



# FACTSHEET

## FY 2016 MHPAEA ENFORCEMENT

### ENFORCEMENT OVERVIEW: ENSURING PARITY

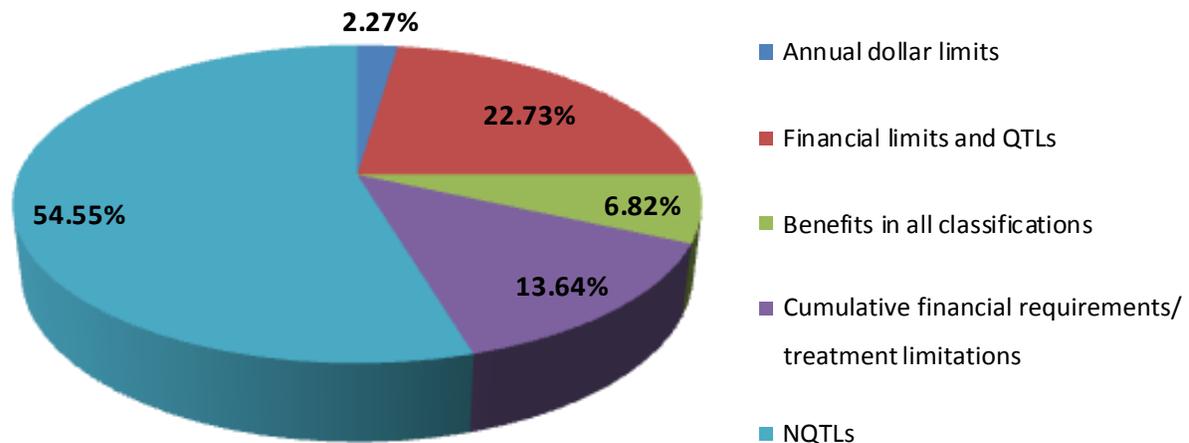
The Employee Benefits Security Administration (EBSA) enforces the law governing 2.2 million private employment-based group health plans, which cover 130.8 million participants and beneficiaries. EBSA relies on its 460 investigators to review plans for compliance with ERISA, including the Mental Health Parity and Addiction Equity Act (MHPAEA). EBSA also employs 110 Benefit 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.<sup>1</sup>

This FY 2016 enforcement fact sheet summarizes EBSA's activity over the last fiscal year.

### FY 2016 Enforcement Fast Facts:

- EBSA closed 330 health investigations in FY 2016 (and 3,100 health investigations since FY 2011).
- Of these 330 closed investigations in FY2016, 191 involved plans subject to MHPAEA and were, therefore, reviewed for MHPAEA compliance.
- Of these 191 investigations where MHPAEA applied, EBSA cited 44 violations for MHPAEA noncompliance.
- EBSA Benefits Advisors answered over 112 public inquiries in FY 2016 related to MHPAEA (and have answered 1,191 inquiries related to MHPAEA since FY 2011).

### FY2016 MHPAEA Violations



<sup>1</sup> See EBSA enforcement fact sheet, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/fsmhpaeafenforcement.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. Benefit Advisors will 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, the Benefit Advisor will refer the issue for investigation.

**Benefit Advisors obtain results.** An individual diagnosed with an eating disorder contacted an EBSA Benefit Advisor for help because her plan refused to cover the residential treatment that she needed. The Benefit Advisor contacted her plan on her behalf, and explained how the MHPAEA requirements applied to the plan. As a result, the individual's mother, who originally paid out-of-pocket, was reimbursed \$2,250 and the plan agreed to cover residential treatment in parity with medical/surgical benefits for other participants in the plan.

