

2018

Secretary R. Alexander Acosta
U.S. Department of Labor

Report to Congress



[PATHWAY TO FULL PARITY]

In its 2018 report to Congress, the Department of Labor outlines its current implementation and enforcement actions in furtherance of the Mental Health Parity and Addiction Equity Act.

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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 by January 2012, and every two years thereafter.

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 implements 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.¹

When the Department transmitted the 2016 Report to Congress, final rules issued under MHPAEA had been applicable to health plans and insurance issuers for some time. Thus, in addition to summarizing MHPAEA's requirements and recent guidance intended to address discrete issues raised by stakeholders, the report also 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 are entitled.

This report summarizes the Department's activities to further parity implementation since the 2016 Report to Congress. It also provides a roadmap of the Department's vision for the future as the Department continues to identify and correct MHPAEA noncompliance and minimize the likelihood of future violations through effective outreach, compliance assistance, and interpretive guidance.

¹ The Department's 2012 and 2014 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

Benefits for mental health and substance use disorder services are an essential and often lifesaving component of health coverage. These benefits provide security and enable individuals to seek care they might not otherwise be able to receive. For many years, however, most health coverage options failed to provide equal treatment for mental health and substance use disorder treatment compared to treatment for physical health conditions.

Recognizing this disparity, on October 3, 2008, Congress enacted the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which supplemented the Mental Health Parity Act of 1996. MHPAEA generally requires that coverage for health care services for mental health and substance use disorders be comparable to – *or in parity with* – coverage for services for general medical and surgical care. Generally, the Federal parity law and regulations aim to eliminate overly burdensome restrictions health plans placed on mental health and substance use disorder coverage – like higher copayments, separate deductibles, lower annual visit limits, and techniques on how care is managed (such as pre-authorizations or medical necessity reviews) that are more restrictive than those placed on medical and surgical benefits.

MHPAEA provides important protections for the more than 40 million people – one in five American adults – who experienced some form of mental illness in the past year, and the over 20.2 million who had a substance use disorder. These protections are important for all individuals, since over the course of their lifetimes, Americans face a 50 percent chance of needing behavioral health services.² Many challenges remain, but great strides have been made in implementing the vision of MHPAEA in the years since it was enacted.

The Department of Labor plays a key role in implementing and enforcing MHPAEA

The Department is committed to full implementation of MHPAEA, which means using all applicable authority to foster compliance with the statute's requirements, as well as maintaining an active outreach program, and engaging in vigorous compliance assistance and enforcement. Through investigations of employment-based plans, regulations, and guidance, and outreach and education, the Department strives to ensure that coverage offered for mental health and substance use disorder treatment is provided comparably with that offered for other medical care. The Department believes these 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.

Regulations and interpretive guidance are key aspects of the Department's implementation of MHPAEA. Because MHPAEA applies to many types of health plans and coverage options, the

² Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication (available at, <https://www.ncbi.nlm.nih.gov/pubmed/15939837>).

Department, which oversees most employer-sponsored group health plans, coordinates the development of regulations and guidance with the Departments of Health and Human Services (HHS) and the Treasury (collectively, the Departments). After MHPAEA was enacted, the Departments published interim final regulations with a request for comments, followed by final regulations implementing mental health and substance use disorder parity. The Departments also issue subregulatory guidance in response to questions and concerns raised by plan sponsors, health insurance issuers, health care providers, consumer advocates, States, and other interested stakeholders. While the Departments are committed to using the rulemaking process, an appropriate use of guidance, such as frequently asked questions (FAQs), allows the Departments to respond in a quick and effective manner to developing issues. The issuance of FAQs and other sub-regulatory guidance is an ongoing and evolving effort that is undertaken along with the input of stakeholders and that has positive outcomes for covered individuals with mental health conditions and substance use disorders.

Outreach and education are also essential components of implementing the MHPAEA and promoting compliance. The Department recognizes that full MHPAEA implementation cannot be realized unless health plan sponsors and health insurance issuers understand their obligations under MHPAEA. In the same vein, the Department understands how crucial it is for consumers to know their rights under the law, if they are to take full advantage of them. Disseminating timely information can put a stop to problems before they start, which means that fewer consumers will face coverage problems when seeking care for mental health conditions and substance use disorders. To that end, the Department's Employee Benefits Security Administration (EBSA) gives presentations at numerous outreach events around the country each year to discuss the obligations of health plans and rights of participants and beneficiaries under the Federal parity requirements. EBSA also holds webinars, develops consumer-oriented publications, and provides compliance assistance tools and check sheets designed to improve understanding of MHPAEA's requirements.

EBSA also actively enforces MHPAEA with respect to 2.2 million private employment-based group health plans, which cover 130.8 million participants and beneficiaries. These plans can be self-insured, fully-insured or a combination of both. EBSA relies on its investigators to review plans for compliance with MHPAEA as well as its benefits advisors (or customer service representatives) to provide participant education and compliance assistance regarding MHPAEA. Investigators and benefits advisors also pursue voluntary compliance from plans on behalf of participants and beneficiaries.

