



FACT SHEET

FY 2022 MHPAEA ENFORCEMENT

ENFORCEMENT OVERVIEW: ENSURING PARITY

The Mental Health Parity and Addiction Equity Act (MHPAEA) was signed into law in 2008 to limit financial requirements and treatment limitations on benefits for mental health conditions and substance use disorders as compared to medical/surgical benefits. These protections are vital for America's workers, health insurance consumers, and their families. The Employee Benefits Security Administration (EBSA) and the Centers for Medicare & Medicaid Services (CMS) are responsible for enforcing MHPAEA, together with the states. This enforcement fact sheet summarizes EBSA's and CMS's closed investigations and public inquiries related to MHPAEA during fiscal year (FY) 2022 to better inform the public of EBSA's and CMS's enforcement of MHPAEA.¹

EBSA enforces Title I of the Employee Retirement Income Security Act (ERISA) for 2.5 million private employment-based group health plans, which cover 133 million participants and beneficiaries. EBSA relies on its approximately 326 investigators to review all pension and welfare benefit plans for compliance with ERISA, including the group health plan provisions added by MHPAEA. EBSA also employs approximately 113 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.

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.^{2, 3} CMS also enforces applicable provisions of Title XXVII of the PHS Act, including the provisions added by MHPAEA for 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 or another PHS Act provision.^{4, 5} CMS oversees approximately 90,000 non-federal governmental group health plans, and 41 health insurance issuers in states where CMS is responsible for MHPAEA enforcement. CMS currently has 15 investigators who review plans and issuers for compliance with MHPAEA and other applicable PHS Act provisions. CMS also performs market conduct examinations in states where CMS is responsible for enforcement and in states with a collaborative enforcement agreement when the state requests assistance.

EBSA has released annual MHPAEA enforcement fact sheets, summarizing its enforcement activities in

¹ See also section 13003 of the 21st Century Cures Act, as amended by section 7182 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act).

² CMS is responsible for enforcement of applicable PHS Act provisions with respect to non-federal governmental group health plans in all 50 states, the territories, and the District of Columbia. See section 2723(b)(1)(B) of the PHS Act.

³ For FY 2022, sponsors of self-insured non-federal governmental group health plans could elect to exempt those plans from (opt out of) certain requirements of Title XXVII of the PHS Act, including MHPAEA. See former section 2722(a)(2) of the PHS Act and implementing regulations at 45 CFR 146.180. The Consolidated Appropriations Act, 2023 amended section 2722(a)(2) of the PHS Act such that sponsors of self-insured non-federal governmental group health plans generally cannot opt out of MHPAEA, effective December 29, 2022.

⁴ See section 2723(a)(2) and (b)(1)(A) of the PHS Act.

⁵ In FY 2022, CMS was responsible for enforcement of MHPAEA with regard to issuers in Missouri, Texas, and Wyoming. In addition, CMS had collaborative enforcement agreements with Alabama, Florida, Louisiana, Montana, Oklahoma, and Wisconsin. These states with collaborative enforcement agreements with CMS perform state regulatory and oversight functions with respect to some or all of the applicable provisions of Title XXVII of the PHS Act, 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.

each FY, since FY 2015.⁶ CMS has released annual MHPAEA enforcement reports and fact sheets summarizing its enforcement activities since 2016.⁷

This enforcement fact sheet does not report ongoing investigations, including those that were opened but not closed during FY 2022. These cases will be reported for the FY in which these cases are closed. It is not uncommon for complex MHPAEA investigations to take multiple years, especially those that involve large service providers (such as issuers, third-party administrators, and managed behavioral health organizations).

During FY 2022, in response to requirements imposed on plans and issuers by the Consolidated Appropriations Act, 2021 (CAA),⁸ EBSA and CMS significantly increased their nonquantitative treatment limitation (NQTL) enforcement activity. However, this fact sheet does not fully capture results from EBSA's and CMS's increased activity because many of these investigations were ongoing at the end of FY 2022.

