

**2020 Report to Congress**

**Secretary Eugene Scalia**

**U.S. Department of Labor**

# **Parity Partnerships: Working Together**



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## **PREFACE**

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires the Secretary of Labor to submit a report to the appropriate committees of Congress on compliance of group health plans (and health insurance coverage offered in connection with such plans) with MHPAEA's requirements. The first such Report was due by January 2012, and additional Reports have been delivered every two years since.

The Department of Labor's (Department) 2012 and 2014 Reports to Congress provided an overview of interim final rules, final rules, and related guidance that implement MHPAEA. The 2012 and 2014 Reports also described the Department's general strategy of working with plans, issuers, consumers, providers, states, and other stakeholders to help the regulated community comply with the law and help families and individuals understand the law and benefit from it, as Congress intended.<sup>1</sup>

In addition to summarizing recent guidance issued by the Department, the 2016 Report to Congress detailed the Department's significant enforcement efforts and provided numerous examples of situations where the Department was able to intervene on behalf of participants and beneficiaries to ensure that they received coverage for the health care to which they were entitled. The Department's 2018 Report to Congress supplemented the 2016 submission by further highlighting the Department's continued parity implementation efforts. It also outlined the Department's strategy for continuing to identify and correct MHPAEA noncompliance and minimize the likelihood of future violations through effective outreach, compliance assistance, and interpretive guidance.

This Report summarizes the Department's activities to further parity implementation since the 2018 Report to Congress. Most notably, the Report provides an overview of the Department's partnership efforts across the Administration, as well as with plans, issuers, consumers, providers, states, and other stakeholders. The Report details the Department's intent to use the information gathered from these partnerships to develop a roadmap to compliance for the regulated community so that health plan participants and beneficiaries are able to realize the full benefits of MHPAEA.

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<sup>1</sup> The Department's previous Reports to Congress are available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

## I. INTRODUCTION

Millions of Americans are affected by mental illness and suffer from substance use disorders. In 2018, 47.6 million people (or 1 in every 5 adults) experienced a mental illness.<sup>2</sup> Approximately 20.3 million people aged 12 or older had a substance use disorder, including 14.8 million people with an alcohol use disorder and 8.1 million people with an illicit drug use disorder. Approximately 2.0 million of these struggled with an opioid use disorder.<sup>3</sup> While these are staggering figures, they do not account for millions more who are affected, such as family members.

While so many Americans are affected by mental illness, less than half receive the treatment they need.<sup>4</sup> Even when individuals can access care, life-saving treatment too often is not covered by their health plans. In 2016, while large employers covered \$2.3 billion in addiction and overdose services, patients paid approximately \$335 million out-of-pocket.<sup>5</sup>

The data demonstrate the magnitude of the problem individuals face in their attempts to access behavioral health and substance use treatment. This is a national concern. Within the Department, and across government, agencies have been evaluating what can be done to combat this crisis. For example, the Department's Office of Workers' Compensation Programs has dedicated significant resources to stem the abuse, misuse, and proliferation of opioids to protect 2.7 million federal workers from harmful opioid prescription practices. The Centers for Disease Control and Prevention promotes a public health approach to combating the opioid overdose epidemic and has dedicated \$475 million for opioid overdose prevention surveillance activities, with the majority of these funds supporting state-based prevention efforts.<sup>6</sup>

The Administration has worked to identify ways to streamline and coordinate efforts to increase access to treatment. Most notably, in 2017, President Trump signed an executive order establishing a Commission on Combating Drug Addiction and the Opioid Crisis (the Opioid Commission). The Opioid Commission's mission is to study the scope and effectiveness of the federal response to drug addiction and the opioid crisis and to make recommendations to the President for improving that response.

In addition, several legislative actions have focused on fostering a concerted national response to increasing access to mental health and substance use treatment. The 21st Century Cures Act (the Cures Act) authorized an Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) to enhance coordination across federal agencies to improve service access and

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<sup>2</sup> See *Key Substance Use and Mental Health Indicators in the United States*, available at <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf>.

<sup>3</sup> *Id.*

<sup>4</sup> In 2018, approximately 43.3 percent of adults with mental illness received treatment. See <https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers>.

<sup>5</sup> See *Peterson-KFF Health System Tracker A look at how the opioid crisis has affected people with employer coverage*, available at <https://www.healthsystemtracker.org/brief/a-look-at-how-the-opioid-crisis-has-affected-people-with-employer-coverage/>.

<sup>6</sup> See *CDC's Response to the Opioid Overdose Epidemic*, available at <https://www.cdc.gov/opioids/strategy.html>.

delivery of care for people with serious mental illness. The Department has been an active ISMICC participant since the committee's inception.

The Department's Employee Benefits Security Administration (EBSA) has worked hard to support this national response within the limits of its statutory authority. In particular, EBSA has primary enforcement jurisdiction over MHPAEA for approximately 2.4 million group health plans covering roughly 135 million Americans. EBSA shares interpretive jurisdiction of MHPAEA with the Departments of Health and Human Services (HHS) and the Treasury (collectively, the Departments). MHPAEA promotes access to treatment for mental illness and substance use disorders by eliminating discriminatory coverage restrictions on that treatment as compared to other medical treatments, including higher copayments, separate deductibles, and stricter preauthorization or medical necessity reviews.

