EMPLOYEE BENEFITS SECURITY ADMINISTRATION
UNITED STATES DEPARTMENT OF LABOR

FACT SHEET

dol.gov/agencies/ebsa

FY 2023 MHPAEA ENFORCEMENT

ENFORCEMENT OVERVIEW: ENSURING PARITY

The Mental Health Parity and Addiction Equity Act (MHPAEA) was signed into law in 2008 to ensure parity between financial requirements and treatment limitations on benefits for mental health conditions and substance use disorders as compared to medical/surgical benefits. These protections are vital for America's workers, health insurance consumers, and their families. The Employee Benefits Security Administration (EBSA) and the Centers for Medicare & Medicaid Services (CMS) are responsible for enforcing MHPAEA, together with the states. This enforcement fact sheet summarizes EBSA's and CMS's closed investigations and public inquiries related to MHPAEA during fiscal year (FY) 2023 to better inform the public of EBSA's and CMS's enforcement of MHPAEA.[1]

EBSA enforces Title I of the Employee Retirement Income Security Act (ERISA) for 2.6 million private employment-based group health plans,[2] which cover 136 million participants and beneficiaries[3]. EBSA relies on its approximately 302 investigators to review all retirement and welfare benefit plans for compliance with ERISA, including the group health plan provisions added by MHPAEA. EBSA also employs approximately 113 benefits advisors who provide participant education and compliance assistance, including education and assistance regarding MHPAEA. Benefits advisors further pursue voluntary compliance from plans on behalf of participants and beneficiaries.

CMS enforces MHPAEA and other applicable provisions of Title XXVII of the Public Health Service Act (PHS Act) with respect to non-federal governmental plans, such as plans for employees of state and local governments.[4,5] CMS also enforces applicable provisions of Title XXVII of the PHS Act, including the provisions added by MHPAEA, for health insurance issuers selling products in the individual and fully insured group markets in states that are not substantially enforcing MHPAEA or another PHS Act provision.[6, 7] CMS oversees approximately 91,000 non-federal governmental plans[8] and 67 health insurance issuers in states where CMS is responsible for MHPAEA enforcement.[9] CMS currently has 15 investigators who review plans and issuers for compliance with MHPAEA and other applicable PHS Act provisions. CMS also performs market conduct examinations in states where CMS is responsible for

[1] See also section 13003 of the 21st Century Cures Act, as amended by section 7182 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act), which over a 6-year period required an annual report to Congress on complaints and investigations concerning compliance with the requirements of MHPAEA.
[2] U.S. Department of Labor, EBSA calculations using the 2023 Medical Expenditure Panel Survey, Insurance Component (MEPS-IC), Form 5500 filings, and the 2021 Census Bureau County Business Patterns.
[3] U.S. Department of Labor, EBSA calculations using the Auxiliary Data for the March 2022 Census Bureau Annual Social and Economic Supplement of the Current Population Survey.
[4] CMS is responsible for enforcement of applicable PHS Act provisions with respect to non-federal governmental plans in all 50 states, the territories, and the District of Columbia. See section 2723(b)(1)(B) of the PHS Act.
[5] Sponsors of self-insured non-federal governmental plans previously could elect to exempt those plans from (i.e., opt out of) certain requirements of Title XXVII of the PHS Act, including MHPAEA. See former section 2722(a)(2) of the PHS Act and implementing regulations at 45 CFR 146.180. The Consolidated Appropriations Act, 2023, amended section 2722(a)(2) of the PHS Act such that sponsors of self-insured non-federal governmental plans generally cannot opt out of MHPAEA, effective December 29, 2022.
[6] See section 2723(a)(2) and (b)(1)(A) of the PHS Act.
[7] In FY 2023, CMS was responsible for enforcement of MHPAEA with regard to issuers in Texas and Wyoming. In addition, CMS had collaborative enforcement agreements with Alabama, Florida, Louisiana, Montana, and Wisconsin. These states with collaborative enforcement agreements with CMS perform state regulatory and oversight functions with respect to some or all of the applicable provisions of Title XXVII of the PHS Act, including MHPAEA. However, if the state finds a potential violation and is unable to obtain compliance by an issuer, the state will refer the matter to CMS for possible enforcement action.
[8] Estimate based on data from the 2022 Census of Governments.
[9] U.S Department of Health and Human Services, CMS calculations using 2023 MLR data of issuers with enrollment in the individual, small group, or large group markets.

enforcement and in states with a collaborative enforcement agreement when the state requests assistance.