A summary of EBSA's and CMS's CAA-related MHPAEA enforcement activities and related results are detailed in the 2022 MHPAEA Report to Congress⁹ and the MHPAEA Comparative Analysis Report to Congress, July 2023.¹⁰ If EBSA or CMS cited a MHPAEA NQTL violation, including violations of the CAA's comparative analysis requirements, and the investigation was closed during FY 2022, the results of those investigations and any corrective actions are also captured in this fact sheet.

In FY 2022, EBSA and CMS 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
- (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 regulations, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided¹¹
- (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 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

⁶ See EBSA's previous MHPAEA Enforcement Fact Sheets, available at www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity, under "Related Information."

⁷ See CMS's previous MHPAEA Enforcement Reports and Fact Sheets, available at www.cms.gov/ccio/Resources/Forms-Reports-and-Other-Resources/index#mental-health-parity.

⁸ Section 203 of Title II of Division BB of the CAA.

⁹ See 2022 MHPAEA Report to Congress: Realizing Parity, Reducing Stigma, and Raising Awareness, available at www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.

¹⁰ See MHPAEA Comparative Analysis Report to Congress, July 2023, available at www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis.pdf.

¹¹ 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.

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. CMS also investigated other potential PHS Act violations (such as non-discrimination and disclosure violations) affecting these benefits. Examples of corrections that result from these non-MHPAEA investigations that impact mental health and substance use disorder benefits are also included in the FY 2022 in Review section below.

FY 2022 Enforcement Fast Facts:

EBSA Investigations

- EBSA investigated and closed 145 health plan investigations in FY 2022. Of these investigations, 58 involved fully-insured plans, 65 involved self-insured plans, and 22 involved plans of both types (the plan or service provider offered both fully insured and self-insured options). EBSA has closed 4,231 health plan investigations since FY 2011.
- Of the 145 closed investigations in FY 2022, 86 involved plans subject to MHPAEA. Twenty of these investigations involved fully-insured plans, 50 involved self-insured plans, and 16 involved plans of both types.
- EBSA cited 18 MHPAEA violations in 11 investigations. One of these investigations involved a fully-insured plan, and 10 involved self-insured plans. The violations included
 - 3 annual/lifetime limits,
 - 2 financial requirements,
 - 2 QTLs,
 - 10 NQTLs, and
 - 1 final determination of noncompliance with the NQTL comparative analysis requirements in a closed investigation.
- EBSA investigations focused on MHPAEA compliance are generally complex, resource-intensive, and often involve specialized interdisciplinary teams and expert consultations. EBSA strives to broadly ensure compliance and is committed to rigorous enforcement with an emphasis on high-impact cases.
- EBSA benefits advisors answered 160 MHPAEA-related public inquiries, including 142 complaints, in FY 2022. They have answered 1,729 MHPAEA-related inquiries since FY 2011.

CMS Investigations

- In FY 2022, CMS received 5 MHPAEA-related complaints, which were resolved by caseworkers within the Center for Consumer Information and Insurance Oversight (CCIIO).
- In FY 2022, CMS closed 4 self-insured non-federal governmental group health plan MHPAEA investigations and 9 MHPAEA NQTL comparative analysis reviews of non-federal governmental group health plans and health insurance issuers in states where CMS is responsible for MHPAEA enforcement.
- CMS cited 7 MHPAEA violations as a result of the NQTL comparative analysis reviews required by the CAA.

THE EBSA ENFORCEMENT PROCESS

Assisting Participants

EBSA receives inquiries from participants who believe their mental health or substance use disorder benefits have been improperly denied. 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.

Investigating Plans

EBSA conducts MHPAEA compliance reviews, including reviews of QTLs and NQTLs, in all open cases in which MHPAEA applies. Cases may stem from participant complaints to an EBSA benefits advisor or from other sources. States are invaluable partners in increasing access to treatment for mental health and substance use disorders, as they are primary regulators of insurance and overseers of public health. EBSA regularly partners with states in its MHPAEA implementation and enforcement activities.