EBSA's work on a national parity implementation strategy has paid close attention to recommendations of the President's Opioid Commission, in addition to the Congressional directives expressed through the Cures Act. In its Final Report, the Opioid Commission cited stakeholders' emphasis of the need for systematic monitoring and enforcement of MHPAEA. The Final Report also highlighted the need for federal and state regulators to coordinate more closely on the enforcement of MHPAEA. In the Cures Act, Congress directed the Department, along with HHS and the Treasury, to issue guidance to further implement MHPAEA, with input from stakeholders. The Cures Act also directed HHS to convene a public meeting of stakeholders to gather feedback regarding ways to improve federal and state coordination in connection with the enforcement of MHPAEA. The Cures Act was later amended by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the SUPPORT Act). Among other things, the SUPPORT Act requires additional reporting on the Department's MHPAEA enforcement activities as well as coordination efforts with state regulators.

In response to these directives, the Department has given special attention to strengthening the national parity implementation and enforcement framework through partnerships with states and other regulators. EBSA has worked particularly closely with state regulators and the National Association of Insurance Commissioners (NAIC) to facilitate uniform implementation and enforcement of MHPAEA. EBSA has also engaged in an ongoing dialogue with plans, issuers, consumers, providers and other stakeholders to identify the challenges to realizing full compliance so that individuals can receive the benefit of mental health parity, as Congress intended.

Because of these partnerships, EBSA expects that its parity implementation and enforcement efforts are better informed and will have a lasting national impact. Specifically, EBSA is employing the information acquired through these partnerships to develop a roadmap for compliance to empower the regulated community to fulfill its obligation under the law. As the primary enforcement agency for private employer-sponsored group health plans, EBSA is also continuing to shift its enforcement posture to target investigations that have a national impact for the greatest number of health plan participants and beneficiaries.

## **II. EBSA's MHPAEA IMPLEMENTATION AND ENFORCEMENT EFFORTS**

EBSA continues to maintain and refine its active outreach, compliance assistance, and enforcement programs. As part of its commitment to implement MHPAEA, the Department continues to employ all applicable authority to foster compliance with the statute's requirements. Through investigations of employment-based plans, regulations, and guidance, and through outreach and education, the Department strives to ensure that coverage offered for mental health and substance use disorder (MH/SUD) treatment is comparable with that offered for other medical care. The Department believes these enforcement and compliance efforts are crucial to improving coverage of mental health conditions and substance use disorders in employment-based group health plans, and to help address the tragic losses caused by untreated conditions.

### **A. Enforcement Efforts**

EBSA has approximately 400 investigators and 100 benefits advisors to oversee over 5 million health, pension, and other employee benefit plans (such as those providing life or disability insurance). These plans cover about 150 million workers and their dependents and include assets of over \$10 trillion. That equates to less than one investigator for every 12,500 plans. In light of its small size relative to its jurisdiction, EBSA has developed an enforcement strategy that leverages its resources to achieve the greatest impact.

#### *1. Parity Enforcement Strategy*

While EBSA investigators in its 10 regional offices are trained to conduct a wide variety of complex investigations, vigorous enforcement of MHPAEA has been one of the agency's top enforcement priorities. In addition to investigating referrals from benefits advisors, EBSA pursues investigations based on leads from other enforcement agencies, feedback from consumer groups, and implementation of advanced case development methods that incorporate various sources. Since October 2010, EBSA has conducted approximately 2,000 investigations in which MHPAEA compliance was reviewed, and cited approximately 345 violations that involve MH/SUD benefits. These MHPAEA violations included impermissible annual and lifetime dollar limits, improper financial requirements, quantitative treatment limitations (QTLs) such as higher copayments or lower visit limits than for medical/surgical services, and impermissible nonquantitative treatment limitations (NQTLs), including overly restrictive fail-first policies, prior authorization requirements, and written treatment plan requirements.

EBSA utilizes specialized, interdisciplinary teams to target and evaluate complex MHPAEA compliance issues. To evaluate compliance, EBSA has formed teams consisting of experienced health plan investigators from the various Regional Offices who specialize in medical claims data review and analysis. The teams are supported by the Department's regulatory subject matter experts and economists, as well as attorneys from the Department's Office of the Solicitor. EBSA also coordinates its work with its counterparts at HHS and the Treasury, who share interpretive jurisdiction over MHPAEA, and uses outside experts as needed for further support. These teams have worked together on several ongoing investigations of service providers and the Department intends to report their findings to Congress as these investigations conclude.

Using this specialized and targeted approach, EBSA strives to broadly ensure compliance without compromising its commitment to rigorous enforcement. Specifically, EBSA works with health insurance issuers and other service providers (such as third-party administrators and managed behavioral health organizations) to obtain voluntary global corrections whenever possible in cases where a violation relates to an insurance product, prototype document, or systemic operation affecting multiple group health plans. Additionally, EBSA has jurisdiction to enforce MHPAEA with respect to insurance companies when they serve as administrative services-only providers (ASOs) to self-funded plans covered by the Employee Retirement Income Security Act of 1974 (ERISA). ASOs whose administration policies are not in compliance with MHPAEA can cause many ERISA-covered plans to also be out of compliance. EBSA pursues these cases against the ASOs to achieve widespread compliance and greater impact for participants and beneficiaries. EBSA also cooperates with state departments of insurance and conducts parallel investigations of issuers who act as both insurers and ASOs within the state's jurisdiction.

