EMPLOYEE BENEFITS SECURITY ADMINISTRATION
UNITED STATES DEPARTMENT OF LABOR

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FACT SHEET

FY 2018 MHPAEA ENFORCEMENT

ENFORCEMENT OVERVIEW: ENSURING PARITY

The Employee Benefits Security Administration (EBSA) enforces Title I of the Employee Retirement Income Security Act of 1974 (ERISA), on behalf of 2.3 million private employment-based group health plans, which cover 131.6 million participants and beneficiaries. EBSA relies on its approximately 400 Investigators to review plans for compliance with ERISA, including the Mental Health Parity and Addiction Equity Act (MHPAEA). EBSA also employs approximately 100 Benefits Advisors who provide participant education and compliance assistance, including education and assistance regarding MHPAEA. Benefits Advisors also pursue voluntary compliance from plans on behalf of participants and beneficiaries. In January 2016, EBSA released its first annual MHPAEA enforcement fact sheet, summarizing its enforcement activity in fiscal year (FY) 2015.[1]

This enforcement fact sheet summarizes EBSA's closed investigations and public inquiries related to MHPAEA during fiscal year 2018. This Fact Sheet does not report ongoing investigations that were open but not closed during FY 2018. Those cases will be reported in a subsequent report for the year in which they are closed. Multi-year investigations are not uncommon with respect to complex MHPAEA issues, especially for investigations that involve large service providers.

EBSA investigated MHPAEA violations in the following categories:

(1) ***Annual dollar limits***: dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan or health insurance coverage for any coverage unit.

(2) ***Aggregate lifetime dollar limits***: dollar limitation on the total amount of specified benefits that may be paid under a group health plan or health insurance coverage for any coverage unit.

(3) ***Benefits in all classifications***: if a plan or issuer provides mental health or substance use disorder benefits in any classification described in the MHPAEA final regulation, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided.[2]

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

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

[1] The six permitted classifications of benefits are: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.
[2] *See* EBSA's MHPAEA Enforcement Fact Sheet and 2016 and 2017 MHPAEA Enforcement Fact Sheets, *available at* https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement.pdf, https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2016.pdf and https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2017.pdf, respectively.

nonquantitative treatment limitations (NQTLs), which otherwise limit the scope or duration of benefits for treatment under a plan or coverage.

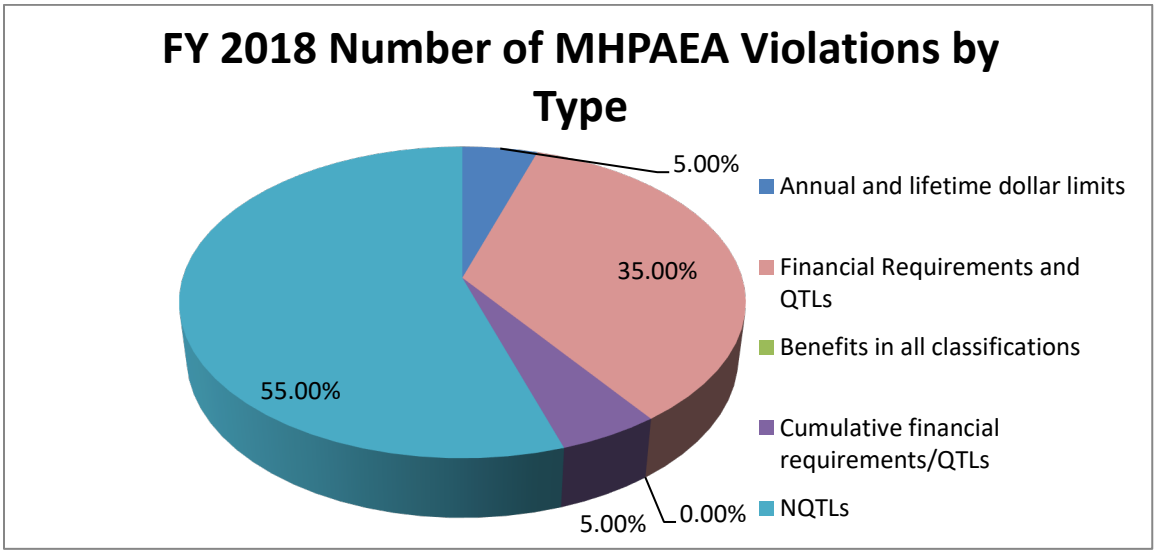
(6) ***Cumulative financial requirements and QTLs*****:** financial requirements and treatment limitations that determine whether or to what extent benefits are provided based on certain accumulated amounts. They include deductibles and out-of-pocket maximums.

In addition, EBSA investigated other ERISA violations (such as claims processing and disclosure violations) affecting mental health and substance use disorder benefits.

FY 2018 Enforcement Fast Facts:

- EBSA investigated and closed 285 health plan investigations in FY 2018 (and 3,571 health plan investigations since FY 2011).
- 115 of these closed investigations involved plans subject to MHPAEA, which were reviewed for MPHAEA compliance.
- EBSA cited 21 MHPAEA violations as a result of these investigations.
- EBSA Benefits Advisors answered 127 public inquiries in FY 2018 related to MHPAEA (and have answered 1,445 inquiries related to MHPAEA since FY 2011).