### Investigating Plans

EBSA conducts MHPAEA compliance reviews, including for compliance with the requirements for quantitative and nonquantitative treatment limitations in all benefit

**Achieving global correction.** An EBSA Investigator uncovered a fully-insured plan that excluded residential treatment for participants that failed to complete a course of treatment, even though this requirement did not apply in parity to medical benefits. As a result of this investigation, the issuer removed the impermissible language from the plan's documents and from its 2016 Kentucky group business and non-grandfathered small group business contracts - affecting 4,677 insured groups and 106,814 participants in the State of Kentucky.

classifications where the plan offers medical/surgical benefits, in all open cases where MHPAEA applies. Many times, these cases stem from participant complaints received by a Benefit Advisor where the facts suggest the problems are systemic and affect other participants. Generally, if violations are found, 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

- ✓ *Unfair penalties related to mental health and substance use disorder benefits eliminated.* EBSA's San Francisco Regional Office discovered a fully-insured plan that excluded treatment of chronic behavior disorders (any condition lasting more than six months), and required participants to obtain prior authorization for substance use disorder treatment and non-emergency admissions to mental health/substance use disorder treatment facilities. The plan also held the participant responsible for the entire cost of treatment if prior authorization was not obtained. Under the plan, failure to obtain prior authorization for medical/surgical benefits only resulted in a reduction of covered benefits in certain cases - never a full denial. The plan also did not impose any restrictions on medical or surgical benefits on the basis that the underlying condition was 'chronic.' As a result of this investigation, both the restriction on behavioral conditions that last longer than six months and the penalty requiring the participant to pay the entire cost of substance use disorder treatment for failing to obtain preauthorization were removed. The issuer included these changes in its 2016-2017 contract endorsements, affecting 3,489 small and large non-grandfathered groups and 363,122 member participants.
- ✓ *Inequitable Residential Treatment Exclusions Removed.* An investigation by EBSA's Dallas Regional Office revealed a plan that excluded coverage for residential level of treatment for substance use disorders in a substance use disorder treatment center. However, the plan provided benefits for extended care expenses for medical and surgical benefits in similar settings such as a skilled nursing facility and hospice through home health care services. The plan was unable to demonstrate a process that would permit this exclusion to apply only to benefits for substance use disorders. As such, the plan did not provide parity with respect to mental health/substance use disorder benefits. As a result of EBSA's efforts, the service provider revised the exclusion to comply with the parity requirements. Upon further approval from the Texas Department of Insurance and the Centers for Medicare and Medicaid Services, this change will be made to all other Texas insured products and the booklets that contained this provision, including small group and large group PPOs, and HMO groups, have been revised to reflect the change in the exclusion.
- ✓ *Overly Stringent Prior Authorization Requirements Eliminated.* EBSA's Miami District Office determined that a fully-insured plan required participants to obtain prior authorization for all mental health or substance use disorder care and treatment services. Similar restrictions were not imposed on all medical and surgical benefits. As a result of the office's enforcement efforts, as of December 1, 2014, the Plan no longer required prior authorization for mental health or substance use disorder care and treatment services. In addition, the issuer incorporated this change into all its products marketed in the state of Florida, affecting over 100,000 member participants.

- ✓ *Improper Written Treatment Plans Requirements Eliminated.* EBSA's Los Angeles Regional Office encountered a fully-insured plan that imposed the following requirements for mental health and substance use disorder benefits: (1) a written treatment plan prescribed and supervised by a behavioral health provider, (2) follow-up treatment, and (3) a restriction that the written plan should be for a condition that can favorably be changed.

However, no comparable requirements applied to medical and surgical benefits. Due to EBSA's diligence, not only did the issuer agree to remove this impermissible nonquantitative treatment limitation from the plan under investigation, the issuer also agreed to remove the limitation from all group health plans subject to MHPAEA in the state of California, affecting 3,034 large group health plans and 288,947 member participants.

- ✓ *Unnecessary Delays in Treatment Eradicated.* A participant contacted a Benefits Advisor for assistance on behalf of her son, who is covered under her plan. The participant informed the Benefits Advisor that her son has a history of thoughts of self-harm, bipolar disorder, and is developmentally delayed. Although his doctor determined that he required intensive outpatient therapy, none of the in-network medical providers could adequately treat his specific mental health issues. The participant requested that the plan allow her son to be seen by an out-of-network provider. After waiting five days for a response on this urgent issue, the participant reached out to EBSA. The Benefits Advisor contacted the plan's service provider to inquire about the delay in making a determination on the participant's request. The plan determined that her son could see the specified out-of-network provider that was able to provide the intensive treatment needed by the beneficiary.

**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](http://www.dol.gov/agencies/ebsa)

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