Overall, this voluntary global correction approach, which focuses on service providers that work with hundreds or thousands of plans, results in fewer MHPAEA case openings than in some previous years, but results in more broad-based compliance. Such investigations can directly improve MHPAEA compliance with respect to hundreds of plans and thousands of MH/SUD claims.

When EBSA identifies violations in a particular group health plan, EBSA asks the plan to make necessary changes to any noncompliant plan provision and to re-adjudicate any improperly denied benefit claims. EBSA may also require the plan or service provider to provide notice to potentially affected participants and beneficiaries. In addition to seeking such retrospective relief, EBSA also requests that plan correct the violation prospectively, or in other words, for the remainder of the plan year and for future plan years so that participants and beneficiaries receive the benefits that they are entitled to. While EBSA's results generally track recoveries for claims affected in the current and past year, they generally do not account for potential claims that will be impacted in future plan years by EBSA's efforts.<sup>7</sup>

## *2. Sample Enforcement Results*

In a recent investigation, EBSA received a referral from a state department of insurance indicating that a plan service provider was imposing NQTLs in a manner that potentially violated MHPAEA. Based on this referral, EBSA's Kansas City Regional Office worked with the state department of insurance and HHS to complete an investigation of the service provider for several

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<sup>7</sup> In its 2018 MHPAEA Report to Congress "Pathway to Parity," EBSA's Office of Policy and Research estimated the ongoing impact of several prospective corrections featured in the report, in order to provide an idea of how each EBSA correction has an ongoing impact. These estimations were based on plan-level cases. EBSA is currently reevaluating the information that it collects on corrections in service provider cases, which may allow it to perform such estimates in the future.

hundred group health plans. EBSA reviewed the service provider's behavioral health guidelines and requested evidence of the service provider's MHPAEA compliance analysis.

EBSA's Kansas City Regional Office determined that many of the plans contracting with the service provider imposed a medical necessity review requirement on outpatient MH/SUD benefits after 30 visits. Although the service provider indicated there was a similar medical necessity review requirement for comparable medical/surgical benefits, the Kansas City Regional Office discovered that the plans permitted 52 visits before requiring any additional medical necessity review for medical/surgical services. Additionally, the service provider could not show that it applied comparable factors in establishing these two requirements. As a result of the investigation, the service provider increased the threshold for medical necessity review of MH/SUD services from 30 to 52 visits, which paralleled the standards for medical necessity review on outpatient medical surgical benefits. Participants will now receive greater MH/SUD benefits without additional administrative burden. In addition, the service provider agreed to reprocess 198 claims, which resulted in \$19,744 in MH/SUD benefits recovered for 29 participants.

As part of this same investigation, EBSA's Kansas City Regional Office found that the service provider's claims processing handbook provided that drug screening tests with a sole diagnosis of addiction would be treated as not medically necessary. The service provider was unable to establish that comparable processes, strategies, evidentiary standards, and other factors were applied to medical/surgical benefits. Because of the investigation, the service provider eliminated the automatic denial for drug screening tests with a diagnosis of addiction and conducted a national training for its claims reviewers on the new requirements. Finally, the service provider reprocessed drug screening claims for 32 participants, resulting in payment of \$146,278 in MH/SUD benefits.

In another investigation, after reviewing an annual report filed by a multiple employer welfare arrangement (MEWA), EBSA's Cincinnati Regional Office opened an investigation to check for compliance with federal requirements, including review for compliance with MHPAEA. EBSA's Cincinnati Regional Office found that certain plans within the MEWA, which approximately 500 schools relied upon to sponsor group health plans for their employees, imposed annual and lifetime visit limits for alcohol or substance abuse treatment. EBSA's Cincinnati Regional Office reviewed these limitations and determined that these plans violated MHPAEA, as they imposed cumulative treatment limitations that applied only to substance use disorder services. The plans removed the improper limits and the Cincinnati Regional Office conducted a claims review to identify participants and beneficiaries affected by the annual limit. EBSA's Cincinnati Regional Office ensured that the MEWA reprocessed and paid claims for substance use disorder treatment that had been improperly denied due to the treatment limitations.

EBSA's 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 MH/SUD visits, contrary to the



standards for financial requirements under MHPAEA. Specifically, a \$35 copayment was applied for the first three medical/surgical office visits, after which 30 percent coinsurance was applied for subsequent visits for the remainder of the year; by contrast, all MH/SUD office visits were charged the 30 percent coinsurance for the entire year. As a result of the investigation, claims were readjudicated and excessive MH/SUD 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.

## **B. Consumer and Compliance Assistance**

### *1. Benefits Advisor Results*

EBSA's benefits advisors are on the front lines assisting participants and beneficiaries to ensure they receive the benefits to which they are entitled. Through EBSA's toll-free hotline and online web portal, and in response to mail sent to regional offices, benefits advisors provide expert assistance to participants and beneficiaries across the country who have questions or complaints related to their health plan's compliance with MHPAEA and other federal laws. If a participant's inquiry suggests that there may be violations of the law or improper benefit denials, benefits advisors may investigate and seek voluntary compliance by working with participants and their health plans to help participants obtain the benefits to which they are entitled. Benefits advisors also provide compliance assistance to employers and other stakeholders. These interactions help inform the Department's understanding of where additional guidance is needed for both consumers and the regulated community. In fiscal years 2018 and 2019, EBSA received 217 inquiries in connection with MHPAEA.