FY2018 MHPAEA Violations



THE ENFORCEMENT PROCESS

Assisting Participants

EBSA receives inquiries from participants who believe their mental health or substance use disorder benefits were denied improperly. Benefits Advisors work with participants and their plans to help participants receive the benefits to which they are entitled. Benefits Advisors are the public's initial point of contact with EBSA. If a Benefits Advisor thinks a violation may have occurred and is unable to obtain voluntary compliance from a plan, EBSA may open a formal investigation.

Benefits Advisors obtain results.

An individual contacted an EBSA Benefits Advisor for help with a claim for substance use disorder treatment. The individual's plan initially preauthorized treatment at an inpatient rehabilitation program, but subsequently denied her claim and retracted payment, forcing the participant to pay out of pocket for these services. EBSA's Benefits Advisor contacted the individual's plan and requested the plan review the post-service denial. Upon review, the plan determined the claim was, in fact, covered under the plan and paid $15,500 for treatment.

Investigating Plans

EBSA conducts MHPAEA compliance reviews, including for compliance with the requirements for QTLs and NQTLs, in all open cases where MHPAEA applies. Many of these cases stem from participant complaints received by a Benefits Advisor, where the facts suggest the problems are systemic and adversely impact other participants.

Achieving global corrections.

A self-funded plan contained a provision that required a written treatment plan for mental health and substance use disorders. The plan documents also required that the treatment plan be for a condition that can be improved, and not solely managed by treatment. The plan did not impose these requirements on medical/surgical benefits. As a result of the investigation, the service provider removed the impermissible requirements from all plan documents. Additionally, the service provider issued a letter and the revised plan document language to all self-insured plan sponsors for plans it administered.

Generally, if violations are found by an EBSA Investigator, the Investigator requires the plan to remove any non-compliant plan provisions and pay any improperly denied benefits. To achieve the greatest impact, EBSA Investigators seek a global correction, working with the plans' service providers (such as third-party administrators or managed behavioral health organizations) to find improperly denied claims in other plans they service and correct the problem for those plans as well. EBSA Investigators have worked with several large insurance companies to remove impermissible barriers to mental health benefits, such as overly restrictive written treatment plan requirements and overly broad preauthorization requirements that did not apply in a comparable manner to medical/surgical benefits. These global changes have impacted hundreds of thousands of group health plans and millions of participants.

FY 18 IN REVIEW: EXAMPLES OF ENFORCEMENT ACTIONS AFFECTING MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

- ✓ *Preauthorization for outpatient mental health and substance use disorder treatment eliminated.* The Chicago Regional Office discovered a self-funded plan that imposed a preauthorization requirement for all outpatient mental health and substance use disorder benefits after 24 visits. This requirement did not apply to outpatient medical/surgical benefits. As a result of the investigation, the plan completely removed preauthorization requirements (including the visit limit threshold) for mental health and substance use disorder benefits from its plan documents, and notified participants that the plan's requirement to provide documentation for medical necessity to continue treatment after 24 mental health or substance use disorder visits was eliminated. The plan re-adjudicated 174 impacted claims for 47 participants, and paid $20,075 in claims to the affected participants and their providers.

- ✓ *Restrictive financial requirements eliminated and participants reimbursed for excessive copayments.* The New York Regional Office reviewed a self-funded plan that charged a higher, specialist co-payment of $40 for all in-network mental health and substance use disorder outpatient visits, compared to the predominant copay that was charged for substantially all in-network medical/surgical outpatient visits, which was only $20. As a result of this investigation, the plan refunded the $20 difference between the higher specialist copayment and the primary care copayment for all in-network, outpatient mental health and substance use disorder claims from the 2011 through 2015 plan years. In total, approximately $26,000 was reimbursed to 94 participants. The plan also removed the impermissible financial requirement for future years.

- ✓ *Contradictory plan language corrected.* The San Francisco Regional Office found contradictory language in a self-funded plan's Summary of Benefits. The Summary of Benefits contained one provision which stated that the maximum lifetime benefit for treatment of alcohol misuse was unlimited, and another provision stated that alcohol misuse benefits were limited to five years. As a result of this investigation, the plan removed the provision that limited benefits for treatment of alcohol misuse, which was inconsistent with the permissible plan language of unlimited benefits.

- ✓ *Overly stringent treatment limitations eliminated.* The Cincinnati Regional Office discovered a self-funded plan that imposed a more stringent NQTL on inpatient and outpatient mental health and substance use disorder benefits than was applied to medical/surgical benefits. Specifically, for mental health or substance use disorder benefits to be payable, the plan required measurable goals and continued progress toward functional behavior and termination of treatment. Under the plan, continued coverage could be denied when positive response to treatment was not evident. This requirement did not apply to inpatient and outpatient medical/surgical benefits. As a result of the investigation, the company amended the plan documents to remove the more stringent treatment limitations.

- ✓ *Assistance with claims processing.* An authorized representative for an ERISA plan participant contacted an EBSA Benefits Advisor for help for a participant who was diagnosed with a substance use disorder. The participant's health plan denied his claims for coverage in a residential rehabilitation program due to insufficient documentation, even after multiple documents were submitted. The Benefits Advisor contacted the plan, determined precisely what type of documentation was needed (i.e., demonstrating that the facility met the requirements for coverage), and helped to provide the necessary information to the plan. As a result, the participant's treatment was covered and the plan paid $35,600 for the treatment.

Need Help with Your Mental Health or Substance Use Disorder Benefits?

Visit the Mental Health and Addiction Insurance Help Consumer Portal

https://www.hhs.gov/programs/topic-sites/mental-health-parity/mental-health-and-addiction-insurance-help/index.html

Contact EBSA

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