COMPLIANCE BULLETIN

DOL Continues Vigorous Enforcement of Mental Health Parity Law

The Employee Benefits Security Administration (EBSA) released its annual enforcement report on the Mental Health Parity and Addiction Equity Act (MHPAEA) for 2019. EBSA is an agency within the U.S. Department of Labor (DOL). According to EBSA, vigorous enforcement of MHPAEA is one of its **top enforcement priorities**.

MHPAEA is a federal law that prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than medical and surgical benefits.

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, treatment limitations 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.

Generally, if violations are found by an EBSA investigator, the health plan must remove any noncompliant plan provisions and pay any improperly denied benefits.

Action Steps

Employers should work with their issuers and benefits administrators to confirm that their health plan's coverage of MH/SUD benefits complies with MHPAEA, including any NQTLs.

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Active Enforcement

- EBSA conducts MHPAEA compliance reviews in all its investigations where MHPAEA applies.
- When EBSA identifies MHPAEA violations, it asks the plan to make necessary changes to any noncompliant plan provision and to pay any improperly denied benefit claims.
- EBSA may also require the plan or service provider to provide notice to potentially affected participants and beneficiaries.

Parity Requirements

MHPAEA requires parity between a plan's MH/SUD benefits and medical and surgical benefits with respect to:

- Financial requirements (for example, copayments)
- Treatment limitations (for example, visit limits)
- NQTLs (for example, prior authorization)

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Mental Health Parity

MHPAEA is a federal law that generally prevents group health plans and health insurance issuers that provide MH/SUD benefits from imposing less favorable limitations on those benefits than on medical and surgical coverage. MHPAEA's parity requirements generally apply to group health plans and health insurance issuers that provide coverage for MH/SUD benefits in addition to medical and surgical benefits.

Applicable Health Plans

MHPAEA generally applies to plans sponsored by employers with **more than 50 employees**, including self-insured plans and fully insured arrangements. MHPAEA does not require large group health plans and their health insurance issuers to cover MH/SUD benefits. MHPAEA's requirements apply only to large group health plans and their health insurance issuers that choose to include MH/SUD benefits in their benefits packages. However, other state and federal laws may require a plan to provide these benefits.

The Affordable Care Act (ACA) requires some plans to cover MH/SUD services as an essential health benefit. Specifically, non-grandfathered health plans in the individual and small group markets are required to provide essential health benefits (which include MH/SUD services), as well as comply with the federal parity law requirements.

Nonfederal governmental plans that are self-funded may elect to opt out of MHPAEA's parity requirements. In order to opt out, the plan must file an election with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each plan year and must notify the plan participants of its choice to opt out.

Parity Requirements

MHPAEA contains the following parity requirements:

- ☑ The **financial requirements** (such as deductibles, copayments, coinsurance and out-of-pocket limits) applicable to MH/SUD benefits cannot be more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits.
- ☑ **Treatment limitations** (such as frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of coverage) must also comply with the MHPAEA's parity requirements.

In addition, MHPAEA imposes parity requirements on the **nonquantitative treatment limitations (NQTLs)** that plans may place on MH/SUD benefits. NQTLs include, for example, medical management standards, formulary designs for prescription drugs, plan methods for determining usual, customary and reasonable charges, exclusions based on a failure to complete a course of treatment and restrictions based on facility type or provider specialty.

Available Resources

The Departments' final FAQs and warning signs of problematic NQTLs highlight aspects of plan design that should be carefully reviewed for MHPAEA compliance. The self-compliance tool includes a questionnaire that employers can complete to help determine whether their group health plan complies with MHPAEA.

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MHPAEA Enforcement

EBSA enforces MHPAEA's requirements for private-sector employment-based health plans. EBSA conducts MHPAEA compliance reviews, including for compliance with NQTL requirements, in all its investigations where MHPAEA applies. When EBSA identifies MHPAEA violations in a specific group health plan, it asks the plan to make necessary **changes to any noncompliant plan provision and to pay any improperly denied benefit claims**. EBSA may also require the plan or service provider to provide **notice to potentially affected participants and beneficiaries**.

To achieve the greatest impact, EBSA investigators seek a global correction, working with the plans' service providers (such as third-party administrators or managed behavioral health organizations) to find improperly denied claims in other plans they service and correct the problem for those plans as well. According to EBSA, its investigators have worked with several large insurance companies to remove impermissible barriers to mental health benefits, such as overly restrictive written treatment plan requirements and overly broad preauthorization requirements that did not apply in a comparable manner to medical/surgical benefits. These global changes have impacted hundreds of thousands of group health plans and millions of participants and beneficiaries.

2019 Enforcement Results

In fiscal year 2019, EBSA closed 186 health plan investigations, 183 of which included reviews of MHPAEA compliance. These investigations resulted in 12 citations for MHPAEA violations. As an example of the size and scope of these investigations, in the course of one investigation involving a service provider, the service provider reported providing services to 99 self-insured and 210 fully-insured plans, covering 67,724 participants.

EBSA Enforcement Examples:

- The EBSA Kansas City Regional Office reviewed a service provider with multiple self-insured and fully-insured plans. Some of those plans imposed a medical necessity review requirement on outpatient MH/SUD benefits after 30 visits. The plans permitted 52 outpatient visits before requiring any additional medical necessity review of medical/surgical benefits. Additionally, the service provider was unable to show that it applied comparable factors in establishing the two requirements. As a result of the investigation, the number of MH/SUD office visits allowed before the plan would conduct a medical necessity review was increased to 52, utilizing standards parallel for medical/surgical benefits. Additionally, 198 claims were readjudicated for nine different plans, and the plan service provider issued payments totaling $19,744 to 29 participants.
- 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% coinsurance was applied for subsequent visits for the remainder of the year; by contrast, all MH/SUD office visits were charged the 30% 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.

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