In one example, a dependent's mother contacted EBSA for assistance after her child was in need of treatment for addiction and sought care in an inpatient setting for six weeks. The dependent's mother paid for the treatment out-of-pocket and then requested reimbursement from her group health plan. The plan approved the first three weeks of coverage but denied coverage for the remainder of the inpatient stay. Additionally, while the plan approved the first three weeks of the inpatient stay, the dependent's mother had still 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 inpatient stay.

In addition to intervening directly on behalf of participants and beneficiaries, EBSA's benefits advisors refer systemic issues to the appropriate EBSA field office to pursue formal investigations. For example, a participant contacted EBSA for assistance because the 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 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, which is still ongoing.

## *2. Outreach Initiatives*

EBSA conducts robust outreach initiatives and extensively promotes a better understanding of MHPAEA among plans, issuers, participants and beneficiaries, health care providers, and state regulators. These initiatives include webcasts, in-person seminars, and nationwide compliance outreach events for the regulated community. In fiscal years 2018 and 2019, EBSA conducted 46 compliance assistance outreach events nationwide, which were attended by employers, employee benefit plan administrators, attorneys, accountants, and other plan officials. Attendees at these events were educated about their responsibilities under federal laws affecting group health plans, including MHPAEA. In addition to the compliance assistance events, EBSA participated in 141 participant assistance and public awareness events that educated workers and other stakeholders about the rights and benefits of MHPAEA.

Since the last MHPAEA Report to Congress, EBSA has also conducted compliance and consumer webcasts to provide information and education on MHPAEA. The goal of consumer webcasts is to help consumers make informed decisions and empower them with information about their rights under MHPAEA. Compliance webcasts are designed to address common issues that plan and issuers grapple with as they work toward parity compliance. Most recently, on May 23, 2019, EBSA conducted a MHPAEA compliance assistance webcast that provided information on the latest guidance related to the requirements of the Cures Act. These materials included the proposed (subsequently finalized) Frequently Asked Questions (FAQs) Part 39, proposed (and subsequently finalized) disclosure template, MHPAEA self-compliance tool, and the FY 2017 MHPAEA Enforcement Fact Sheet with the Department's latest MHPAEA enforcement information. 291 people attended the live webcast. An additional 31 individuals viewed the archived webcast.

### **III. PARTNERSHIP WITH STATES**

EBSA has always considered state regulators as partners in carrying out its obligations to regulate group health plans. Although EBSA has primary enforcement jurisdiction over employer-sponsored group health plans, states are the primary enforcers for health insurance issuers. Additionally, many group health plan requirements included in ERISA create a federal floor and states may be more protective of consumers in carrying out their obligations that relate to health insurance issuers under parallel provisions in the Public Health Service Act.<sup>8</sup> Moreover, states have great latitude to enact policies concerning public health.

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<sup>8</sup> In general, ERISA section 514 provides that state laws are preempted to the extent that they relate to any ERISA-covered employee benefit plan, but state laws that regulate insurance, banking, or securities are preserved. ERISA section 731 further provides that state laws relating to health insurance issuers in connection with group health insurance are not preempted to the extent they do not prevent the application of any requirement of ERISA part 7 (which includes MHPAEA).

In light of states' unique position as primary regulators of insurance and overseers of public health more generally, states are invaluable partners in increasing access to treatment for mental illness and substance use disorders. Accordingly, EBSA has partnered with states in its parity implementation and enforcement. Additionally, EBSA is engaged in an ongoing dialogue with its state partners to identify other opportunities for collaboration that will increase access to treatment for mental illness and substance abuse.

### **A. Regional Coordination Efforts**

In the last report to Congress, the Department highlighted efforts by EBSA's Kansas City Regional Office to cooperate with other governmental organizations in response to the opioid crisis within the midwestern states. EBSA's Kansas City Regional Office worked with the Substance Abuse and Mental Health Services Administration (SAMHSA), the Nebraska Department of Insurance and the Minnesota Department of Commerce, as well as health care provider organizations, in order to improve enforcement efforts and provide subject matter expertise. EBSA's Kansas City Regional Office has continued its collaboration with other stakeholders. More recently, EBSA's Kansas City Regional Office participated in a workshop with stakeholders, including behavioral health professional associations and advocacy groups on MHPAEA compliance. This workshop was particularly focused on increasing awareness of EBSA's enforcement capabilities and developing leads for future investigation. Finally, EBSA's Kansas City Regional Office cooperated with state and federal partners in conducting its service provider investigation discussed above.

