



FACT SHEET

FY 2020 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) with respect to 2.5 million private employment-based group health plans, which cover 136 million participants and beneficiaries. EBSA relies on its approximately 350 investigators to review all pension and welfare benefit plans for compliance with ERISA, including the group health plan provisions added by 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. EBSA has released annual MHPAEA enforcement fact sheets, summarizing its enforcement activities in each fiscal year (FY), since FY 2015.¹

The Centers for Medicare & Medicaid Services (CMS) enforces applicable provisions of Title XXVII of the Public Health Service Act (PHS Act), including the provisions added by MHPAEA, with respect to non-federal governmental group health plans, such as plans for employees of state and local governments.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.³ 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. CMS also performs market conduct examinations, where issuers are audited for compliance with applicable federal requirements in states where CMS is responsible for enforcement and in states with a collaborative enforcement agreement when the state requests assistance. CMS has released annual MHPAEA enforcement reports and fact sheets summarizing its enforcement activities since 2016.⁴

This enforcement fact sheet summarizes EBSA's and CMS's investigations and public inquiries related to MHPAEA during FY 2020. This fact sheet does not report ongoing investigations that were open but not closed during FY 2020. These cases will be reported in a subsequent report for the FY in which these cases 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).

¹ See EBSA's previous MHPAEA Enforcement Fact Sheets, available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

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

³ In FY2020, CMS was responsible for enforcement of MHPAEA with regard to issuers in Missouri, Oklahoma, Texas, and Wyoming. In addition, CMS had collaborative enforcement agreements with Alabama, Florida, Louisiana, Montana, and Wisconsin. These states perform state regulatory and oversight functions with respect to 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.

⁴ See CMS's previous MHPAEA Enforcement Reports, available at <https://www.cms.gov/ccio/Resources/Forms-Reports-and-Other-Resources/index#mental-health-parity>.

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 (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 regulations, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided.⁵
- (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 **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.

⁵ 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 2020 Enforcement Fast Facts:

EBSA Investigations

- EBSA investigated and closed 180 health plan investigations in FY 2020 (and 3,938 health plan investigations since FY 2011). Fifty-six of these investigations involved fully insured plans, 103 involved self-insured plans, and 21 involved plans of both types (the plan or service provider offered both fully insured and self-insured options).
- Of the 180 closed investigations, 127 involved plans subject to MHPAEA, and EBSA reviewed the plans for MHPAEA compliance. Twenty-five of these investigations involved fully-insured plans, 86 involved self-insured plans, and 16 involved plans of both types (the plan or service provider offered both fully-insured and self-insured options).
- EBSA cited eight MHPAEA violations in four investigations. Those four investigations involved self-funded group health plans. The cited violations involved four QTLs, two NQTLs, and two failures to offer benefits in all classifications.
- EBSA investigations focused on MHPAEA compliance are generally complex, resource-intensive, and often involve specialized interdisciplinary teams and consultations with experts. EBSA strives to broadly ensure compliance without compromising its commitment to rigorous enforcement with an emphasis on high-impact cases. As an example of the size and scope of these investigations, in the course of one investigation closed in FY 2020 involving a large self-insured multiemployer plan that was found not to be in compliance with MHPAEA, EBSA obtained corrections that affected access to benefits for over 29,000 plan participants.
- EBSA benefits advisors answered 99 public inquiries, including 92 complaints, in FY 2020 related to MHPAEA (and have answered 1,544 inquiries related to MHPAEA since FY 2011).⁶

⁶ EBSA implemented improvements to internal data capturing systems during FY 2020 to better track inquiries and complaints received that relate to mental health and substance use disorder benefits, even if they are not initially presented as parity issues. Accordingly, in addition to parity-specific inquiries and complaints, this number also includes inquiries and complaints that relate to mental health or substance use disorder benefits generally (for example, a complaint regarding a potential claims procedure violation for a claim involving a mental health benefit).

CMS Investigations and Market Conduct Examinations

- CMS received three complaints in FY 2020 related to MHPAEA, which were resolved by caseworkers within the Center for Consumer Information and Insurance Oversight (CCIIO).
- In FY 2020, CMS/CCIIO closed one self-funded non-federal governmental plan investigation and one market conduct examination related to MHPAEA.
- CMS cited one MHPAEA violation as a result of the market conduct examination. The examination involved a health insurance issuer of fully insured products and its affiliate that provided third-party administrative services to self-funded non-federal governmental plans.
- As a result of the market conduct examination, the issuer and its affiliate processed a total of \$651,103.71 in additional benefits for both the issuer's insured plans and self-funded non-federal governmental plans where the issuer's affiliate acted as a third-party administrator (TPA).

THE EBSA ENFORCEMENT PROCESS

Assisting Participants

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

Investigating Plans

EBSA conducts MHPAEA compliance reviews, including reviews for compliance with the requirements for QTLs and NQTLs, in all open cases where MHPAEA applies. Cases may stem from participant complaints first to a benefits advisor or from other sources. Also, 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 health and substance use disorders. EBSA regularly partners with states in its MHPAEA implementation and enforcement activities.

Benefits advisors obtain results.

