



## FACT SHEET

# FY 2021 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 two million private employment-based group health plans, which cover approximately 137 million participants and beneficiaries. EBSA relies on its approximately 340 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.<sup>1</sup>

The Centers for Medicare & Medicaid Services (CMS) enforces MHPAEA and other applicable provisions of Title XXVII of the Public Health Service Act (PHS Act) with respect to non-Federal governmental group health plans, such as plans for employees of state and local governments.<sup>2,3</sup> In addition, CMS enforces applicable provisions of Title XXVII of the PHS Act 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 or another PHS Act provision.<sup>4,5</sup> In states that are not enforcing MHPAEA, CMS reviews health insurance policy forms of issuers in the individual and group markets for compliance with MHPAEA before the products are offered for sale. CMS also performs market conduct examinations, in which issuers are audited for compliance with MHPAEA in states where CMS is responsible for enforcement and in states with a collaborative enforcement agreement when the state requests assistance. CMS has released MHPAEA enforcement reports and fact sheets summarizing its enforcement activities since 2016.<sup>6</sup>

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<sup>1</sup> 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>.

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

<sup>3</sup> Sponsors of self-insured non-Federal governmental group health 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.

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

<sup>5</sup> In FY2021, 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 latter states perform state regulatory and oversight functions with respect to some or all 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.

<sup>6</sup> See CMS's previous MHPAEA Enforcement Reports, available at <https://www.cms.gov/ccio/Resources/Forms-Reports-and-Other-Resources/index#mental-health-parity>.

This enforcement fact sheet summarizes EBSA's and CMS's investigations and public inquiries, including complaints related to MHPAEA during FY 2021. This fact sheet does not report ongoing investigations that were open but not closed during FY 2021. 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). During FY2021, in response to requirements imposed on plans and issuers by section 203 of Title II of Division BB of the Consolidated Appropriations Act, 2021 (CAA), EBSA and CMS significantly increased their MHPAEA enforcement activity with respect to nonquantitative treatment limitations. This fact sheet does not capture results from EBSA's increased activity as a result of the CAA because the related investigations were ongoing and not yet closed during FY 2021. A summary of EBSA's and CMS' FY2021 CAA-related MHPAEA enforcement activities and related results are detailed in the annual 2022 MHPAEA Report to Congress.

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.<sup>7</sup>
- (4) **Financial requirements (FR):** 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 FRs 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 potential 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 mental health and substance use disorder benefits.

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<sup>7</sup> 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 2021 Enforcement Fast Facts:

### *EBSA Investigations*

- EBSA investigated and closed 148 health plan investigations in FY 2021 (and 4,086 health plan investigations since FY 2011). 59 of these investigations involved fully-insured plans, 64 involved self-insured plans, and 25 involved plans that offered both fully-insured and self-insured options.
- Of the 148 closed investigations, 74 involved plans subject to MHPAEA, and EBSA reviewed those plans for MHPAEA compliance. 17 of these investigations involved fully-insured plans, 41 involved self-insured plans, and 16 involved plans that offered both fully-insured and self-insured options.
- EBSA cited 14 MHPAEA violations in 12 of those investigations. 8 of those investigations involved self-insured group health plans and 4 involved plans that offered both fully-insured and self-insured options. The cited violations involved 8 FRs, 3 QTLs, and 3 NQTLs.
- 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.
- EBSA benefits advisors answered 175 public inquiries, including 144 complaints, in FY 2021 related to MHPAEA (and have answered 1,719 inquiries related to MHPAEA since FY 2011).<sup>8</sup>

### *CMS Investigations and Market Conduct Examinations (Direct Enforcement States)<sup>9</sup>*

- CMS received three complaints in FY 2021 related to MHPAEA, which were reviewed by caseworkers within the Center for Consumer Information and Insurance Oversight (CCIIO). None of the complaints received and reviewed by CMS resulted in a finding of a MHPAEA violation.
- In FY 2021, CMS closed four market conduct examinations related to MHPAEA and four comparative analysis reviews of NQTLs required by the CAA. The examinations involved health insurance issuers of fully insured products in two states where CMS directly enforces MHPAEA requirements.

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<sup>8</sup> 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 these 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).

<sup>9</sup> CMS is responsible for enforcement of MHPAEA with respect to non-Federal governmental group health plans in all 50 states, the District of Columbia, and the U.S. territories. In FY2021, CMS was also the direct enforcer of MHPAEA with regard to issuers in Missouri, Texas, and Wyoming.

- CMS cited one MHPAEA violation found in two products as a result of one of the market conduct examinations. The cited violation involved FR. CMS cited no MHPAEA violations as a result of the comparative analysis reviews of NQTLs required by the CAA.
  - As a result of the one market conduct examination that resulted in a cited MHPAEA violation, the issuer processed a total of \$5,309.23 in payments, including additional benefits and interest, to correct the violation.