Other EBSA regional offices are also collaborating within their communities to further MHPAEA compliance. EBSA's Chicago Regional Office regularly partners with regional stakeholders, including participating in the quarterly meeting of the Heroin/Opioid Prevention and Education Taskforce with the DuPage County (Illinois) Health Department. EBSA's Cincinnati Regional Office has met frequently with providers and consumer advocates, in order to foster relationships with the community and to target and evaluate NQTLs being imposed by large behavioral health providers/issuers. The Cincinnati Regional Office also works closely with local law enforcement agencies, as well as the Department of Justice, the Federal Bureau of Investigation, the Drug Enforcement Administration, HHS, and state Medicaid Fraud Control Units, on investigations and strategies relating to opioid investigations. EBSA's Philadelphia Regional Office regularly attends and participates in the HHS Region 3 Federal Opioid Taskforce (with a variety of state and local government partners), facilitating coordination among agencies addressing opioid-related issues and audiences. EBSA's Philadelphia Regional Office also participates in frequent meetings with the insurance department of Pennsylvania to coordinate enforcement efforts. Finally, EBSA's Philadelphia Regional Office participated in a meeting with Virginia state agencies and SAMHSA to discuss enforcement of MHPAEA and Virginia parity laws.

These efforts are just examples of the many ways in which EBSA and its regional offices cooperate with its regional partners to promote parity and access to MH/SUD treatment. EBSA is exploring how best to expand and standardize its regional coordination efforts.

### **B. Coordination with State Regulators through the National Association of Insurance Commissioners**

In addition to partnerships formed at the regional level, EBSA fosters its partnership with state regulators by participating in regular and ongoing dialogue with the NAIC. EBSA staff attends quarterly national NAIC meetings to engage state regulators on MHPAEA implementation and enforcement efforts. As part of this dialogue, EBSA provides technical assistance to state regulators on complex parity issues. EBSA and the states exchange ideas to help inform and to promote greater uniformity in parity implementation and enforcement efforts. In addition to the quarterly meetings, EBSA, along with HHS, participates in regular conference calls with state regulators through the NAIC to address discrete issues that arise between the quarterly meetings. Lastly, EBSA staff provides individual technical assistance to state regulators, as requested.

## **IV. STAKEHOLDER PARTNERSHIP EFFORTS**

The best mental health parity results are achieved not only through enforcement of MHPAEA, but through collaboration with all stakeholders, including plans, issuers, providers, and consumer advocates. In light of EBSA's limited resources, it is imperative to focus on the areas where such efforts are most needed, and where the greatest impact can be achieved. Furthermore, in order to ensure that meaningful guidance is issued, it is crucial to know where there are gaps in the understanding of the regulated community, and where consumers feel that barriers still remain. Stakeholders are in the best position to provide this information, as they are the entities tasked with navigating parity compliance. Consumer advocacy groups, as well as provider organizations, are uniquely positioned to communicate the challenges that consumers still face in realizing parity. EBSA recognizes the efforts of stakeholders in moving toward full parity compliance and values their input.

### **A. The Department of Labor Roundtable Discussion**

EBSA often receives questions and requests for meetings from a variety of stakeholder groups, including industry representatives, provider associations, and consumer advocacy organizations. In an effort to facilitate an open dialogue on parity, EBSA meets regularly with stakeholders to provide technical assistance and to understand the challenges and concerns that they face related to parity compliance and implementation. Following EBSA's issuance of proposed NQTL and disclosure guidance, as directed by the Cures Act, a number of stakeholders requested meetings with EBSA to discuss their feedback. Recognizing an opportunity for collaboration and an

exchange of ideas amongst stakeholders, EBSA organized a roundtable discussion on January 10, 2019 to bring the regulated community together with provider and consumer organizations to exchange perspectives on not just the proposed guidance, but on parity implementation and enforcement more generally. In addition to EBSA's federal and state partners, this roundtable was attended by approximately 60 external stakeholders representing employers, the insurance industry, managed behavioral health organizations, and medical providers. The goal of the roundtable was to facilitate an open and interactive dialogue between stakeholders to advance MHPAEA parity implementation and best practices.

The roundtable discussion primarily focused on disclosure, NQTLs, and federal and state coordination. A number of stakeholders representing provider and consumer groups stressed that they often had difficulty receiving requested documents from plans and issuers, and provided examples of what they felt was inadequate disclosure. However, industry groups highlighted the challenges associated with fulfilling consumer disclosure requests and suggested a more streamlined disclosure process might be appropriate.

Several stakeholders discussed the challenges of ensuring that provider reimbursement rates and network adequacy comply with the NQTL requirements of MHPAEA, with consumer groups stressing the difficulties in seeking in-network MH/SUD care. Insurers, on the other hand, highlighted challenges in securing in-network providers for certain MH/SUD specialties, and the lack of clarity in how MHPAEA applied to network adequacy. Some stakeholders questioned whether discrepancies in claim denial rates between medical/surgical and MH/SUD services was an indicator of a MHPAEA violation. Finally, stakeholders emphasized the need for ongoing education and collaboration with states, in order to improve their knowledge and harmonize their enforcement efforts with EBSA.

EBSA used the additional feedback received from the interactive roundtable to help inform the final MHPAEA FAQs Part 39 and model disclosure template. Several clarifications arose from these discussions by the stakeholders, as well as the commenters on the proposed MHPAEA FAQs, as discussed in more detail below. EBSA also used this discussion to inform its ongoing partnerships with state regulators.