Finally, EBSA frequently coordinates with other Federal and State agencies to ensure that MHPAEA is being interpreted consistently, provide education, and improve enforcement of parity requirements. EBSA has worked with the Substance Abuse and Mental Health Services Administration (SAMHSA) to issue consumer publications to help individuals understand their rights under the law and to host several policy academies intended to provide support for State insurance regulators tasked with MHPAEA enforcement responsibilities. In 2016, EBSA

participated in the Mental Health and Substance Use Disorder Parity Task Force, which was established to increase awareness of the protections that parity provides, improve understanding of the law, and enhance compliance and enforcement efforts. In 2017, EBSA also worked closely with President Trump's Commission on Combating Drug Addiction and the Opioid Crisis to highlight the vital role that parity plays in ensuring access to treatment for substance use disorders, including opioid use disorder.

MHPAEA Challenges

EBSA works to implement and enforce MHPAEA to the fullest extent possible. 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 143 million workers and their dependents and include assets of over \$8.7 trillion (as of October 2, 2015). That equates to less than one investigator for every 12,500 plans. By statute, EBSA is precluded from directly enforcing the law against insurance companies, even when EBSA obtains evidence that the insurance company is the party responsible for the parity violation. EBSA also cannot assess civil monetary penalties in egregious cases of noncompliance to deter bad actors. This report highlights these implementation challenges.

MHPAEA continues to be an agency priority. In furtherance of its commitment to parity, EBSA has designated MHPAEA enforcement a national initiative for fiscal year (FY) 2018. EBSA also continues to brainstorm innovative ways to bolster MHPAEA compliance and leverage its limited enforcement resources. Through these efforts, EBSA is hopeful that it will continue to improve outcomes for individuals living with mental health conditions and substance use disorders.

II. EBSA'S MHPAEA PROGRAM OVERVIEW

A. EBSA's enforcement program

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 top enforcement priorities of the agency. In addition to referrals from benefits advisors, EBSA pursues investigations based on leads from other enforcement agencies, feedback from consumer groups, and utilization of advanced targeting methods that incorporate various sources. Since October 2010, EBSA has conducted over 1,700 carefully targeted investigations in connection with MHPAEA, and cited more than 300 violations that involve mental health and substance use disorder 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.

When EBSA identifies violations in a particular group health plan, the Department asks the plan to make necessary changes to any noncompliant plan provision and to re-adjudicate any improperly denied benefit claims. Under current law, the penalties for parity violations are limited to equitable relief, which generally means requiring the offender to provide reimbursement to and/or coverage for participants and beneficiaries whose past claims were improperly denied. In 2016, a report issued by the Mental Health and Substance Use Disorder Parity Task Force found that authority to impose civil monetary penalties for MHPAEA violations, similar to the authority granted to the Department for enforcement of other laws relating to group health plans, would lead to more meaningful incentives and penalties for non-compliance.

Although EBSA has been able to work with health insurance issuers in a number of cases to achieve global corrections, the Department does not have the authority to enforce MHPAEA directly against issuers to correct noncompliant health insurance policies that are designed, marketed, and sold by the issuer to numerous employers for purposes of offering the health plans their employees. To leverage its limited resources and achieve greater impact, EBSA tries to obtain global corrections whenever possible in cases where a violation relates to an insurance product that is being offered to multiple employers by working with issuers to seek a voluntary correction on all policies with the same compliance issue. Such corrections can impact thousands of plans with millions of participants and beneficiaries whose mental health and substance use disorder benefits may be improperly denied. Both the Mental Health Parity and Substance Use Disorder Parity Task Force and the President's Commission on Combating Drug Addiction and the Opioid Crisis have recommended that Congress enact legislation to allow direct enforcement against health insurance issuers to ensure compliance with the law.

1. DOL MHPAEA investigations – under the hood

There is no one-size-fits-all approach to performing an EBSA MHPAEA investigation. The investigative steps may vary based on the type of potential MHPAEA issue and how the issue comes to EBSA's attention. Due to the complex nature of these cases, a MHPAEA investigation can take a year or more, depending on a variety of factors, including whether EBSA has to engage experts or refer the matter to another DOL agency to litigate the issue.

Generally, the first step in an EBSA MHPAEA investigation is obtaining relevant documents including the plan document, summary plan description (SPD), and/or certificate of coverage that contain the plan provisions regarding mental health and substance use disorder and medical/surgical benefits. In addition to the SPD or certificate, EBSA may also request the contracts the plan has executed with its service providers (such as a third party administrator) as well as any relevant internal guidelines the plan may use, as these documents often contain information relevant to determining whether the plan complies with MHPAEA. Often times, plan limits on mental health and substance use disorder benefits may not be explicitly stated in the relevant documents, and EBSA investigators spend a great deal of time analyzing plan information to identify a plan's policies and practices. Generally, a single MHPAEA case involves reviewing and analyzing hundreds of pages of documents at the outset.