EBSA has released annual MHPAEA enforcement fact sheets, summarizing its enforcement activities in each fiscal year, since FY 2015.[10] CMS has released annual MHPAEA enforcement reports and fact sheets summarizing its enforcement activities since 2016.[11]

This enforcement fact sheet does not report on ongoing investigations, including those that were opened but not closed during FY 2023. These cases will be reported for the fiscal year in which they are closed. It is not uncommon for complex MHPAEA investigations to take multiple years to complete, especially those that involve large service providers (such as issuers, third-party administrators, and managed behavioral health organizations).

Following the enactment of the Consolidated Appropriations Act, 2021 (CAA, 2021),[12] EBSA and CMS significantly increased their enforcement activity related to nonquantitative treatment limitations (NQTLs)[13] in FY 2021 and FY 2022. The results of some of these investigations are included in the fact sheet. However, this fact sheet does not fully capture results from EBSA's and CMS's increased enforcement activity related to NQTLs because many of these investigations opened in FY 2021 and FY 2022 were ongoing at the end of FY 2023.

A summary of EBSA's and CMS's CAA, 2021-related MHPAEA enforcement activities and related results are detailed in the 2024 MHPAEA Report to Congress[14] and the MHPAEA Comparative Analysis Report to Congress, July 2023.[15] If EBSA or CMS cited a MHPAEA NQTL violation (including violations of the CAA, 2021's comparative analysis requirements) and the investigation was closed during FY 2023, the results of those investigations and any corrective actions are also captured in this fact sheet.

In FY 2023, EBSA and CMS investigated MHPAEA violations in the following categories:

(1) ***Annual dollar limits*****:** dollar limitations on the total amount of specified benefits that may be paid in a 12-month period under a group health plan or health insurance coverage for any coverage unit.

(2) ***Aggregate lifetime dollar limits*****:** dollar limitations on the total amount of specified benefits that may be paid under a group health plan or health insurance coverage for any coverage unit.

(3) ***Benefits in all classifications*****:** requirement that if a plan or issuer provides mental health or substance use disorder benefits in any classification described in the MHPAEA final regulations, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided.[16]

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[10] 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/tools-and-resources, under "Get the facts on MHPAEA Enforcement."

[11] See CMS's previous MHPAEA Enforcement Reports and Fact Sheets, available at https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index#mental-health-parity.

[12] Section 203 of Title II of Division BB of the CAA, 2021.

[13] NQTLs are treatment limitations, usually expressed non-numerically, on the scope or duration of benefits for treatment under a plan or coverage. Examples of NQTLs include, but are not limited to: medical management standards; formulary design for prescription drugs; network tier design (for plans with multiple network tiers (such as preferred providers and participating providers)); and standards for provider admission to participate in a network.

[14] See 2024 MHPAEA Report to Congress, available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2024.pdf.

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

[16] 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.

(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 (such as 50 outpatient visits per year), and NQTLs (such as medical management standards), which otherwise limit the scope or duration of benefits for treatment under a plan or coverage.

(6) ***Cumulative financial requirements and cumulative 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.