## 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 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 benefits advisor in EBSA's Seattle District Office assisted a family that was having difficulty with claims for assessment and treatment of autism spectrum disorder. At issue was the "allowed amount" on the claims, which was a small fraction of the billed charges. The claimant's parents attempted multiple times to communicate with the health plan to resolve the problem but were unable to do so. The benefits advisor contacted the plan to inquire into the processing of claims for approximately 40 dates of service. The plan reprocessed the claims and paid approximately \$20,000 more for the services.

### Referring for Investigation.

EBSA's Dallas Regional Office received a complaint from a medical facility that provided behavioral health treatments. The complainant stated that a health plan initially paid the patient's claims but later tried to recoup \$82,946 in payments. The reason for the recoupment was a purported change in plan terms governing outpatient facility-based claims for group therapy. However, there appeared to be no plan terms/rules that required denial of these claims. The benefits advisor referred the matter to EBSA enforcement staff for an investigation of the plan.

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 just for the particular plans investigated, but for other plans that contract 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.

# 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 stakeholders to help ensure consumers receive 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 MHPAEA questions for plans and issuers.

### **State engagement coordinators collaborate with state regulators.**

CMS works closely with state regulators to help ensure consistency in enforcement of MHPAEA. In addition, CMS and EBSA regularly participate in the National Association of Insurance Commissioners' MHPAEA Working Group meetings to help ensure understanding of the Federal requirements and provide technical guidance.

## Investigating Non-Federal Governmental Group Health Plans and Issuers in Direct Enforcement States

CMS conducts MHPAEA enforcement in several ways. For issuers offering coverage in the group or individual market in direct enforcement states, CMS collects and reviews issuers' plan documents before the products are offered for sale. In addition, CMS receives complaints and other information regarding issuer and non-Federal governmental group health plan compliance with MHPAEA in the direct enforcement states. CMS also performs market conduct examinations and investigations based on complaints or information received, as appropriate. Finally, with the enactment of the CAA, CMS reviews NQTL comparative analyses of non-Federal governmental group health plans and issuers in the direct enforcement states. Some states have entered into collaborative enforcement agreements with CMS with respect to MHPAEA. 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 from the issuer, the state will refer the matter to CMS for possible enforcement action.

Generally, if a CMS examiner finds MHPAEA violations, the examiner works with the issuer or non-Federal governmental group health plan sponsor to identify corrective actions to address the areas of non-compliance. In addition, when appropriate, CMS requires the issuer or plan to complete a self-audit of claims that may have been affected. The issuer or non-Fed plan sponsor reports the findings of the self-audit to CMS and is directed to re-adjudicate any claims that were improperly denied. To achieve the greatest impact, CMS examiners also direct issuers and non-Federal governmental group health plan sponsors to review other plans in their portfolio to identify similar situations and obtain broad corrections, not just for the particular plans investigated.

## FY 2021 IN REVIEW: EXAMPLES OF EBSA'S AND CMS'S ACTIONS PROTECTING MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

- ✓ *Participants and beneficiaries reimbursed, improperly denied claims paid, and disclosures improved.* In August 2021, EBSA and the New York Attorney General's Office jointly entered into settlement agreements with United Behavioral Health and United Healthcare Insurance Co., and Oxford Health Insurance Inc. (United) totaling \$13.6 million in restitution to participants and beneficiaries, \$2.08 million in penalties, \$3.35 million in attorneys' fees, and \$750,000 already paid to affected participants and beneficiaries, plus processing commitments. The issues investigated by EBSA's New York Regional Office included: a provider reimbursement NQTL that discounted mental health and substance use disorder lower-level licensures disproportionately, the Algorithms for Effective Reporting and Treatment (ALERT), an outlier management NQTL that disproportionately applied to mental health and substance use disorder services, and disclosures to participants and beneficiaries that failed to provide detailed information about the NQTLs such that participants and beneficiaries did not have enough information regarding the application of the NQTLs to adequately appeal denials or reductions in benefits.

In the settlement, United agreed to cease the practices investigated, improve its disclosures to plan participants and beneficiaries, and committed to future compliance. The settlement provided for a Common Fund to pay for improperly denied or reduced claims relating to the provider reimbursement and ALERT policies. Additionally, United raised its reimbursements for mental health and substance use disorder out-of-network providers (resulting in lower costs for participants and beneficiaries), discontinued the use of the ALERT policies to deny or reduce coverage, and committed to providing disclosures to participants and beneficiaries that will provide more individualized information to allow for adequate appeal of denials or reductions in benefits. The Department of Labor's Office of the Solicitor provided legal support to EBSA in this matter.