In addition to documents, EBSA also often requests that the plan provide information regarding covered and denied claims. A sample of mental health and substance use disorder benefit claims, as well as medical/surgical claims may be requested to confirm whether, in practice, the plan's operation is consistent with plan provisions, which can be very important since compliance as written does not necessarily indicate compliance in practice. Furthermore, evaluating the claims data enables EBSA to identify which individuals may have been harmed by a potential MHPAEA violation. Particularly with NQTLs such as pre-authorization or medical necessity rules, it is often necessary to review individual claims to determine how the plan operates in practice. If analyzing large amounts of data, an EBSA investigator may require assistance from agency economists, or even an outside contractor. Even when it is not necessary to review the actual claims, an analysis of the claims data is often necessary to determine the claims that were affected by the MHPAEA issue and identify those claims that may need to be reprocessed by the issuer or plan. Typically, a MHPAEA case can involve analyzing several years of claims data (or thousands of individual claims).

After analyzing the documents and the relevant claims data, EBSA will perform interviews and depositions to clarify any outstanding questions or issues regarding the plan's policies, protocols and operations. This usually involves speaking with representatives of the plan sponsor and with the health insurance issuer or third party administrator that administers the plan provisions that EBSA believes may be in violation. Many times this will require a series of conversations or depositions with plan representatives, including but not limited to medical doctors, behavioral

health specialists, and claims processors, as each of these individuals may have knowledge about the plan's practices that is critical to determining MHPAEA compliance. More often than not, these conversations generate additional documents that must also be evaluated by the investigator.

To the extent that the MHPAEA issues under investigation are complex or novel, particularly with respect to potential NQTL violations, the Department may need to retain an expert for consultation or testimony. Therefore, during the course of the investigation, the investigator may need to research, interview, and engage outside individuals or entities for subject matter expertise with regard to the specific areas under review.

After the investigator completes the initial analysis of the potential MHPAEA issue, the investigator often engages in multiple layers of coordination, within the Department with MHPAEA subject matter experts, attorneys, and economists, as well as externally with Federal and often State partners.³ Under section 104 of the Health Insurance Portability and Accountability Act (HIPAA), DOL is required to coordinate with HHS and Treasury as the Department shares interpretive jurisdiction over MHPAEA with these Departments. To the extent the plan being investigated has purchased a policy from an insurance company, the investigator may also coordinate with the applicable State insurance department that has primary enforcement jurisdiction in the relevant state.

After it is determined that the plan has violated MHPAEA, the investigator will attempt to achieve voluntary correction. If the plan is fully-insured and utilizes a prototype (or off-the-shelf) insurance policy, the investigator will attempt to achieve voluntary global correction through the insurance company for all plan sponsors utilizing that policy. For instance, if the issue involves a higher copayment on mental health and substance use disorder benefits that was set by the plan sponsor and that only affected the plan sponsor's plan, correction would be requested just for that single plan. But if a violation involves an NQTL in the issuer's prototype document that applies to some, or all, of the issuer's clients, the investigator would request that the issuer correct the problem for all affected clients. These widespread corrections, which EBSA calls global corrections, can potentially impact thousands of plans and millions of participants. To initiate the voluntary correction process, the investigator typically drafts a detailed voluntary compliance letter with the preliminary investigation findings and sends it to the plan sponsor.

³ The Department complies with all applicable privacy laws related to personally identifiable information and protected health information. Furthermore, the Department works with the entity that is the subject of an investigation to safeguard all proprietary or confidential information as it coordinates on any underlying interpretive issues. Furthermore, when working with State partners, EBSA generally shares information pursuant to a Memorandum of Understanding executed between EBSA and the entity. In addition, EBSA will enter into Common Interest Agreements with its State partners to discuss specific investigations and enforcement actions.