## **B. Collaborative Parity Guidance**

The Cures Act directed the Departments to gather feedback from stakeholders and issue guidance regarding the disclosure and NQTL requirements of MHPAEA. Section 13001(b) of the Cures Act requires the Departments to issue clarifying information and illustrative examples of methods that a plan or issuer offering group or individual health insurance coverage can use to disclose information in compliance with MHPAEA. Section 13001(b) also directs the Departments to issue clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that plans and issuers may use regarding the development and application of NQTLs such as:

1. Medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;
2. Limitations with respect to prescription drug formulary design, and use of “step therapy” protocols or “fail-first” policies;
3. Network admission standards (such as credentialing);
4. Factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy; and
5. Examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of NQTLs.

Consistent with this direction, the Departments proposed *FAQs about Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39* and a revised draft MHPAEA disclosure template. The FAQs included proposed guidance that the Departments believed would promote understanding of how the law applies to such issues as experimental or investigational treatments, dosage limits, network adequacy, step therapy, exclusions for specific treatments, provider reimbursement rates, and exclusions based on facility type for eating disorders. The Departments also requested comments on the revised draft MHPAEA disclosure template, including ways to reduce burden on individuals, families, health care providers, states, group health plans, health insurance issuers, and other stakeholders. The Departments requested comments on the FAQs and the MHPAEA disclosure template by June 22, 2018.

The Departments received comments from a broad range of stakeholders, including managed behavioral health organizations, issuers, treatment centers, physicians, and consumer advocates. Commenters generally supported the Departments’ efforts to provide additional guidance and compliance assistance. Stakeholders also provided insight on certain compliance issues faced by plans and issuers, as well as by plan participants and their authorized representatives, when they are seeking information about MH/SUD benefits. The Departments carefully considered these comments, as well as stakeholder perspectives shared at the roundtable, and made several refinements to the proposed guidance (including, where necessary, deleting language that commenters had identified as confusing or unclear). After reviewing the comments and the feedback from the Roundtable, the Departments finalized *FAQs about Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39* (Final FAQs Part 39) and the MHPAEA disclosure template on September 5, 2019.

### *1. Guidance on Nonquantitative Treatment Limitations*

Final FAQs Part 39 aimed to help stakeholders identify and address important NQTL issues. In an effort to promote compliance, the FAQs provided additional examples of how the MHPAEA

final regulations apply to different fact patterns. For example, the FAQs included guidance clarifying that if a plan defines coverage of treatment for autism as a mental health benefit, it must apply comparable processes, strategies, evidentiary standards, and other factors when deciding whether to cover applied behavior analysis therapy to treat autism as the plan uses for medical/surgical benefits in the classification of benefits. Similarly, when a plan relies on a comparable standard for MH/SUD benefits and medical/surgical benefits, if the plan, in operation, provides an exception to such standards when applying the standard to medical/surgical benefits, it may not apply the exception more stringently to MH/SUD benefits in the same classification.

The Cures Act highlighted uncertainty about application of MHPAEA to benefits for the treatment of eating disorders. Final FAQs Part 39 built upon prior guidance clarifying that these benefits are MH/SUD benefits for purposes of MHPAEA and further explained that a plan exclusion of all inpatient, out-of-network treatment outside a hospital setting for eating disorders would not be permissible if the plan did not impose a similar limitation on treatment outside hospital settings for medical/surgical benefits. This guidance clarifies how eating disorders must be covered and helps the regulated community properly administer benefits related to eating disorders.

In recognition of the ongoing opioid crisis and the demand for guidance from the regulated community on coverage of substance use disorders, Final FAQs Part 39 provided additional guidance regarding dosage limits for buprenorphine, which is used to treat opioid use disorder. The FAQs highlighted that if the plan follows dosage recommendations in professionally recognized treatment guidelines to set dosage limits for prescription drugs in its formulary to treat medical/surgical conditions, it must also follow comparable treatment guidelines, and apply them no more stringently, for coverage of buprenorphine to treat opioid use disorder. Alternatively, if the plan uses Pharmacy and Therapeutics (P&T) committees to decide which prescription drug benefits to cover, these processes must comply with MHPAEA's NQTL standard in practice. However, the FAQs noted that a plan may permissibly have a general exclusion for items and services to treat a specific mental health or substance use disorder condition, including prescription drugs to treat that condition.

Final FAQs Part 39 also provides guidance on how MHPAEA applies to step therapy requirements. It addresses the circumstance where a plan requires a participant to have two unsuccessful attempts at outpatient treatment in the past 12 months to be eligible for certain inpatient in-network substance use disorder benefits, but requires only one unsuccessful attempt at outpatient treatment in the past 12 months to be eligible for inpatient, in-network medical/surgical benefits. The FAQ explains that the NQTL did not comply with MHPAEA, unless the plan could demonstrate that it utilized comparable evidentiary standards and other factors in developing and applying the differing step therapy requirements for these MH/SUD and medical/surgical benefits. Collectively, these FAQs will assist our regulated partners in fighting the opioid epidemic and ensuring that they properly cover substance use disorder benefits.

