EMPLOYEE BENEFITS SECURITY ADMINISTRATION
UNITED STATES DEPARTMENT OF LABOR

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FACT SHEET

FY 2019 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 2.4 million private employment-based group health plans, which cover roughly 135 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]

The Centers for Medicare & Medicaid Services (CMS) enforces MHPAEA and other applicable provisions of Title XXVII of the Public Health Service Act (PHS Act) with respect to non-federal governmental group health plans, such as plans for employees of state and local governments. Sponsors of self-funded, non-federal governmental plans may elect to exempt those plans from (opt out of) certain requirements of Title XXVII of the PHS Act, including MHPAEA.[2] In addition, CMS enforces MHPAEA with respect to health insurance issuers selling products in the individual and fully insured group markets in states that elect not to enforce or fail to substantially enforce MHPAEA. Currently, CMS is responsible for enforcement of MHPAEA with regard to issuers in four states: Missouri, Oklahoma, Texas and Wyoming. In these states, CMS reviews health insurance policy forms of issuers in the individual and group markets for compliance with MHPAEA prior to the products being offered for sale. In addition, CMS has collaborative enforcement agreements with five states: Alabama, Florida, Louisiana, Montana, and Wisconsin. These states perform state regulatory and oversight functions with respect to the federal requirements, including MHPAEA. However, if the state finds a potential violation and is unable to obtain compliance by an issuer, the state will refer the matter to CMS for possible enforcement action. CMS also performs market conduct examinations, where issuers are audited for compliance with applicable federal requirements, including MHPAEA, in states where CMS is responsible for enforcement and in states with a collaborative enforcement agreement when the state requests assistance. In December 2017, CMS published its first MHPAEA enforcement report, summarizing its MHPAEA investigations completed in 2016 and 2017. In March 2019, CMS published its second MHPAEA enforcement report, summarizing MHPAEA investigations completed in FY 2018.[3]

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[1] See EBSA's previous 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, https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2017.pdf, and https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2018.pdf, respectively.

[2] See section 2722(a)(2) of the PHS Act and implementing regulations at 45 CFR 146.180.

[3] See CMS's MHPAEA Enforcement Reports, available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HHS-2008-MHPAEA-Enforcement-Period.pdf and https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/FY2018-MHPAEA-Enforcement-Report.pdf.

This enforcement fact sheet summarizes EBSA's and CMS's closed investigations and public inquiries related to MHPAEA during FY 2019. This Fact Sheet does not report ongoing investigations that were open but not closed during FY 2019. Those cases will be reported in a subsequent fact sheet 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 (such as issuers, third-party administrators, and managed behavioral health organizations).

EBSA investigated MHPAEA violations in the following categories:

(1) ***Annual dollar limits*****:** dollar limitations 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 (such as self-only or family coverage).

(2) ***Aggregate lifetime dollar limits*****:** dollar limitations 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***: requirement that 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.[4]

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

(5) ***Treatment limitations*****:** includes 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 (such as 50 outpatient visits per year), and **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, out-of-pocket maximums and annual or lifetime day or visit limits.

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

[4] 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.

FY 2019 DOL Enforcement Fast Facts:

EBSA Investigations

- EBSA investigated and closed 186 health plan investigations in FY 2019 (and 3,758 health plan investigations since FY 2011). Of these, 71 investigations involved fully-insured plans, 91 investigations involved self-insured plans, and 24 investigations involved plans of both types (the plan or service provider offered both fully-insured and self-insured options).

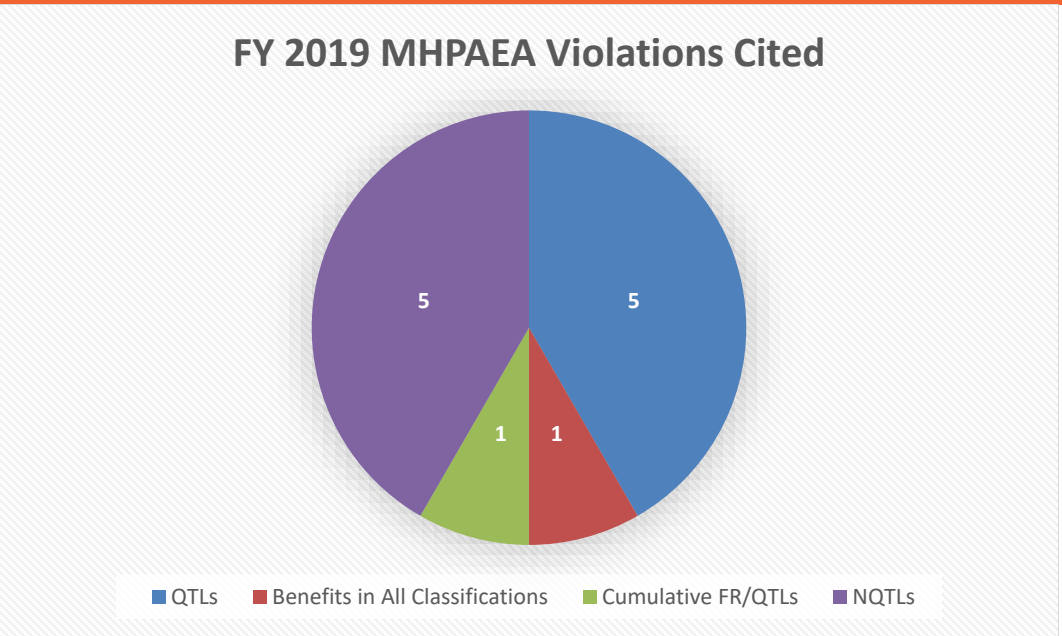
- 183 of these closed investigations involved plans subject to MHPAEA, which were reviewed for MHPAEA compliance. Of these, 68 investigations involved fully-insured plans, 91 investigations involved self-insured plans, and 24 investigations involved plans of both types (the plan or service provider offered both fully-insured and self-insured options).