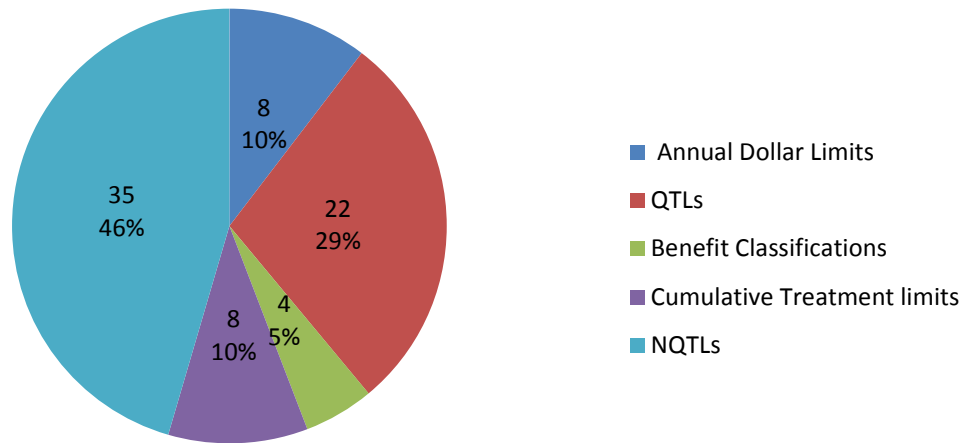
To the extent the plan or issuer agrees to remedy the MHPAEA violation, the investigator works to identify the appropriate way to redress the violation and monitors its implementation. The investigator is often involved in an arduous process to confirm the scope of the harm based on information the plan provides. Previously denied claims may need to be reprocessed as if the plan had been compliant with MHPAEA, which may result in those claims being approved and/or refunds of cost-sharing amounts being dispersed to the participants. Once the plan agrees to reprocess the claims, the investigator will monitor the status of any corrections to ensure that all the impacted individuals are compensated based on what was agreed upon between the plan and the investigator. The investigator also confirms that the plan updates any documents and plan practices to ensure that the problem is fixed for future plan years. As the final step, the investigator generally sends a closing letter to the plan sponsor letting them know that the investigation is closed.

Sometimes, the plan or issuer is not willing to voluntarily correct the issue. Many times, the plan may request to discuss the preliminary investigative findings with EBSA, and the investigator will engage in a series of meetings or conference calls with multiple representatives from the Department and the plan or issuer. If the issues are not resolved at this phase of the investigation, the case may then be referred to the Department's Solicitor's Office for potential litigation. The status of the investigator then changes from conducting the investigation to providing litigation support. The investigator may be involved in a series of additional meetings, or conference calls, and works closely with the Solicitor's office in any settlement negotiations or agreements.

2. Behind the numbers – EBSA enforcement results

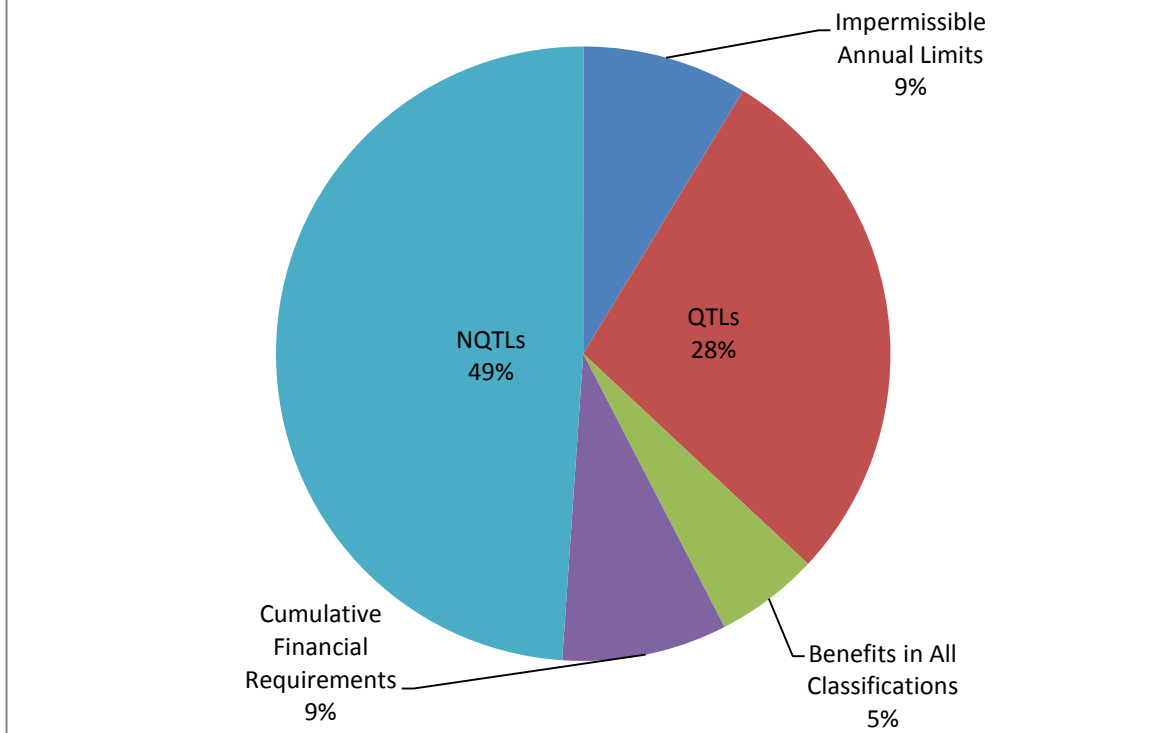
In fiscal years 2016 and 2017, EBSA closed 671 health plan investigations, 378 of which included reviews of MHPAEA compliance. These investigations resulted in 136 citations for MHPAEA violations.