FY 2023 Enforcement Fast Facts:

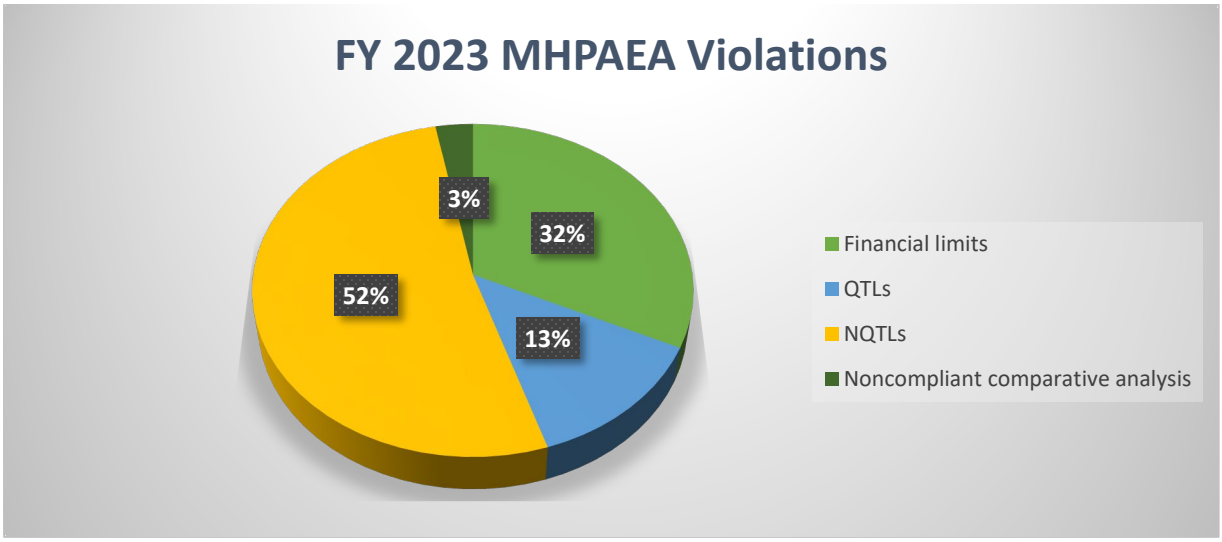
EBSA Investigations

- EBSA investigated and closed 102 health plan investigations in FY 2023. Of those investigations, 25 involved fully insured plans, 51 involved self-insured plans, and 26 involved plans of both types (where the plan or service provider offered both fully insured and self-insured options). EBSA has closed 4,333 health plan investigations since FY 2011.

- Of the 102 closed investigations in FY 2023, 51 involved plans or service providers that were reviewed for compliance with MHPAEA. Of the 51 investigations, 10 involved fully insured plans, 27 involved self-insured plans, and 14 involved plans of both types (where the plan or service provider offered both fully insured and self-insured options).

- EBSA cited 31 MHPAEA violations in 17 investigations. Of those investigations, 11 involved self-insured plans, and 6 involved a plan of both types (where the plan or service provider offered both fully insured and self-insured options). The violations related to, as further shown below in the chart:

    - 10 financial limits;
    - 4 QTLs;
    - 16 NQTLs, including 8 separate treatment limitations that were benefit exclusions; and
    - 1 final determination of noncompliance with the NQTL comparative analysis requirements in a closed investigation (this final determination was also reported in the July 2023 Comparative Analysis Report to Congress).



- EBSA investigations that focus on MHPAEA compliance are generally complex, resource-intensive, and often involve specialized interdisciplinary teams and consultations with experts. EBSA strives to broadly ensure compliance with an emphasis on high-impact cases, without compromising its commitment to rigorous enforcement.

- EBSA benefits advisors answered 196 MHPAEA-related public inquiries, including 183 complaints, in FY 2023. They have answered 1,725 MHPAEA-related inquiries since FY 2011.

CMS Investigations

- In FY 2023, CMS received 43 MHPAEA-related complaints through the No Surprises Help Desk, which were reviewed, and when appropriate, investigated, by the Center for Consumer Information and Insurance Oversight (CCIIO).
- CMS investigated and closed 599 health plan investigations in FY 2023. Of those investigations, 457 involved issuers offering fully insured group or individual health insurance coverage and 142 involved self-funded non-federal governmental plans.
- Of the 599 closed investigations in FY 2023, 5 involved plans that were reviewed for compliance with MHPAEA. All were self-funded non-federal governmental plans.
- CMS cited two MHPAEA violations. The violations included:
    - 1 NQTL concerning ABA therapy where prior authorization requirements were more stringently applied to ABA therapy (a mental health service) than to medical/surgical services. Specifically, prior authorization for ABA therapy was required every six months. No such timeframe was imposed for prior authorization of medical/surgical services in the outpatient, in-network classification; and
    - 1 QTL related to a more stringent financial requirement for mental health and substance use disorder benefits as compared to medical/surgical benefits.