Benefits Advisors Obtain Results

A plan participant contacted a benefits advisor in EBSA's Chicago Regional Office regarding a prescription drug provision in their plan that limited coverage of attention-deficit hyperactivity disorder and narcolepsy drugs to participants and beneficiaries under the age of 26. When the EBSA benefits advisor contacted the plan to ask about the limitation, the plan removed it, which impacted 76 plan participants. The benefits advisor also referred the matter to EBSA enforcement staff for investigation.

Referring for Investigation

A member of a multiemployer plan contacted a benefits advisor in EBSA's Philadelphia Regional Office because his plan offered mental health coverage to dependents that was not in parity with coverage for employees. While he had coverage for himself and his family, there were restrictions on the dependents' coverage. After reviewing the plan's Summary Plan Description, the benefits advisor referred the matter for enforcement, and EBSA opened a case.

Generally, if an EBSA investigator finds violations, the investigator recommends the plan remove any non-compliant plan provisions and pay any improperly denied benefits. To achieve the greatest impact, EBSA investigators work with the plans' service providers (such as third-party administrators or managed behavioral health organizations) to obtain broad corrections, not only for the particular plans investigated, but also for other plans that contract with those service providers. EBSA investigators have worked with several large issuers to remove unlawful barriers to mental health benefits, such as overly restrictive requirements for written treatment plans or preauthorization 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.

THE CMS ENFORCEMENT PROCESS

Providing Technical Assistance

CMS receives inquiries from states, plans, issuers, and others regarding compliance with MHPAEA. CMS's state engagement coordinators and MHPAEA subject matter experts work with interested parties to help ensure consumers receive the mental health and substance use disorder benefits to which they are entitled. State engagement coordinators are the initial point of contact for states to receive technical assistance, and MHPAEA subject matter experts can answer specific questions for plans and issuers. In 2022, consumers were also able to directly submit MHPAEA complaints through the No Surprises Help Desk.¹²

Investigating Plans and Issuers

CMS conducts MHPAEA enforcement in several ways.

Document Review

For issuers offering coverage in the group or individual market in states that elect not to enforce or do not substantially enforce MHPAEA (direct enforcement states),¹³ CMS reviews issuers' plan documents before the products are offered for sale.

Investigations and Market Conduct Examinations

In states where CMS is responsible for enforcement of MHPAEA, CMS investigates complaints about plan and issuer compliance with MHPAEA. In these states, CMS also performs market conduct examinations in which plans and issuers are audited for compliance with MHPAEA, as appropriate.

Comparative Analysis Reviews

Following the enactment of the CAA, CMS reviews NQTL comparative analyses of issuers in direct enforcement states and non-federal governmental group health plans in all states.

Collaboration with States

Some states have entered into collaborative enforcement agreements with CMS.¹⁴ In these states, the state attempts to obtain voluntary compliance from the issuer to correct any MHPAEA compliance concerns. If the state is unable to obtain voluntary compliance, the state will refer the matter to CMS for possible enforcement.

Generally, if a CMS examiner finds MHPAEA violations, the examiner works with the issuer or non-federal governmental group health plan sponsor to identify and take corrective actions to address the areas of non-compliance. In addition, when appropriate, CMS requires the issuer or plan sponsor to complete a self-audit of claims that may have been affected. The issuer or plan sponsor is instructed to report the findings of the self-

CMS Collaborates with State Regulators

CMS continues to work closely with state regulators, both on an individual basis and through the National Association of Insurance Commissioners, to help ensure understanding of federal requirements and provide technical assistance. These efforts to collaborate with states can lead to tremendous results. For example, CMS successfully transitioned MHPAEA enforcement responsibility to the state of Oklahoma in FY 2022.

¹² The No Surprises Help Desk is available at 1-800-985-3059 or via webform available at www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.

¹³ In FY 2022, CMS was the direct enforcer of MHPAEA with regard to issuers in Missouri, Texas, and Wyoming.

¹⁴ See supra note 5.

audit to CMS and re-adjudicate any improperly denied claims. To achieve the greatest impact, CMS also directs these issuers and plan sponsors to review other plans in their portfolio to identify similar situations and obtain broad corrections.