In recognition of stakeholder confusion concerning how MHPAEA applies to provider reimbursement and network participation requirements, the Departments issued several FAQs dealing with these topics. The first of these FAQs clarified that where a plan varies reimbursement for non-physician providers (as compared to physicians) for the medical/surgical services based on a number of factors but reduces the reimbursement rate by the same percentage for every MH/SUD service rendered by a non-physician practitioner, the plan fails to comply with MHPAEA. This guidance will help to ensure that plans and issuers are able to help ensure parity in access to mental health providers. In response to comments and concerns from the stakeholders, the Departments clarified through another FAQ how MHPAEA would apply to network participation requirements. The FAQs highlighted that where a plan uses time and distance standards to craft their network admission standards (including reimbursement rates) for medical/surgical providers, the plan must similarly utilize time and distance standards when defining their network admission standards for MH/SUD providers.

Finally, in response to concerns from stakeholders about how coverage denial rates should be considered in determining compliance, the Departments added language to clarify that the NQTL analysis does not focus on whether the final result, such as denial rates, is the same for medical/surgical and MH/SUD benefits. Compliance depends on parity in development and application of the underlying NQTL processes and strategies. However, the FAQs also clarified that although outcomes are not determinative of compliance, higher rates of denials for MH/SUD benefits may be viewed as a warning sign, and vast differences can serve as a strong indicator of potential parity noncompliance.

## *2. Guidance on Disclosure*

Final FAQs Part 39 also included additional guidance to help plans and issuers understand how to carry out their responsibility to make disclosures to participants and beneficiaries. Additionally, contemporaneous with the release of Final FAQs Part 39, the Departments also finalized a previously proposed model form that will enable these participants and beneficiaries to make requests for important information regarding limitations on MH/SUD benefits.

Due to the comparative nature of any parity analysis performed under MHPAEA, access to information is a key component of ensuring compliance. It is impossible to discern whether MH/SUD benefits are offered in parity with medical/surgical benefits if participants, beneficiaries, and their authorized representatives are unable to obtain information about both categories of benefits. The statutory MHPAEA provisions expressly provide that a plan or issuer must disclose the criteria for medical necessity determinations with respect to MH/SUD benefits to any current or potential participant, beneficiary, or contracting provider upon request, and that the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits must be made available to any participant or beneficiary.

The final MHPAEA regulations provides that ERISA's general disclosure obligation in ERISA section 104 requires plans to provide participants with information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies,



evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan.

Since the enactment of MHPAEA, the Departments have clarified in regulations and subregulatory guidance the breadth of disclosure required, as well as the documents that participants, beneficiaries, and their authorized representatives have a right to receive (and generally may find helpful) under MHPAEA and other federal laws such as ERISA and the Patient Protection and Affordable Care Act. However, stakeholders continued to emphasize the need for further guidance and assistance for participants and beneficiaries.

In response to this, Final FAQs Part 39 included several additional examples of how participants and beneficiaries may seek information relevant to MH/SUD benefits. The FAQs pointed out that under ERISA, plans are required to provide summary plan descriptions (SPDs) that describe, in terms understandable to the average plan participant, the rights, benefits, and responsibilities of participants and beneficiaries. Plans are also required to provide a Summary of Benefits and Coverage (SBC) that includes, among other elements, a description of the coverage; the exceptions, reductions, and limitations of the coverage; and the cost-sharing provisions of the coverage. Participants and beneficiaries should first consult these documents for information on how their plan covers MH/SUD benefits.

The FAQs also pointed to the availability of the model disclosure request form. This model form can be used for general requests for information regarding MH/SUD benefits and treatment limitations, such as a request for the relevant portions of the SPD or plan document. This model form can also be used to obtain documentation after an adverse benefit determination involving MH/SUD benefits to support an appeal. Furthermore, plans and issuers may find that making this model disclosure form available to their participants or enrollees may help clarify and streamline requests for information. In response to the feedback received, the Departments revised the final model disclosure request form to steer participants toward the information they might require and to facilitate efficient communication with the plan.

The Departments are also aware that provider directories often include information that is out-of-date or inaccurate, leading some participants and beneficiaries to believe that their plan has more in-network providers of MH/SUD services than it actually does. Many stakeholders and commenters highlighted that participants and beneficiaries have difficulty finding providers who are still in-network, or are accepting new patients. While their plans appear to have a robust network, in actuality many of the listed providers are either not accepting new patients, or are no longer providing in-network MH/SUD services. Final FAQs Part 39 clarified that ERISA-covered plans must provide an SPD that describes provisions related to the use of network providers, and the composition of the provider network. Such information may be provided as a separate document and, in many circumstances, may be provided electronically. However, the provider directory must be up-to-date, accurate, and complete (using reasonable efforts). The FAQs further clarified that Qualified Health Plan issuers are obligated to comply with HHS's regulations that require the issuer to publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, and the

provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to enrollees.

## **V. Partnership through Concerted Administration Efforts**

### ***A. Turning the Tide – Improving Access to Addiction Care and Overcoming Obstacles to Parity, hosted by the Office of National Drug Control Policy***

As part of its collaborative parity efforts, EBSA also worked closely with the Office of National Drug Control Policy (ONDCP), as well as HHS and Treasury, to support ONDCP in developing an event focused on identifying ways in which the Administration and the regulated community can work together to improve access to addiction treatment. The event convened a variety of stakeholders, including national insurance companies, health systems, and employers. To facilitate the discussion, the event included panels of experts in health economics, addiction science and treatment, and key players in providing behavioral health coverage. Panelists discussed best practices and innovative approaches to increasing access to treatment, as well as the barriers to successfully increasing access to care. Following the moderated discussion, attendees were assigned to break-out discussion groups and tasked with contemplating key issues that impact access to addiction treatment. Some of the key topics discussed included network adequacy and parity implementation. At the closure of this meeting, each group reported on potential ideas for advancing access to treatment.