- EBSA cited 12 MHPAEA violations in 9 of these investigations.

- Of these 9 investigations, 1 investigation involved a fully-insured group health plan, 3 investigations involved self-funded group health plans, 2 investigations involved partially self-funded group health plans and 3 were service provider investigations.

    - As an example of the size and scope of these investigations, in the course of one investigation involving a service provider, the service provider reported providing services to 99 self-insured and 210 fully-insured plans, covering 67,724 participants.

- EBSA benefits advisors answered 90 public inquiries, including 62 complaints, in FY 2019 related to MHPAEA (and answered 1,445 inquiries related to MHPAEA since FY 2011).



FY 2019 CMS Enforcement Fast Facts:

CMS Investigations

- CMS received 259 complaints in FY 2019 related to MHPAEA.
- Of those, 198 complaints were referred to the appropriate federal and state agency with jurisdiction to investigate the complaint. This included referring 43 complaints to EBSA, 94 complaints to CMS's Center for Medicaid and CHIP Services (CMCS) and Center for Consumer Information and Insurance Oversight (CCIIO), and 61 complaints to state insurance regulators.
- 61 of the 259 complaints were resolved directly by caseworkers within CCIIO.
- In FY 2019, CMS/CCIIO closed 2 self-funded non-federal governmental plan investigations related to MHPAEA. No MHPAEA violations were found as a result of the investigations.

THE EBSA 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.

The dependent's mother contacted EBSA. Her child was in need of treatment for addiction and was required to seek care in an inpatient setting for six weeks. The dependent's mother paid for the treatment out-of-pocket and then sought reimbursement from her group health plan. The plan had approved the first 3 weeks of coverage but denied reimbursement for the remainder of the inpatient stay. Additionally, while the plan approved the first 3 weeks of the inpatient stay, the dependent's mother had not received reimbursement months after receiving that approval.

The benefits advisor contacted the plan and inquired about the delay in reimbursement and the denial of the remainder of the inpatient stay. After the benefits advisor's intervention, the plan reimbursed the mother $34,000 in incurred claims for the first three weeks of the stay, and advised the mother of her appeal rights regarding the remainder of the stay.

Investigating Plans

EBSA conducts MHPAEA compliance reviews, including for compliance with the requirements for QTLs and NQTLs, in all open cases where MHPAEA applies to private employment-based group health plans. Cases may stem from participant complaints received by a benefits advisor, where the facts suggest the problems are systemic and may adversely impact other participants and beneficiaries.

Referring for Investigation.

A participant contacted EBSA for assistance because her group health plan refused to cover dietary counseling for treatment of her eating disorder. The participant was concerned that the plan's handling of her claims for dietary counseling was in violation of the MHPAEA. After collecting and reviewing the relevant documentation, the benefits advisor determined that there was a potential violation of MHPAEA's NQTL requirements. Therefore, the benefits advisor referred the matter for formal investigation by EBSA.

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 and beneficiaries.

FY 2019 IN REVIEW: EXAMPLES OF ENFORCEMENT ACTIONS AFFECTING MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

- ✓ *Annual visit limits for mental health and substance use disorder treatment eliminated.* The EBSA Cincinnati Regional Office investigated a multiple employer welfare arrangement (MEWA), which 500 schools relied upon to sponsor group health plans for their employees. Certain groups covered under the MEWA had more than 50 full-time employees and did not qualify for the small-employer exemption to MHPAEA. However, these plans imposed an annual office visit limit on benefits for alcohol and chemical abuse, in violation of MHPAEA, as they imposed cumulative treatment limitations that applied only to substance use disorder benefits. In response to the investigation, the plans removed the improper visit limits, and the Cincinnati Regional Office conducted a claims review to identify participants affected by the annual visit limit. The Regional Office ensured that the MEWA reprocessed and paid claims for substance use disorder treatment that had been improperly denied due to the impermissible visit limit.

