EMPLOYEE BENEFITS SECURITY ADMINISTRATION
UNITED STATES DEPARTMENT OF LABOR

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FACTSHEET

FY 2017 MHPAEA ENFORCEMENT

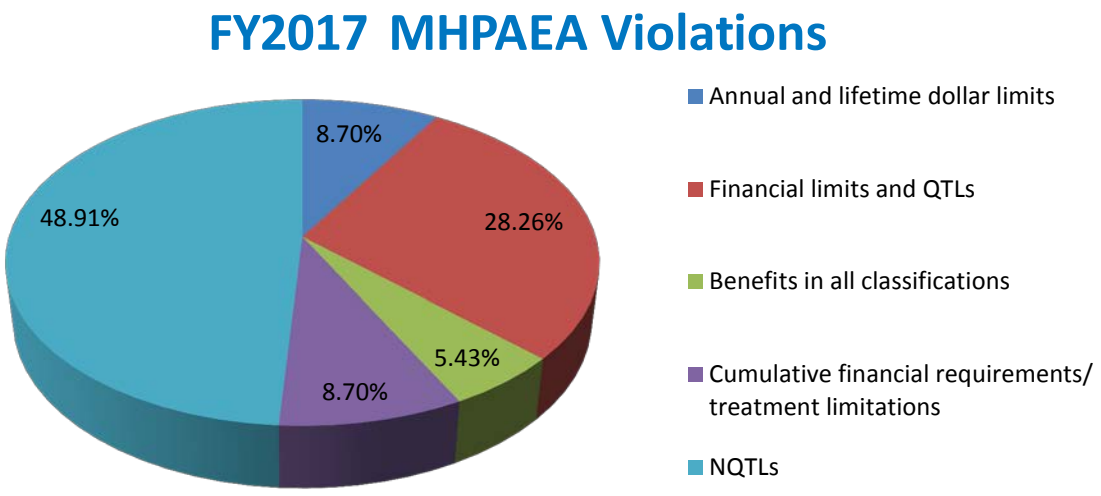
ENFORCEMENT OVERVIEW: ENSURING PARITY

The Employee Benefits Security Administration (EBSA) enforces Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA), on 2.2 million private employment-based group health plans, which cover 130.8 million participants and beneficiaries. EBSA relies on its 400 Investigators to review plans for compliance with ERISA, including the Mental Health Parity and Addiction Equity Act (MHPAEA). EBSA also employs 110 Benefits Advisors who provide participant education and compliance 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 FY 2017 enforcement fact sheet summarizes EBSA's activity over the last fiscal year.

FY 2017 Enforcement Fast Facts:

- EBSA closed 347 health investigations in FY 2017 (and 3,286 health investigations since FY 2011).
- Of these 347 closed investigations in FY 2017, 187 involved plans subject to MHPAEA and were, therefore, reviewed for MHPAEA compliance.
- Of these 187 investigations where MHPAEA applied, EBSA cited 92 violations for MHPAEA noncompliance.
- EBSA Benefits Advisors answered over 127 public inquiries in FY 2017 related to MHPAEA (and have answered 1,318 inquiries related to MHPAEA since FY 2011).



[1] *See* EBSA's FY 2015 and 2016 enforcement fact sheets, *available at* https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/fsmhpaeaenforcement.pdf and https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2016.pdf

THE EBSA MHPAEA 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 the participant receive the benefits to which they are entitled. If the inquiry suggests the problem may affect multiple participants and the Benefits Advisor is unable to obtain voluntary compliance, the Benefits Advisor will refer the issue for investigation.

Benefits Advisors obtain results. An ERISA plan participant contacted an EBSA Benefits Advisor for help after the mental health claims for his dependent son were denied based on the grounds that the treatment was not medically necessary. The plan also initially refused to provide its criteria for medical necessity, claiming that it was proprietary. The Benefits Advisor contacted the plan administrator on the participant's behalf, explained how the MHPAEA requirements applied to the plan, and asked that the claims be reviewed. As a result, the plan voluntarily complied and paid $48,000 in claims for intensive outpatient therapy for the participant's dependent son.