THE EBSA ENFORCEMENT PROCESS AND RESULTS

Assisting Participants

EBSA receives inquiries from participants who believe their mental health or substance use disorder benefits have been improperly denied. Benefits advisors work with participants and their plans to help participants receive the benefits to which they are entitled. Benefits advisors are the public's initial point of contact with EBSA. If a benefits advisor thinks a violation may have occurred and is unable to obtain voluntary compliance from a plan, EBSA may open a formal investigation.

Achieving Global Corrections

EBSA's New York Regional Office investigated a plan that appeared to impose a higher psychotherapy experience requirement for social workers than required by the plan's credentialing process. The same plan also appeared to only cover nutritional counseling for certain medical conditions and surgical procedures, but not for mental health conditions. As a result of EBSA's efforts, the plan's service provider applied global correction across its entire book of business, clarifying plan document language and sending notices to all affected participants, resulting in corrections to 703 plans covering 1,242,389 participants.

Investigating Plans

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

Referring for Investigation

A benefits advisor in EBSA's Boston Regional Office was contacted by a mental health treatment facility regarding unfair practices by an issuer operating in the northeastern United States. Representatives from the mental health treatment facility asserted that the insurer had failed to negotiate reimbursement rates for mental health treatment for more than 8 years. As over 80% of the facility's patients were covered by this insurer, these lower reimbursement rates placed the facility in danger of closing. They also alleged that the insurer processes claims beyond a reasonable amount of time. Following the benefits advisor inquiry, the Boston Regional Office opened an investigation on this issuer.

Generally, if an EBSA investigator finds violations, the investigator recommends the plan remove any non-compliant plan provisions and pay any improperly denied benefits. To achieve the greatest impact, EBSA investigators work with the plans' service providers (such as third-party administrators or managed behavioral health organizations) to obtain broad corrections, not only for the particular plans investigated, but also for other plans that contract with those service providers and that employ the same problematic plan terms or practices. EBSA investigators have worked with several large issuers to remove unlawful barriers to mental health benefits, such as 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 and continue to help impacted participants and beneficiaries by increasing access to benefits going forward.

THE CMS ENFORCEMENT PROCESS

Providing Technical Assistance

CMS receives inquiries from states, plans, issuers, and others regarding compliance with MHPAEA. CMS's state engagement coordinators and MHPAEA subject matter experts work with interested parties to help ensure consumers receive the mental health and substance use disorder benefits to which they are entitled. State engagement coordinators are the initial point of contact for states to receive technical assistance, and MHPAEA subject matter experts can answer specific questions for plans and issuers. In FY 2023, consumers were also able to directly submit MHPAEA complaints through the No Surprises Help Desk.[17]

CMS Collaborates with State Regulators

CMS continues to work closely with state regulators, both on an individual basis and through the National Association of Insurance Commissioners, to help ensure understanding of federal requirements and provide technical assistance. These efforts to collaborate with states can lead to tremendous results. For example, CMS successfully transitioned MHPAEA enforcement responsibility to the state of Missouri in FY 2023.

Investigating Plans and Issuers

CMS conducts MHPAEA enforcement in several ways.

Document Review

For issuers offering coverage in the fully insured group or individual markets in states where CMS is responsible for enforcement of MHPAEA,[18] CMS reviews issuers' plan documents for potential violations before the products are offered for sale.

Investigations and Market Conduct Examinations

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

Comparative Analysis Reviews

Following the enactment of the CAA, 2021, CMS reviews NQTL comparative analyses of issuers in states where CMS is responsible for enforcement and of non-federal governmental plans in all states.