### **B. The Interdepartmental Serious Mental Illness Coordinating Committee**

The Department also participated in the fifth full committee meeting of the Interdepartmental Serious Mental Illness Coordinating Committee. This Committee was established by the Cures Act to enhance coordination across the federal government to improve access and delivery of care for individuals with serious mental illness and serious emotional disturbances. The Committee is charged with reporting on advances in serious mental illness; research related to the prevention, diagnosis, and treatment of serious mental illness; and access to services. The Committee is also required to evaluate the effect federal programs related to serious mental illness have on public health. Finally, the Committee is empowered to make specific recommendations for actions that agencies can take and provide a report to Congress and the relevant federal departments.

At the meeting, EBSA discussed its parity implementation and enforcement efforts with its federal partners and stakeholders. EBSA especially highlighted its MHPAEA self-compliance tool and its availability to state regulators. Additionally, EBSA emphasized its continued efforts in providing technical assistance, the January 2019 MHPAEA roundtable, and the collaboration between SAMHSA and EBSA in an ongoing opioid task force. Finally, the Department emphasized its efforts in coordinating with state and federal partners in enforcement, including by entering into common interest agreements to coordinate investigations. This forum provides an opportunity to collaborate with other agencies and stakeholders that are working toward

improving access to treatment for mental health conditions, but generally outside of the parity context.

## **VI. Conclusion—EBSA’s FY 2020 MH/SUD Enforcement Evaluation Program**

The Department is steadfastly committed to vigorously enforcing MHPAEA, providing compliance assistance to plans and issuers, and conducting outreach and education to consumers about their parity rights.

Since MHPAEA’s enactment, the Department, in conjunction with the Departments of HHS and the Treasury, issued interim and final regulations. To help support compliance, the Departments also published:

- 11 sets of FAQs, with a total of 70 questions, to help the public understand MHPAEA;
- 8 compliance assistance publications aimed at the regulated community; and
- 5 consumer assistance publications to help employees and their families understand their rights under MHPAEA.

From FY 2011 through FY 2019, EBSA:

- Received approximately 1,150 public inquiries regarding MHPAEA;
- Conducted over 2,100 MHPAEA investigations; and
- Cited approximately 345 violations of MHPAEA.

EBSA is very proud of these results. At the same time, it is EBSA’s practice to continuously review and improve its enforcement, compliance assistance, and education programs to ensure compliance with ERISA (including MHPAEA) in an effective and efficient manner.

Accordingly, EBSA has developed a Five-Point MH/SUD Enforcement Evaluation Program, which consists of the following:

1. ***Quality assurance review.*** EBSA will conduct a quality review of MHPAEA investigations, to ensure EBSA investigators are conducting full and accurate investigations, assess current industry practices and trends, and inform investigator training.
2. ***Capturing data on other ERISA violations impacting mental health and substance use disorder benefits.*** Because not all violations of ERISA affecting MH/SUD benefits are MHPAEA violations, EBSA is updating its information tracking systems to better track all types of ERISA violations that involve MH/SUD benefits (including those related to ERISA’s fiduciary standards, claims procedures, and reporting and disclosure obligations).<sup>9</sup>

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<sup>9</sup> See e.g., *Wit v. United Behavioral Health*, No. 14-CV-02346-JCS, 2019 WL 1033730 (N.D. Cal. Mar. 5, 2019).

3. **Compliance assistance.** EBSA will update its self-compliance tool to reflect new trends and red flags.<sup>10</sup> EBSA will solicit public input before finalizing the tool.
4. **Stakeholder engagement.** Stakeholders have shown continuous interest in having an open dialogue with the Department and other regulators on MHPAEA implementation.<sup>11</sup> EBSA will host a Listening Session with consumer advocates, group health plan representatives, health insurance issuers, managed behavioral health organizations, provider groups, federal and state regulators, and other interested parties to hear feedback on EBSA's interpretive guidance and enforcement program.
5. **FY 2021 national enforcement initiative.** EBSA will use the information gathered from its quality assurance review and stakeholder engagement to inform a new national MHPAEA enforcement project for FY 2021.

As part of its enforcement efforts, EBSA will continue to explore opportunities for collaboration with other federal and state regulators. EBSA also remains committed to leveraging its resources to achieve the biggest impact for participants and beneficiaries, and to using specialized, interdisciplinary teams to evaluate complex MHPAEA compliance issues.

The Department is hopeful that, as a result of its efforts, individuals will continue to receive the benefits of parity protections under the law and receive the often times life-saving treatment they need.

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<sup>10</sup> See the DOL MHPAEA Self-Compliance tool, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf>.

<sup>11</sup> EBSA previously hosted a Listening Session in January 2019 covering NQTLs, disclosure, and Federal and State coordination.