A plan participant contacted an EBSA benefits advisor seeking help regarding a claim for treatment for her daughter. Her daughter was receiving out-of-network, inpatient treatment related to her diagnosis of autism spectrum disorder. The plan paid for 14 days of treatment but denied reimbursement for the remainder of the inpatient stay without sufficient explanation. The benefits advisor contacted the plan's issuer and it was determined that, based on the terms of the plan, the plan should have paid the claim at a higher reimbursement level. As a result, the plan reimbursed the mother for \$11,384 in denied claims.

Referring for Investigation.

A plan participant contacted EBSA's Los Angeles Regional Office on a matter unrelated to mental health and substance use disorder benefits. While reviewing the plan's Summary of Benefits and Coverage, the benefits advisor discovered a potential mental health parity violation involving higher copayment requirements for some mental health benefits as compared to medical and surgical. The benefits advisor referred the matter to investigators and a formal investigation was opened.

Generally, if an EBSA investigator finds violations, 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 work with the plans' service providers (such as third-party administrators or managed behavioral health organizations) to obtain broad correction, not just for the particular plans investigated, but for other plans that work with the service provider. 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.

FY 2020 IN REVIEW: EXAMPLES OF EBSA'S AND CMS'S ACTIONS PROTECTING MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

- ✓ *Elimination of impermissibly restrictive financial requirements and reimbursement of excessive cost sharing.* EBSA's New York Regional Office reviewed a self-insured multiple employer welfare arrangement (MEWA). The MEWA covered over 10,770 participants and offered several PPO and HMO options. EBSA's investigation revealed that 14 of the options imposed impermissible financial requirements on mental health and substance use disorder benefits in the outpatient office visit sub-classification. In response to the investigation, the MEWA removed the impermissible financial requirements and re-adjudicated claims. Because of the agency's work, 951 plan participants received reimbursements for cost-sharing totaling \$182,260 plus \$16,158 in interest on those amounts.
- ✓ *Removal of impermissible treatment limitation and reimbursement for excessive payments.* EBSA's New York Regional Office investigated a large multiemployer plan with over 29,000 participants that provided health and prescription drug benefits. The plan imposed a multi-year waiting period before participants qualified for substance use disorder benefits, but imposed no comparable eligibility requirement for medical/surgical benefits. The investigation resulted in the removal of the waiting period and reimbursement of over \$27,000 to participants affected by the waiting period.
- ✓ *Elimination of impermissibly restrictive financial requirements and reimbursement for excessive cost sharing.* EBSA's Cincinnati Regional Office investigated a self-insured multiemployer plan with over 8,200 participants and discovered that the plan imposed greater cost-sharing requirements for both in-network and out-of-network mental health and substance use disorder benefits than for the predominant financial requirements applied to substantially all medical/surgical benefits on those classifications. As a result of the investigation, the plan eliminated the impermissible financial requirements and issued reimbursements totaling \$76,085 to over 100 plan participants.
- ✓ *Assistance with unpaid claims resulting from impermissible visit limits.* A plan participant contacted an EBSA benefits advisor for assistance in getting reimbursed for her treatment of diagnosed depression. The participant's plan had advised her that the claims were denied as exceeding the plan's annual limit of 20 outpatient mental health visits. However, plan documents did not include a visit limit for mental health (or medical/surgical) outpatient visits. After the benefits advisor intervened, the plan reimbursed the participant for \$2,652 in mental health claims.

- ✓ *Limits for drug screening related to substance use disorder treatment removed.* CMS conducted a targeted market conduct examination of an issuer for compliance with requirements regarding financial requirements, NQTLs, and QTLs in all classifications following a referral from a state with which CMS has a collaborative enforcement agreement. CMS concluded that the issuer and non-federal governmental plans administered by an affiliate of the issuer violated the parity requirements for NQTLs. Specifically, the issuer's affiliate, in its capacity as the TPA for self-funded non-Federal governmental plans, processed 37 claims for drug screening tests involving substance use disorder diagnoses based on processes, strategies, and evidentiary standards with respect to medical necessity that were not comparable to those applied for a medical/surgical diagnosis. In addition, the issuer's Policies and Procedures Manual required a medical necessity review after 30 visits for all mental health/substance use disorder outpatient visits, but only for certain medical/surgical outpatient visits which did not comply with the NQTL parity requirements. The issuer disagreed with the findings, and upon review of the issuer's position, CMS maintained the findings of a violation. As a result of the examination, the issuer and the issuer's affiliate conducted a self-audit, revised policies and procedures, and re-adjudicated improperly denied claims. A total of \$651,103.71 in additional benefits were processed for both the issuer's insured plans and self-funded non-federal governmental plans for which the issuer's affiliate acted as a TPA.
- ✓ *Outpatient treatment for autism spectrum disorder investigated.* A plan participant complained that a self-funded non-federal governmental plan for a large school district improperly denied claims for treatment of autism spectrum disorder. The claims denial was submitted for external review to an independent review organization (IRO), and although the IRO overturned the denial, the plan did not abide by the IRO's binding determination. Therefore, CMS enforced the requirement for the plan to abide by the IRO's determination. In addition to requiring the plan to repay the autism treatment claims at issue, totaling at least \$2,464, CMS conducted a MHPAEA investigation of the plan's compliance with financial requirements, NQTLs, and QTLs in the outpatient, in-network and outpatient, out-of-network classifications. CMS did not find any MHPAEA violations.

**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

PHIG@cms.hhs.gov