FY 2022 IN REVIEW: EXAMPLES OF EBSA AND CMS ACTIONS PROTECTING MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

EBSA Actions

- ✓ *Reprocessing of improperly denied drug testing claims and adoption of operational drug testing policies and procedures.* During a plan-level investigation, EBSA's Kansas City Regional Office found a service provider had failed to follow certain of the plan document's substance use disorder benefits provisions. The office conducted an investigation at the service-provider level to determine whether the issue was systemic across all of the service provider's clients. This investigation caused the service provider to reprocess thousands of claims, resulting in \$1,006,857 in additional claim payments, impacting 533 participants across 30 plans. It also resulted in \$927,755 in network savings, which impacted 145 participants across 22 plans. Although this issue did not involve a MHPAEA violation, this correction directly impacted participants receiving substance use disorder treatment.
- ✓ *Elimination of impermissible preauthorization requirements and payment of improperly denied claims.* EBSA's Atlanta Regional Office investigated a service provider that provided administrative services to 97 ERISA-covered self-insured group health plans. Investigators found that several of these plans contained blanket preauthorization requirements for all outpatient mental health and substance use disorder benefits but contained preauthorization requirements for only some outpatient medical/surgical benefits. The investigation led to the blanket preauthorization requirement being eliminated and replaced with a limited list of outpatient mental health and substance use disorder benefits requiring preauthorization. This change affected 97 plans and 319,458 participants. The service provider also reprocessed 126 improperly denied claims, resulting in \$44,277 in additional claim payments.
- ✓ *Elimination of impermissible preauthorization requirements and obtaining coverage for residential treatment and treatment of chronic conditions found to have achieved the maximum therapeutic benefit.* EBSA's Philadelphia Regional Office investigated a self-insured multiemployer plan and found multiple MHPAEA violations. The plan imposed a preauthorization requirement for mental health benefits and substance use disorder benefits but imposed no comparable preauthorization requirement on medical/surgical benefits. It excluded coverage for all residential treatment for mental health and substance use disorders, while containing no comparable exclusion for medical/surgical care in the relevant classifications. Finally, the plan also excluded coverage for treatment of chronic mental health or substance use disorder conditions found to have achieved the maximum therapeutic benefit but did not find a comparable exclusion for medical/surgical benefits. As a result of the investigation, the plan made amendments eliminating the impermissible preauthorization requirements and the exclusions, affecting all 2,954 participants.
- ✓ *Obtained coverage for nutritional counseling.* EBSA's Boston Regional Office investigated a self-insured single employer plan and discovered that the plan limited coverage of nutritional counseling to three visits

per calendar year. The plan carved out an exception to this limitation for the treatment of diabetes (a medical/surgical condition) but included no carve out for any mental health or substance use disorder benefits. In response to the investigation, the plan was amended to state that the three-visit limitation did not apply to the treatment of any mental or behavioral health diagnoses (including eating disorders), and all 300 affected participants were notified of the change.