FY 2017 Number of Cases with MHPAEA Violations Cited by Type



Recently, EBSA’s San Francisco Regional Office discovered a fully-insured plan that excluded treatment of chronic behavior disorders and required participants to obtain prior authorization for substance use disorder treatment and non-emergency admissions to mental health/substance use disorder treatment facilities. If prior authorization was not obtained for mental health or substance use disorder services, the plan would deny the claim and require the individual seeking treatment to pay the entire cost of treatment. By contrast, failure to obtain prior authorization for medical/surgical services only resulted in a reduction of covered benefits in certain cases – never a full denial. The plan also did not impose any restrictions on medical or surgical benefits when the underlying condition was “chronic”. As a result of EBSA’s investigation, both the restriction on chronic behavioral conditions and the penalty requiring the participant to pay the entire cost of substance use disorder treatment for failing to obtain preauthorization were removed. The issuer included these changes in its 2016-2017 contract endorsements, which meant that these restrictions no longer applied to 3,489 small and large group health plans and their 363,122 member participants.

FY 2017 Number of MHPAEA Violations by Type



EBSA's Los Angeles Regional Office also closed an important case in 2017 regarding a fully-insured plan that imposed the following requirements for mental health and substance use disorder benefits: (1) a written treatment plan prescribed and supervised by a behavioral health provider, (2) follow-up treatment, and (3) a restriction that the written plan should be for a condition that can favorably be changed. However, no comparable requirements applied to medical and surgical benefits. Due to EBSA's diligence, not only did the issuer agree to remove this impermissible NQTL from the plan under investigation, the issuer also agreed to remove it from all group health plans subject to MHPAEA in the state of California, which affected 3,034 large group health plans and 288,947 member participants.

3. Assessing the impact of EBSA results

In addition to seeking retrospective relief, EBSA also requests that plans 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 do not account for potential claims that will be impacted in future plan years by EBSA's efforts. In order to provide an idea of how each EBSA correction has an ongoing impact, EBSA's Office of Policy and Research estimated the number of total participants and beneficiaries from the number of participants using CPS CY 2015 data. They then relied on data from SAMHSA's "Results from the 2016 National Survey on Drug Use and Health" and the CDC's Morbidity and Mortality Weekly Report, "Mental Health Surveillance Among Children – United States 2005-2011" to estimate the numbers of individuals who may seek care that was subject to impermissible denials prior to the DOL's efforts. Using this process, EBSA is providing examples of how two investigations have an ongoing impact on the lives of individuals suffering from mental illness and substance abuse.

In the first example, EBSA evaluated the ongoing impact of a recovery obtained from a plan that imposed an impermissible day limit on residential treatment for substance use disorders. This limit accumulated separately from the day limit imposed on the plan's medical/surgical benefits, a violation of MHPAEA's restrictions on separate cumulative QTLs. In response, the plan agreed to remove the day limit on residential treatment. The plan reprocessed and paid claims for previously denied benefits for the estimated 26,728 participants and beneficiaries in the plan. Additionally, EBSA estimates that approximately 1,616 participants and beneficiaries with a substance use disorder who require treatment will potentially be impacted annually by the prospective correction of this limit.⁴

In the next example, EBSA analyzed the impact of a recovery obtained from a plan that denied coverage for out-of-network treatment for inpatient and outpatient mental health and substance use disorders, despite covering such care for medical/surgical benefits. In addition to reprocessing claims and paying previously denied benefits for its 33,740 participants and beneficiaries, EBSA estimates that 6,548⁵ participants and beneficiaries will be impacted the

⁴ EBSA used the March 2016 CPS for CY 2015 to project the number of participants and beneficiaries by age in the plan. EBSA then used incidence rates of individuals who needed specialty treatment for substance abuse issues from SAMHSA) "Results from the 2016 National Survey on Drug Use and Health" for individuals 12 and older to determine the number of participants and beneficiaries of the plan who might potentially require residential treatment.

⁵ EBSA used the March 2016 CPS for CY 2015 to project the number of participants and beneficiaries by age in the plan. EBSA then used incidence rates of mental health and/or substance abuse issues from SAMHSA, "Results from the 2016 National Survey on Drug Use and Health" for individuals 12 and older to determine the number of participants and beneficiaries who might potentially seek out-of-network care. Similarly, mental health incidence rates for those under 12 were based on the Center for Disease Control and Prevention Morbidity and Mortality Weekly Report, "Mental Health Surveillance Among Children – United States 2005-2011" and included ADHD, autism, depression and behavior conduct.

prospective revision of plan documents to cover out-of-network mental health and substance use disorder benefits in parity.