Collaboration with States

Some states have entered into collaborative enforcement agreements with CMS.[19] In these states, the state attempts to obtain voluntary compliance from the issuer to correct any MHPAEA-compliance concerns. If the state is unable to obtain voluntary compliance, the state will refer the matter to CMS for possible enforcement.

Generally, if a CMS examiner finds MHPAEA violations, the examiner works with the issuer or non-federal governmental plan to identify and ensure corrective actions are taken 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 plan is instructed to report the findings of the self-audit to CMS and re-adjudicate any improperly denied claims. To achieve the greatest impact, CMS also directs these issuers and plans to review other plans in their portfolio to identify similar situations and obtain broad corrections.

[17] The No Surprises Help Desk is available at 1-800-985-3059 or via webform available at https://www.cms.gov/medical-bill-rights/help/submit-a-complaint.
[18] In FY 2023, CMS was the direct enforcer of MHPAEA with regard to issuers in Texas and Wyoming.
[19] See supra note 7.

FY 2023 IN REVIEW: EXAMPLES OF EBSA AND CMS ACTIONS PROTECTING MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

EBSA Actions

- ✓ *Restrictions on services related to autism spectrum disorder (ASD) and substance use disorder treatment eliminated.* EBSA's Chicago and Dallas Regional Offices worked together to investigate a service provider that offered plan options to ERISA-covered self-funded group health plans that excluded applied behavior analysis (ABA) therapy. As a result of EBSA's efforts, 619 participants and beneficiaries enrolled in the affected ERISA-covered plans were issued payments totaling approximately $1.3 million for previously denied claims for ABA therapy. Additionally, the service provider agreed to make ABA therapy a standard benefit offering for self-funded and fully insured plans, so that over 1 million participants and their families now have coverage of ABA therapy if needed.

  The service provider had also imposed visit limits on other ASD-related services including physical therapy, occupational therapy, and speech therapy. As a result of EBSA's investigation, the service provider further agreed to remove visit limits on ASD-related physical therapy, occupational therapy, and speech therapy, expanding benefits for over 15 million participants across approximately 52,000 ERISA plans.

  Further, the service provider updated its claims processing system to adjudicate claims for methadone, a medication to assist in the treatment of opioid addiction, in accordance with plan documents and claims processing regulations. This change affected over 14 million participants.

- ✓ *Excess cost sharing refunded and impermissible precertification requirement removed.* EBSA's New York Regional Office investigated an ERISA plan that was charging participants 30% coinsurance for outpatient mental health and substance use disorder services. The investigation found that the plan did not apply the 30% coinsurance to substantially all medical or surgical benefits under the plan and therefore this 30% coinsurance on mental health and substance use disorder services was an impermissible financial requirement imposed on mental health services. As a result of the investigation, the plan changed cost-sharing amounts for mental health services to be comparable to those for medical and surgical services. The plan also issued 250 benefit checks to participants and beneficiaries to reimburse them a total of $34,309 in cost-sharing that they had paid out-of-pocket but should have been covered by the plan.

  Additionally, the plan's summary plan description (SPD) included a blanket precertification requirement that applied to all mental health and substance use disorder services, even though there was no such blanket requirement for medical/surgical services. The plan also removed the blanket precertification requirement from the SPD and confirmed that there were no denials issued because of it. As a result, participants now pay less for mental health and substance use disorder services and have easier access to those services.

- ✓ *Mental health claims reprocessed and excess cost sharing returned.* EBSA's Atlanta Regional and Miami District Offices investigated a plan service provider that required that drugs for mental health conditions be prescribed by a psychiatrist or neurologist or otherwise be subject to 50% coinsurance due from the participant. No similar requirement limiting the type of prescribing provider was imposed on drugs used to treat medical/surgical conditions. As a result of the investigation, the service provider reprocessed 649 claims with $19,840 reimbursed to 191 participants enrolled in 154 ERISA plans that used the service provider. Additionally, EBSA investigators found the service provider failed to perform an analysis as to

the predominant copay that applied to substantially all medical/surgical benefits. Once the analysis was performed, it revealed that outpatient mental health and substance use disorder office visits were subject to impermissibly higher copays than medical/surgical office visits. As a result of the investigation, the service provider implemented a policy to conduct a recurring copay analysis and reprocessed 94 claims with impermissible cost sharing.