Investigating Plans

EBSA conducts MHPAEA compliance reviews, including for compliance with the requirements for quantitative and nonquantitative treatment limitations in all benefit classifications where the plan offers medical/surgical health benefits, in all open cases where MHPAEA applies. Many times, 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 correction. An EBSA Investigator uncovered that a fully-insured plan required continuation of care review after a patient received eight outpatient sessions. As a result of the investigation, the issuer removed the continuation of care review requirement after eight outpatient sessions. Through the discussions between the issuer and EBSA, the issuer also agreed to remove this requirement from all of its products, which affected 22,000 additional plans.

Generally, if violations are found by an EBSA Investigator, the Investigator requires the plan to remove any offending plan provisions and pay any improperly denied benefits. To achieve the greatest impact, Investigators will also seek a global correction, working with the plans' service providers to find improperly denied claims and correct the problem for other 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. These global changes have impacted hundreds of thousands of group health plans and millions of participants.

THIS YEAR IN REVIEW: EXAMPLES OF MHPAEA ENFORCEMENT ACTIONS

- ✓ *Restrictions on Residential Treatment Removed.* The Los Angeles Regional Office uncovered a plan that imposed an impermissible annual day limit on residential treatment for substance use disorders. As a result of this investigation, the plan issued a special notice to all participants notifying them of a 30-calendar day window for submission of claims affected by the previous limitation on their substance use disorder benefits. Four claims, with billed amounts totaling $74,165, were submitted, reprocessed and paid by the plan. The plan also revised its documents to remove the impermissible limitation for future plan years.

- ✓ *More Restrictive Financial Requirements eliminated and participants reimbursed for excessive copayments.* The New York Regional Office reviewed a plan that charged a higher specialist co-payment of $25 for all in-network mental health and substance use disorder outpatient visits while only a $20 copay was charged for all primary care in-network medical/surgical outpatient visits. As a result of this investigation, the plan refunded the $5 difference from 2010 through the 2016 plan years. In total, $11,340 was reimbursed to over 200 participants. The plan has removed the impermissible financial requirement for future years.

- ✓ *Additional Coverage for Mental Health and Substance Use Disorder Treatment.* The Los Angeles Regional Office discovered that a plan failed to provide out-of-network coverage for inpatient and outpatient mental health and substance use disorder benefits. Based on the findings of the investigation, a settlement agreement was executed to achieve correction of multiple plan violations, including these MHPAEA violations. As a result of the investigation, 52 mental health and substance use disorder claims were reprocessed and the plan paid $24,152 in previously denied mental health and substance use disorder benefits. The plan also revised its documents to comply with parity requirements.

- ✓ *Overly Stringent Precertification Requirements Eliminated.* The Dallas Regional Office discovered that a self-funded plan required precertification for *some* outpatient medical/surgical services but required precertification for *all* outpatient psychiatric, chemical dependency, and substance use disorder therapies. EBSA made the plan aware of its responsibilities under MHPAEA. As a result, the plan agreed to remove the impermissible precertification requirement from its plan documents.

- ✓ *Denied Claims Repaid.* A participant had custody and guardianship of his 14-year-old granddaughter, who has multiple mental health issues, including Post Traumatic Stress Disorder (PTSD). The plan precertified 12 counseling visits for the granddaughter's PTSD and also precertified an outpatient program through the local children's hospital. The plan subsequently denied both the counseling and outpatient hospital claims. The participant timely submitted an appeal, but the plan failed to respond. A Benefits Advisor from EBSA's Cincinnati Regional Office contacted the plan's service provider and the plan sponsor, explained the requirements of the law, and asked that the plan review the claims and the participant's numerous contacts with the service provider about these issues. The service provider determined that there were errors made in the claim administration process and paid approximately $1,700 in claims.

- ✓ *Overly Stringent Benefit Requirements Eliminated.* A fully-insured plan required participants to demonstrate, before he or she could receive in-patient treatment of a mental health condition, that his or her mental illness affected more than one area of daily living to such an extent that he or she was dysfunctional and required the participant to demonstrate that without such inpatient treatment, the participant's condition would deteriorate. There were no similar requirements for medical/surgical treatment. The plan removed these onerous requirements for mental health treatment as a result of the EBSA's enforcement efforts.

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/mental-health- and-addiction-insurance-help/index.html

Contact EBSA

U.S. Department of Labor

www.dol.gov/agencies/ebsa

Telephone: 1-866-444-3272