- ✓ *Impermissibly excluded applied behavior analysis (ABA) therapy covered.* EBSA's Chicago and Dallas Regional Offices conducted an investigation of a large claims administrator for self-insured ERISA health plans. EBSA investigated the exclusion of coverage for ABA therapy, a primary treatment for autism, by self-insured plans, and specifically, whether the exclusion of ABA therapy for autism violated MHPAEA. The claims administrator offered the plans the option to exclude coverage for ABA therapy. As a result of EBSA's investigation, the claims administrator made changes beginning in the 2021 plan year that made ABA therapy coverage the default coverage for all of its self-insured plans instead of offering the option to exclude coverage for ABA therapy. EBSA has been advised that this change resulted in the elimination of the exclusion for ABA therapy for autism for nearly a million participants. The Department of Labor's Office of the Solicitor provided legal support to EBSA in this matter.
- ✓ *Overly restrictive limitations on testing eliminated.* In a plan-level investigation, EBSA's Kansas City Regional Office determined that claims for outpatient drug testing related to substance use disorder diagnoses were being impermissibly denied for failure to establish medical necessity in violation of MHPAEA. As a result of EBSA's investigation, the plan

reprocessed over 250 claims, which resulted in payments to providers and savings to 33 participants in the amount of approximately \$175,000. The plan's Board of Trustees also adopted a new policy for processing claims relating to outpatient drug screening effective 11/30/2020, using a third-party administrator.

- ✓ *Residential treatment claims covered.* EBSA's Boston Regional Office determined that a self-insured plan violated MHPAEA by excluding coverage for out-of-network residential treatment for mental health and substance use disorders, which did not apply to medical/surgical benefits in the same classification. As a result of EBSA's investigation, the plan reprocessed and paid two denied residential treatment claims totaling \$88,402 and agreed to amend its plan language to eliminate the exclusion and to change claims processing procedures to prevent similar claims denials in the future.
- ✓ *Higher copays reduced.* In a plan-level investigation, EBSA's Philadelphia Regional Office found that a plan's financial requirements were not compliant with MHPAEA in the classification of outpatient/in-network services, where participants seeking mental health and substance use disorder benefits were charged higher co-pays when compared to medical/surgical benefits in the same classification. As a result of the investigation, plan fiduciaries re-adjudicated claims spanning a four-year period that were not in parity and reimbursements of overpaid cost sharing were made to 1,945 affected participants in the aggregate amount of \$82,065.
- ✓ *Assistance with unpaid claims provided.* A parent contacted EBSA's Dallas Regional Office for assistance with medical claims for treatment of his child's autism spectrum disorder. The plan rules provided for 60 visits per year for therapy services; additional visits could be covered if the claims were submitted with a specific modifier code. The plan said the medical provider failed to provide the required modifier code, and the medical provider said the claim submission system would not allow them to add the modifier. The benefits advisor contacted the plan to resolve the issue. As a result, the plan paid approximately \$24,000 in claims for this patient.
- ✓ *Access to mental health benefits obtained.* A plan participant contacted EBSA's Boston Regional Office for assistance because she was unable to access the plan's mental health benefits after her employment ended and she transitioned to COBRA continuation coverage. A representative of the plan told her that the mental health benefits were offered through an Employee Assistance Program (EAP) and upon her termination of employment the participant was no longer able to access the EAP's mental health benefits. The benefits advisor contacted the plan's service provider multiple times and the plan corrected its error so that the participant was able to access the mental health benefits offered by the plan. Additionally, while handling this matter, the benefits advisor reviewed the plan's Summary of Benefits and Coverage (SBC). The SBC indicated a potential NQTL issue related to the plan's preauthorization requirements for mental health and substance use disorder benefits. The matter was referred to EBSA enforcement staff, for investigation of the plan.

## CMS Actions

- ✓ *Impermissible financial requirements reimbursed.* Based on public reports of non-compliance with MHPAEA, CMS conducted a market conduct examination of an issuer in Texas. In the issuer's small group market plans, the issuer applied a financial requirement to mental health and substance use disorder benefits in the outpatient, in-network classification that was more restrictive than the predominant financial requirement applied to substantially all medical/surgical benefits in the same classification. As a result of the examination, the issuer conducted a self-audit of similar claims in the identified classification and determined 63 claims needed to be re-adjudicated to apply the correct financial requirement. The re-adjudication of claims resulted in a total of \$5,309.23 in payments to affected individuals, with \$2,259.23 in additional benefits and \$3,049.70 in interest paid.

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

#### **Contact EBSA**

U.S. Department of Labor

[askebsa.dol.gov](https://askebsa.dol.gov)

Telephone: 1-866-444-3272

#### **Contact CMS**

[Submit a complaint](#)

Telephone: 1-800-985-3059