4. Future enforcement efforts

a. Regional Opioid Investigative Task Forces

In addition to its routine enforcement activities, EBSA has also instituted several pilot programs to further prioritize the enforcement of MHPAEA. In response to the opioid crisis, and in light of the Administration's focus on opioid addiction treatment, EBSA has established regional interagency task forces to target areas where there may be parity issues affecting access to treatment for opioid addiction. Under this initiative, the Kansas City Regional Office (KCRO) has convened an internal task force to respond to the opioid crisis within the Midwestern states and the Employee Retirement Income Security Act (ERISA) implications of the epidemic. The task force is focused on the application of MHPAEA to coverage of the treatment of opioid use disorders, including coverage of FDA-approved medications to treat these disorders.

The task force has developed contacts within the oversight community including provider organizations and State governments. Most recently, the KCRO task force, in partnership with the Region VII SAMHSA office, hosted a roundtable discussion with substance use disorder treatment facilities, behavioral health providers, advocacy groups, and the Nebraska Department of Insurance to identify NQTLs on benefits, including preauthorization and precertification requirements, and payment challenges. The KCRO task force has also begun participating on the Minnesota Department of Commerce Mental Health Parity Team and has partnered with SAMHSA in order to improve enforcement efforts and provide subject matter expertise. Through these and future efforts, KCRO intends to aggressively pursue ERISA violations that impact treatment for those suffering from substance use disorders.

b. Specialized MHPAEA teams

In addition to focusing on access to opioid use disorders treatment, EBSA is also piloting MHPAEA specialty teams that will target and evaluate NQTLs imposed by large behavioral health providers and issuers. These teams consist of a cadre of EBSA's most seasoned investigators who specialize in medical claims data review and analysis and have prior experience conducting mental health parity investigations. The team is supported by regulatory subject matter experts as well as attorneys from the Plan Benefits Security Division of the Office of the Solicitor to provide ongoing regulatory and legal advice. EBSA will also bring in outside experts as needed to further support the specialized teams.

B. MHPAEA consumer assistance, education, and outreach

1. Consumer Assistance

EBSA's benefits advisors are on the front lines providing group health plan participants and beneficiaries assistance to ensure they receive the benefits to which they are entitled. Through EBSA's toll-free hotline, online web portal, and mail sent to regional offices, benefits advisors provide expert assistance to individuals across the country who have questions or complaints related to their health plan's compliance with MHPAEA and other Federal laws. If participant's inquiries suggest 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.

In fiscal years 2016 and 2017, EBSA received approximately 240 inquiries in connection with MHPAEA. Benefits advisors provide compliance assistance and also inform the Agency's understanding of where additional guidance is needed for both consumers and the regulated community. In addition, if participant inquiries and complaints suggest that problems are systemic and impact other participants or beneficiaries, benefits advisors refer the issue to the appropriate EBSA field office to pursue formal investigations.

2. Education

EBSA has authored several publications and compliance assistance materials for consumers and the regulated community with respect to mental health and substance use disorder benefits. These resources are available in print and on EBSA's MHPAEA-dedicated webpage.⁶ Over the last two fiscal years, EBSA has distributed 46,415 copies of these publications to participants, beneficiaries and plan administrators.

In May 2016, EBSA published the *Warning Signs* document, which identifies plan provisions and health insurance benefit design elements that are red flags for potential impermissible parity limitations. In fiscal year 2018, EBSA will issue a *Warning Signs 2.0* document, which will address additional potentially problematic MHPAEA limitations and focus particularly on NQTLs.

In addition, SAMHSA and EBSA have collaborated to issue three joint publications to assist consumers seeking to understand how MHPAEA affects their coverage. *Parity of Mental Health and Substance Use Benefits with Other Benefits: Using Your Employer-Sponsored Health Plan to Cover Services* provides an overview of MHPAEA for consumers, as well as information on how consumers can become better informed about their health care coverage and appeal a claim.

⁶ Available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits provides a short overview of MHPAEA for consumers, and identifies some of the common limits placed on mental health and substance use disorder benefits and services. The *Consumer Guide to Disclosure Rights: Making the Most Of Your Mental Health and Substance Use Disorder Benefits* explains the various federal disclosure laws affecting private sector employer-sponsored group health plans and issuers and provides examples of appropriate disclosures.

3. Outreach events

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.

Since fiscal year 2016, EBSA's Regional Offices conducted 278 Compliance Assistance outreach events nationwide, which were attended by 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 provided information at 397 Participant Assistance events that educate workers about their rights and benefits under MHPAEA. EBSA also holds six to seven in-person seminars each year for the regulated community, particularly small businesses, discussing MHPAEA.

As part of its Health Benefits Education Campaign (HBEC), EBSA provided compliance assistance to health plan sponsors and their service providers. Between 2010 and 2017, EBSA staff has presented nationwide at 55 HBEC seminars, including those on MHPAEA.

Over the past three years EBSA has held four consumer webcasts providing information on the benefit protections under MHPAEA. The goal of these webcasts is to help consumers make informed decisions and make the most of their health coverage. Approximately 800 people attended the live webcasts. An additional 372 individuals viewed the archived webcast. EBSA has also conducted two compliance assistance seminars providing information on MHPAEA and other health benefits laws. There were almost 1,000 attendees at the live webcasts, and an additional 658 individuals have viewed the archived seminars. The webcasts are available on EBSA's website for one year.