- ✓ *Higher copays for mental health and substance use disorder benefits in-network, outpatient visits eliminated.* EBSA's Atlanta Regional Office investigated a plan service provider that failed to conduct an analysis as to the predominant copay that applied to substantially all medical/surgical benefits in the outpatient, in-network classification. The plan design utilized by the service provider imposed a specialist cost-sharing amount on outpatient, in-network mental health and substance use disorder visits that was higher than the predominant copay applied to substantially all medical/surgical benefits in the classification. As a result of the investigation, the service provider implemented a policy to conduct a recurring copay analysis and re-adjudicated 2,631 claims.

- ✓ *Coverage for ABA therapy increased.* EBSA's National Office investigated an ERISA self-funded plan whose service providers excluded benefits for ABA therapy for the treatment of ASD. As a result of this investigation, the plan now covers ABA therapy for the treatment of ASD, resulting in increased benefits for 6,555 participants enrolled in the plan.

- ✓ *Improper specialist copay for mental health and substance use disorder office visits removed.* EBSA's New York Regional Office investigated an ERISA plan that imposed a higher specialist copay on all mental health and substance use disorder outpatient services, when the lower, regular office visit copay should have applied. As a result of the investigation, the plan lowered the amount of cost-sharing charged to the appropriate amount for the plan's 1,460 participants. Additionally, the plan refunded 47 participants the excess cost-sharing they had paid. The plan also had an impermissible limit on intensive outpatient treatment for mental health and substance use disorder services, which was removed.

CMS Actions

- ✓ *Removal of impermissible 6-month limit on ABA therapy prior authorization approvals.* During an NQTL comparative analysis review required by the CAA, 2021, a non-federal governmental plan was found to have a prior authorization requirement for ABA therapy, a mental health service, that was more stringent than the prior authorization requirement for medical/surgical services. Whereas the plan limited the length of prior authorization approval for ABA therapy to a six-month time period, there was no such limitation for medical/surgical benefits in the classification. Therefore, ABA therapy was required to obtain new prior authorization every six months, while medical/surgical services did not require required renewed prior authorizations after six months of treatments in the outpatient, in-network classification. After receiving CMS' initial determination letter, the plan removed all prior authorization requirements for outpatient, in-network mental health and substance use disorder services, including for ABA therapy. CMS directed the plan to conduct a claims audit to identify individuals affected by the NQTL. The plan re-adjudicated claims for individuals who were adversely affected by application of the NQTL, resulting in a total refund of $91,789.10 to 29 individuals.

- ✓ *Elimination of exclusions for methadone treatment for opioid use disorder (OUD) and Spravato for individuals with substance use disorders.* A non-federal governmental plan excluded methadone treatment for OUD, a substance use disorder, but did not impose any comparable exclusions of prescription drugs for medical/surgical conditions. The plan also applied a factor for determining whether to cover a prescription drug, "Safety, e.g., Adverse effects of drugs; Contraindications; and Drug interactions," that was not comparable and was applied more stringently to mental health and substance

use disorder prescription drugs compared to medical/surgical prescription drugs. This resulted in the exclusion of a prescription drug, Spravato, for individuals diagnosed with a substance use disorder. As a result of the investigation, the plan began covering methadone treatment for OUD and also eliminated the exclusion of Spravato for individuals with substance use disorders. The plan reviewed claims and authorization requests to determine whether members were denied coverage as a result of these exclusions and found no associated denied claims or authorization requests.

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

Contact EBSA

U.S. Department of Labor
askebsa.dol.gov

Telephone: 1-866-444-3272

Contact CMS

U.S. Department of Health and Human Services

https://www.cms.gov/medical-bill-rights/help/submit-a-complaint

Telephone: 1-800-985-3059