- ✓ *Reimbursement of excessive cost sharing based on impermissible financial requirement.* EBSA's Philadelphia Regional Office investigators found that a plan imposed a higher copay for outpatient, in-network mental health and substance use disorder benefits than the predominant copay applied to substantially all medical/surgical benefits in that same benefit classification. The investigation resulted in the plan issuing reimbursements to those charged an impermissibly high copay, totaling \$5,488 to 29 plan participants and ensured compliance going forward.
- ✓ *Higher copays reduced.* EBSA's New York Regional Office determined that a plan's financial requirements were not in compliance with MHPAEA. The plan placed improper financial requirements on in-network, outpatient mental health and substance use disorder benefits when compared to in-network, outpatient medical/surgical benefits, and participants were paying impermissibly high copays. As a result of the investigation, claims spanning a 4-year period were re-adjudicated and adjusted, recovering \$1,160 for 37 affected participants.
- ✓ *Access to Applied Behavior Analysis (ABA) therapy obtained.* EBSA's Los Angeles Regional Office determined that a self-insured plan violated MHPAEA as it contained an impermissible separate treatment limitation for applied ABA therapy, a primary treatment for autism. Upon review of denied or outstanding ABA therapy claims, EBSA discovered an additional requirement of a treatment plan prior to the therapy. As a result of EBSA's investigation, the plan sponsor removed the ABA therapy exclusion from the plan, affecting 1,229 participants. The plan also removed the treatment plan requirement, and three claims were re-adjudicated, recovering \$182.
- ✓ *Reimbursement rates recalculated.* A state insurance commissioner referred a participant to EBSA because the participant's health plan was self-insured. The participant sought outpatient mental health care from an out-of-network provider. The plan informed her that the reimbursement rate for these behavioral health visits would be \$195/visit. When the plan processed the claims, the reimbursement rate was \$143/visit. Also, the plan sent payment to the provider, but the payment should have been sent to the participant to reimburse her for services she paid for in-full out-of-pocket. The EBSA benefits advisor contacted the plan to inquire into the discrepancy in the quoted reimbursement rate and assisted in getting the payments sent to the participant. The reimbursement rate was corrected so that the plan paid an additional \$2,756 on the claims.
- ✓ *ABA therapy claims corrected.* A state insurance commissioner referred a participant to EBSA because the participant's health plan was self-insured. The participant complained that the plan was not properly reimbursing out-of-network claims for ABA therapy. The EBSA benefits advisor contacted the plan for a review and explanation of the claims processing. After the benefits advisor's intervention, the plan paid an additional \$1,879 on the claims.

CMS Actions

- ✓ *Identification of impermissible “full continuum of care” requirements for mental health and substance use disorder benefits.* During an NQTL investigation, a non-federal governmental group health plan was found to have an impermissible separate treatment limitation for mental health and substance use disorder benefits coverage, as it required the treating facility to certify that the patient completed the “full continuum of care necessary and available at that facility.” If the patient did not fulfill that requirement, then the plan would not provide coverage of the mental health and substance use disorder benefit. There was no similar requirement applied to medical/surgical benefits in the classification. The plan completed a self-audit to identify claims impacted by the impermissible separate treatment limitation and determined that no claims were denied as a result of the limitation. There was no need to eliminate the NQTL in future plan years as the plan was terminated.
- ✓ *Removal of MH/SUD progress and improvement requirements.* An NQTL investigation revealed impermissible separate treatment limitations in the form of continued-stay criteria for mental health and substance use disorder benefits requiring evident progress for continued care coverage. The investigation also revealed discharge criteria for mental health and substance use disorder benefits resulting in loss of coverage if no significant improvement in condition occurred or if the member left against medical advice. There were no similar criteria applied to medical/surgical benefits in the same benefit classification. The issuer revised its continued stay and discharge criteria and provided supporting documentation to show that these limitations on mental health and substance use disorder benefits were removed. In addition, the issuer completed a self-audit to identify and re-adjudicate wrongly denied claims. The issuer did not identify any wrongly denied claims. Finally, the issuer revised external facing websites to remove references to the treatment progress and improvement criteria for mental health and substance use disorder benefits.
- ✓ *Updated provider network participation standards.* In its NQTL comparative analysis, an issuer provided information about distance and time standards used to determine sufficient network access and availability of inpatient facilities. This network access and availability information was one factor used to determine standards for provider admission to their network. The NQTL investigation revealed the issuer used distance and time standards that were not comparable for medical/surgical and mental health and substance use disorder inpatient facilities. As a result of the investigation, the issuer updated its distance and time standards for mental health and substance use disorder provider types to be in parity with the distance and time standards for medical/surgical provider types.

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

Contact EBSA

U.S. Department of Labor

askebsa.dol.gov

Telephone: 1-866-444-3272

Contact CMS

U.S. Department of Health and
Human Services

www.cms.gov/nosurprises/consumers/complaints-about-medical-billing

Telephone: 1-800-985-3059