4. Behind the numbers – EBSA Benefits Advisor results

When EBSA receives inquiries from participants who believe their mental health or substance use disorder benefits were denied improperly, benefits advisors will work with participants and their plans to help the participant receive the benefits to which they are entitled. For example, in 2017,

an ERISA plan participant contacted a benefits advisor for help after the mental health claims for his dependent son were denied on the ground that the treatment was not medically necessary. The plan also initially refused to provide its criteria for medical necessity, improperly claiming that such criteria were proprietary. The benefits advisor contacted the plan administrator on the participant's behalf, asked that the claims be reviewed, and explained how MHPAEA disclosure requirements applied to the plan. As a result, the participant was able to obtain the previously denied benefits and the plan paid \$48,000 in claims for intensive outpatient therapy for the participant's son.

C. Interpretive Guidance

EBSA is committed to ensuring that plans and issuers have the guidance they need, so that individuals receive the benefits to which they are entitled and so that plans and service providers operate in compliance with the law. Since the issuance of the 2016 report to Congress, two issues in particular have prompted questions and concerns among stakeholders. The first issue relates to the requirement under MHPAEA to make information available regarding the reason for a denial and the criteria for a medical necessity determination of a mental health or substance use disorder claim. Several stakeholders have stated that individuals often face challenges obtaining the information they need to ensure their health plan is providing mental health and substance use disorder benefits in full parity with medical and surgical benefits. The second issue relates to the requirement under MHPAEA's implementing regulations to ensure that NQTLs, such as medical management, utilization review, and provider reimbursement rates, are applied comparably to mental health and substance use disorder benefits. Many stakeholders have asked for additional clarification on how to ensure that NQTLs under their plan comply with MHPAEA's requirements. The interpretive guidance DOL has issued in response to these issues is discussed below.

1. Disclosure

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 mental health and substance use disorder 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 mental health or substance use disorder benefits to any current or potential participant, beneficiary, or contracting provider upon request and the reason for any denial of reimbursement or payment for services with respect to mental health and substance use disorder benefits. However, the statute does not address disclosure obligations for similar information for medical/surgical benefits, which is often necessary to evaluate parity.

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. For example, health plans that are subject to ERISA’s broad disclosure obligations are required to provide participants, upon request, with information used to apply benefit limits with respect to medical/surgical and mental health and substance use disorder services under the plan.⁷ Additionally, under internal claims and appeals and external review requirements, most group health plans and health insurance issuers must provide, upon request and free of charge, reasonable access to and copies of documents, records, and other information relevant to an individual’s claims for benefits, including documents of a comparable nature with information on benefit limits for medical/surgical and mental health and substance use disorder services.⁸

Following the issuance of the final regulations implementing MHPAEA, the Departments issued additional guidance clarifying that the law does not permit plans to refuse to provide information on the grounds that it is “proprietary,” but that health plans and issuers can provide summary descriptions of plan documents that are written to be understood by a layperson.⁹ The Departments subsequently issued guidance that provided examples of certain types of documents that participants are entitled to and may find helpful.

In addition to questions regarding the scope of disclosure under MHPAEA and other related laws, the Departments received questions and concerns regarding disclosures specifically related to the NQTL requirements under MHPAEA. Consumer advocates and stakeholders from the regulated community have asked what level of detail is required to satisfy the disclosure requirements for requests related to NQTLs, as often there is potentially voluminous clinical and statistical information that may be relevant to a particular NQTL. Stakeholders have requested guidance on ways in which disclosures, or the process for requesting disclosures, could be more uniform, be more streamlined, or otherwise be simplified.

In FAQs, the Departments requested comments from stakeholders as to whether a model form that could be used to request information regarding NQTLs would be helpful, and if so what content the model forms should include. The Departments also asked what other steps could be taken to improve the scope and quality of disclosures and simplify the processes for requesting disclosures.¹⁰ Comments received by the Departments were generally supportive of increased efforts to improve disclosure processes and the potential for a model disclosure request form.

⁷ See <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xvii.pdf>.

⁸ See <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xvii.pdf>.

⁹ See <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf>.

¹⁰ See FAQs About Affordable Care Act Implementation Part 38 and Mental Health And Substance Use Disorder Parity Implementation <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-38.pdf>.

Based on this feedback, the Departments issued a proposed model disclosure request form that could, but is not be required to, be used to request information.

2. Nonquantitative Treatment Limitations (NQTLS)

NQTLS are generally limits on the scope or duration of benefits for treatment that are not expressed numerically, such as medical management techniques, provider network admission criteria, or fail-first policies. MHPAEA's implementing regulations provide that a plan or issuer may not impose an NQTL with respect to mental health and substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the same classification. The Departments understand the importance of clarifying issues related to the application of NQTLS, which are often quite difficult and complex. Thus, the Departments have issued guidance to address questions and concerns raised by stakeholders.

