DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

The Centers for Medicare & Medicaid Services (CMS) has concluded that Aetna Life Insurance Company (MO) is not in compliance with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA), as codified at Public Health Service Act (PHS Act) § 2726 (42 U.S.C. § 300gg-26). The Issuer must, by January 24, 2025, notify all individuals enrolled in health insurance coverage offered by the Issuer subject to this non-quantitative treatment limitation (NQTL) that the coverage is not compliant with the requirements of MHPAEA. Please provide a copy of the letter, with the date(s) the letter was sent, and a list of recipients to CMS by January 24, 2025.

January 14, 2025

Aetna Life Insurance Company – Missouri – HIOS #48161

Darcey Gartner,
Executive Director Corporate Compliance
dxgartner@aetna.com

Re: Final Determination Letter - Finding of Non-Compliance – Mental Health Parity and Addiction Equity Act (MHPAEA) Non-Quantitative Treatment Limitation (NQTL) Comparative Analysis Review – Prior authorization requirements for outpatient, in-network services.

Dear Darcey Gartner:

This letter informs you that a review of the Corrective Action Plan (CAP) and additional comparative analyses submitted on July 3, 2023, July 25, 2023, and September 13, 2023, to address the instances of non-compliance noted in the Initial Determination Letter for this MHPAEA NQTL Analysis Review (Review), is complete.

The purpose of the Review was to assess Aetna Life Insurance Company's (Issuer) compliance with the following requirements under Title XXVII of the Public Health Service Act (PHS Act) and its implementing regulations:

> PHS Act § 2726, 45 C.F.R. §§ 146.136 and 147.160[1] - Parity In Mental Health And Substance Use Disorder Benefits (MHPAEA and its implementing regulations).

The Review covered prior authorization requirements for outpatient, in-network services for the 2022 plan year (hereinafter referred to as "the NQTL").

[1] In this document, references to C.F.R. §§ 146.136 and 147.160 refer to the regulations applicable during the 2022 plan year.

CMS conducted this Review on behalf of the Secretary of Health and Human Services pursuant to PHS Act § 2726(a)(8)(A) and (B), as added by Section 203 of Title II of Division BB of the Consolidated Appropriations Act, 2021.[2] CMS contracted with Examination Resources, LLC to assist CMS with conducting this Review.

After reviewing the CAP and additional comparative analysis provided, CMS is finalizing the initial determination that the Issuer violated PHS Act § 2726 and its implementing regulations at 45 C.F.R. §§ 146.136 and 147.160 by failing to provide a sufficient comparative analysis as required under PHS Act § 2726(a)(8)(A).

This Final Determination Letter identifies the ways that the Issuer's CAP and comparative analyses fail to comply with PHS Act § 2726. This letter also specifies additional corrective actions for the Issuer to address the findings of non-compliance.

On May 19, 2023, CMS provided an Initial Determination Letter of non-compliance to the Issuer and directed the Issuer to submit a CAP and additional comparative analysis to demonstrate compliance with MHPAEA. After reviewing the Issuer's July 3, 2023, July 25, 2023, and September 13, 2023 CAP submissions and additional comparative analyses, CMS is finalizing the initial determination of non-compliance with MHPAEA in the following areas noted in the May 19, 2023 Initial Determination Letter and discussed below:

I. Failure to Provide Sufficient Information and Supporting Documentation, in Violation of PHS Act § 2726(a)(8)(A).

PHS Act § 2726(a)(8)(A)(ii) and (iii) requires that the Issuer "make available to […] the Secretary of Health and Human Services […] upon request, the comparative analyses" including "[t]he factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits […] provided that every factor shall be defined." CMS identified a violation of this provision in the following instance:

1. Failure to provide sufficient information and supporting documentation regarding the factors considered in the design and application of the NQTL, as written and in operation.

The Issuer identified return on investment (ROI) as a factor used to determine whether the NQTL will continue to apply to a service in its initial submission. On May 18, 2022, CMS requested the Issuer provide additional information on the process used to determine that the NQTL will continue to apply to a service.[3] The Issuer noted in its response dated June 17, 2022, that the ROI factor is calculated annually for each service subject to a prior authorization requirement and that services with a ROI of 3:1 or greater continue to be subject to a prior authorization requirement.[4] In addition, the Issuer provided a description of how the ROI factor

[2] Pub. L. 116-260 (Dec. 27, 2020).
[3] Aetna HIC LIC_MO_PA_Insuff Data Req_051822_Final, Request Item #4.A.
[4] FINAL_Updated_Missouri Insufficiency Letter_PA_Response_6.17.22, pgs. 15-16.

is used in this process, but did not provide definitions of the elements that comprised the ROI factor calculation, as outlined by CMS in the Initial Determination Letter.[5]

Specifically, the Issuer defined its ROI factor as the *"health care cost expense savings related to denials of non-medically necessary care divided by administrative costs"* in its CAP response dated July 3, 2023.[6] The Issuer thereby defined the general formula used to calculate the ROI factor.[7] In the Issuer's CAP submission, the ROI formula was also defined as calculated by dividing (i) by (ii): "(i) Gross dollar amount of claims costs saved through appropriate denials of coverage for that service, and (ii) Gross dollar amount of costs to administer precertification for that service."[8] However, it did not provide further information on how it determines the "cost expense savings for a service" calculation or the "cost to administer prior authorization on a service" input used to calculate the ROI factor.

