA based on the review of the Plan's comparative analysis, as well as the Secretary's conclusions as to whether each plan or issuer submitted sufficient information for the Secretary to review the required comparative analyses for compliance with MHPAEA. ERISA § 712(a)(8)(B)(iv), 29 U.S.C. § 1185a(a)(8)(B)(iv).

You should also be aware that, pursuant to statutory requirements, the Secretary may be required to share information concerning his findings with the State where the Plan is located or, for

coverage offered by a health insurance issuer in the group market, where the issuer is licensed to do business. ERISA § 712(a)(8)(C)(iii), 29 U.S.C. § 1185a(a)(8)(C)(iii).

This initial compliance determination applies only to the NQTL of prior authorization for the following benefit classifications: (1) in-network outpatient; (2) out-of-network outpatient; (3) in-network in-patient; and (4) out-of-network in-patient (including, but not limited to, prior authorization requirements applicable to ABA). We will continue to review and correspond separately with you regarding materials you submitted about other NQTLs and the Secretary's Initial Determination Letter dated October 15, 2021, addressing the Plan's exclusion for outpatient mental health services provided via telephone, e-mail, or internet.

The Secretary's findings detailed in this letter do not bind the Secretary in reviewing or investigating any other employee benefit plan or service provider, or in any subsequent or further review of the Plan, including the review of other Plan provisions and their application for compliance with governing law, including MHPAEA.

Please direct any questions to Senior Investigator Meghann Wilkinson at (859) 394-6585 or wilkinson.meghann@dol.gov. We will work with you during the corrective action period to provide technical assistance on bringing the Plan into compliance with MHPAEA. Thank you for your cooperation.

Sincerely,

L. Joe Rivers Digitally signed by L. Joe Rivers Date: 2022.05.18 13:46:34 -04'00'

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