- ✓ *Restrictive financial requirements eliminated and participants reimbursed for excessive cost-sharing amounts.* The EBSA Seattle District Office investigated an industry trade association trust that offered three different self-funded options and one fully-insured option covering over 1,900 participants. The investigation revealed that one of the self-funded options applied disparate cost sharing requirements for medical/surgical visits as compared to mental health and substance use disorder visits that did not comply with the standards for financial requirements under MHPAEA. Specifically, a $35 copayment was applied for the first three medical/surgical office visits after which 30% coinsurance was applied for subsequent visits for the remainder of the year, while all mental health and substance use disorder office visits were charged the 30% coinsurance for the entire year. As a result of the investigation, claims were readjudicated and excessive mental health and substance use disorder cost-sharing payments totaling $1,559 were reimbursed to 11 affected plan participants. In addition, the plan trustees changed the financial requirements to comply with the MHPAEA regulations.

- ✓ *Restrictive visit limits for outpatient mental health and substance use disorder treatment eliminated.* The EBSA Kansas City Regional Office (KCRO) reviewed a service provider with multiple self-insured and fully-insured plans. Some of those plans imposed a medical necessity review requirement on outpatient mental health and substance use disorder (MH/SUD) benefits after 30 visits. Although the service provider indicated there was a similar medical necessity review requirement for comparable medical/surgical benefits, KCRO discovered that the plans permitted 52 such visits before requiring any additional medical necessity review of medical/surgical benefits. Additionally, the service provider was unable to show that it applied comparable factors in establishing the two requirements. As a result of the investigation, the number of MH/SUD office visits allowed before the plan would conduct a medical necessity review was increased to 52 per 12-month period prior to conducting an independent medical review, utilizing standards parallel for medical/surgical benefits. Additionally, 198 claims were readjudicated for nine different plans, and the plan service provider issued payments totaling $19,744 to 29 participants.

- ✓ *Limits for drug screening related to substance use disorder treatment removed.* The KCRO investigation also revealed that under internal policies and procedures of the service provider, drug screening tests, only for individuals who had been diagnosed with a substance use disorder, were deemed not medically necessary and therefore not an eligible expense. The service provider was unable to establish that comparable processes, strategies, evidentiary standards and other factors were used to apply the NQTL to medical/surgical benefits. As a result of this investigation, the service provider amended its manual to allow drug-screening claims with a diagnosis of addiction and conducted a national training for its claims reviewers on the new requirements. A review of drug screening claims resulted in a readjudication of claims for 12 plans and payments totaling $146,278 issued to 32 plan participants.

- ✓ *Network adequacy concerns investigated.* CMS investigated a complaint that a self-funded non-federal governmental plan for state employees lacked an adequate provider network for mental health services. CMS conducted a MHPAEA investigation of the plan for compliance with requirements for financial requirements and quantitative treatment limitations in the following classifications: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; and emergency care. In addition, CMS reviewed information related to NQTLs imposed under the plan, such as precertification standards, utilization review policies, and medical necessity definitions, as well as the plan's processes, strategies, evidentiary standards, and other factors related to provider admission to participate in the network. CMS did not find any MHPAEA violations with respect to network adequacy and other NQTLs, financial requirements or quantitative treatment limitations.

- ✓ *Parity in coverage of residential treatment investigated.* CMS investigated a consumer complaint that a school district's self-funded non-federal governmental plan denied coverage of residential mental health treatment at an out-of-state facility. CMS conducted a MHPAEA investigation of the plan for compliance with requirements for NQTLs in the following classifications: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; and outpatient, out-of-network. Specifically, the investigation included a review of the plan's handling of residential treatment claims; plan documents that notified members of residential treatment center (RTC) benefits; documented policies, procedures, and guidelines specific to RTC benefits, including claims guidelines, prior authorization and other utilization review/management policies, procedures, and guidelines; and all paid and denied RTC claims over a four-year period. Furthermore, CMS conducted a targeted MHPAEA investigation that included a review of the plan's outpatient, out-of-network prior authorization policies and clinical review process for medical/surgical and mental health and substance use disorder benefits; an explanation of the plan's processes, strategies, evidentiary standards, or other factors used to apply NQTLs to outpatient, out-of-network benefits; clarification of how step therapy was applied to mental health and substance use disorder benefits; materials related to network credentialing; a list of outpatient services that are nonstandard and subject to review; copies of all written medical management standards; and medical policy guidelines, including case management standards and guidelines applicable to medical/surgical inpatient length of stay. Upon careful review of all submitted information, CMS found no parity violations in the plan.

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

U.S. Department of Labor

askebsa.dol.gov

Telephone: 1-866-444-3272