In addition, the Issuer indicated in its initial submission that it considers extenuating factors to apply the NQTL to mental health and substance used disorder (MH/SUD) services and medical/surgical (M/S) services that do not meet the 3:1 ROI threshold and provided a list of extenuating factors in its supplemental response dated June 17, 2022.[9],[10] The Issuer identified a list of extenuating factors it uses to continue to apply the NQTL to services that do not meet the 3:1 ROI threshold in its supplemental response dated June 17, 2022.[11] However, the Issuer did not provide definitions for all the extenuating factors listed and did not provide supporting documentation explaining how the extenuating factors are applied to each service as outlined in the Initial Determination Letter.[12] The Issuer provided document "NPL Policy and Procedure_APPROVED 7.24.23" in its CAP response that included definitions for some of the extenuating factors. The document stated: *"Extenuating factors include,* ***but are not limited to****: […]"* (emphasis added) those enumerated in the document.[13] The language in the provided document indicates the factors identified in the document are not exhaustive of all the extenuating factors considered by the Issuer in applying the NQTL to MH/SUD services and M/S services. The Issuer therefore failed to identify and define all of the extenuating factors used in the application of the NQTL as outlined in the Initial Determination Letter.[14]

Therefore, the Issuer did not provide sufficient information regarding the application of the ROI factor and the extenuating factors considered in the design and application of the NQTL, as written and in operation, in violation of PHS Act § 2726(a)(8)(A)(ii) and (iii).

II. Corrective Actions.

[5]Aetna LIC MO_Initial Determination Letter_PA_Final, pgs. 4-5.
[6] MO ALIC and AHIC Prior Authorization Response, pg. 2.
[7] MO ALIC and AHIC Prior Authorization Response, pg. 2.
[8] MO ALIC and AHIC Prior Authorization Response, pg. 2.
[9] FINAL_Updated_Missouri Insufficiency Letter_PA_Response_6.17.22, pg. 16.
[10] CMS-MO-WY NQTL Analysis, pg. 5.
[11] FINAL_Updated_Missouri Insufficiency Letter_PA_Response_6.17.22, pg. 16.
[12] Aetna LIC MO_Initial Determination Letter_PA_Final, pgs. 4-5.
[13] NPL Policy and Procedure_APPROVED 7.24.23, pg. 5.
[14] Aetna LIC MO_Initial Determination Letter_PA_Final, pgs. 4-5.

In order to resolve the identified instances of non-compliance, CMS identified the following corrective actions. Please take the following corrective actions by February 27, 2025:

- Describe to CMS the process and any evidentiary standards used by the Issuer to determine the cost expense savings through appropriate denials of coverage for a service for prior authorization processes. Include the cost savings per denial for each MH/SUD service and M/S service;
- Describe to CMS the process and any evidentiary standards used by the Issuer to determine the cost to administer prior authorization for a service. Clarify whether the same cost to administer prior authorization is used in calculating ROI for MH/SUD services and M/S services; and
- Provide to CMS an exhaustive list of all extenuating factors considered when determining whether to impose a prior authorization requirement on a MH/SUD service or M/S service that does not meet the 3:1 ROI threshold. Include definitions and any quantitative thresholds or measures used for each extenuating factor.

III. Next Steps.

Pursuant to PHS Act § 2726(a)(8)(B)(iii)(I)(bb), the Issuer must, by January 24, 2025, notify all individuals enrolled in health insurance coverage offered by the Issuer subject to this NQTL that CMS has determined the coverage is not in compliance with the requirements under MHPAEA. Please provide a copy of the letter, with the date(s) the letter was sent, and a list of recipients to CMS by January 24, 2025.

If the Issuer fails to complete the identified corrective actions, provide appropriate notice to its enrollees, or provide documentation of these actions to CMS by the specified dates, CMS may pursue further enforcement action, as warranted, including initiating an investigation or market conduct examination, additional or modified CAPs, and/or assessing civil money penalties under section 2723(b) of the PHS Act and implementing regulations at 45 CFR Part 150, Subpart C and otherwise consistent with law.

CMS' findings detailed in this letter pertain only to the NQTL under review and do not bind CMS in any subsequent or further review of other plan provisions or their application for compliance with governing law, including MHPAEA and its implementing regulations. If additional information is provided to CMS regarding this NQTL or Issuer, CMS reserves the right to conduct an additional review for compliance with MHPAEA or other applicable PHS Act requirements.[15]

CMS' findings pertain only to the specific plans to which the NQTL under review applies and are offered by the Issuer and do not apply to any other plan or issuer, including other plans or coverage for which the Issuer acts as an Administrator. However, these findings should be shared with affiliated entities, and steps should be taken as appropriate to ensure compliance with applicable requirements.

[15] See PHS Act § 2726(a)(8)(B)(i). See also 45 C.F.R. § 150.303.

CMS will include a summary of the comparative analysis, results of CMS' review, determination of non-compliance, and the identity of the Issuer in its annual report to Congress pursuant to PHS Act § 2726(a)(8)(B)(iv).

Sincerely,

Jeffrey C. Wu -S

Digitally signed by Jeffrey C. Wu -S
Date: 2025.01.10 18:05:07 -05'00'

Jeff Wu
Deputy Director of Policy
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services

cc: Missouri Department of Insurance