On October 27, 2016, the Departments issued FAQs to address a number of issues, including prior authorization procedures for mental health and substance use disorder benefits that differ from procedures for medical/surgical health benefits, and the use of fail-first requirements in situations where there are no available providers offering lower-cost mental health and substance use disorder treatments or when such requirements are not similarly applied to medical/surgical benefits.¹¹

In light of the ongoing opioid crisis, the October 2016 FAQs also included clarifications related to common NQTLS that reduce access to substance use disorder treatments in particular. The FAQs contained several questions related to restrictions on medication assisted treatment for opioid use disorder and explained that limiting access to life-saving drugs such as buprenorphine for such disorder is not permitted under the law when the plan or issuer does not impose comparable limits on drugs to treat physical health conditions. Also, because some plans and issuers exclude treatment that is court-ordered, which can affect coverage for substance use disorder treatments, the FAQs clarified that these types of exclusions are NQTLS and are not permissible if they are only applied to mental health or substance use disorder benefits.

3. Eating Disorders

¹¹ See FAQs About Affordable Care Act Implementation Part 34 and Mental Health And Substance Use Disorder Parity Implementation, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf>.

The Departments are aware that some group health plans and issuers have not been properly categorizing benefits for eating disorder treatment as mental health benefits that must be provided in parity with medical/surgical health benefits. To address any misunderstanding, in December 2016, Congress included a clarification in section 13007 of the 21st Century Cures Act to make explicit that these benefits are in fact subject to parity requirements.¹² The Departments also addressed this issue in FAQs issued on June 16, 2017, which clarified that eating disorders are mental health conditions and therefore a benefit for services to treat an eating disorder is a “mental health benefit” within the meaning of that term as defined by MHPAEA.¹³ The Departments solicited comments from stakeholders as to whether any additional clarification is needed regarding how the requirements of MHPAEA apply to benefits for treatment of eating disorders. The Departments are currently reviewing the comments that were received and may provide additional guidance on this topic, if necessary.

¹² 21st Century Cures Act, Pub. L. No. 114-255 (2016).

¹³ See FAQs About Affordable Care Act Implementation Part 38 and Mental Health And Substance Use Disorder Parity Implementation <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-38.pdf>.

III. OTHER INTERGOVERNMENTAL MHPAEA IMPLEMENTATION ACTIVITIES

A. Mental Health and Substance Use Disorder Parity Task Force

In March 2016, a Mental Health and Substance Use Disorder Parity Task Force (Parity Task Force) was established in an effort to improve access to high-quality behavioral health care. The Department was one of the key Federal agencies that were part of the Parity Task Force alongside the Departments of Treasury, Defense, Justice, HHS, Veterans Affairs, and the Offices of Personnel Management and National Drug Control Policy. The objectives of the Parity Task Force were to (1) increase awareness around mental health and substance use disorder parity protections; (2) improve the understanding of parity requirements and their protections among stakeholders; and (3) increase transparency regarding the compliance process, available resources, and tools to improve compliance and enforcement.

The Parity Task Force conducted a series of listening sessions to solicit comments from a diverse group of stakeholders, including consumers, providers, employers, insurance companies, and State regulators on ways for the Federal government and State regulators to improve understanding and promote compliance with MHPAEA. In October 2016, the Parity Task Force published its Final Report, which summarized feedback received from stakeholders and offered a number of recommendations to improve parity compliance in mental health and substance use disorder benefits.

In its Final Report, the Parity Task Force outlined a series of recommendations and actions to enhance understanding of parity protections, clarify parity requirements for better implementation of the rules, and improve oversight and enforcement efforts. The recommendations included amending the law to allow the Department to assess civil monetary penalties for MHPAEA violations. The report also recommended legislative changes to expand the scope of disclosure required for health plans that are not subject to ERISA and to ensure that agencies tasked with MHPAEA implementation and enforcement be provided additional funding to expand their capacity to conduct investigations and enforcement activities. These proposed changes have not yet been enacted.

1. Parity Policy Academies

EBSA also works in partnership with SAMHSA to help inform State regulators and stakeholders of our most recent efforts to ensure parity. In fiscal year 2017, EBSA participated in two policy academies on parity implementation organized by SAMHSA. One of these two policy academies focused on parity in Medicaid and the Children's Health Insurance Program, and the other addressed improving parity compliance in the commercial insurance market. These policy academies brought together State and Federal regulators to discuss parity implementation progress and challenges, and established a forum for Federal representatives to provide technical

assistance for teams of State officials. During these academies, State and Federal regulators shared tools and lessons learned from implementation efforts, and worked to develop strategies to advance parity compliance. In total, regulators from 26 states and territories, representing a total population of over 200 million, participated in one or both of the parity academies.

2. Parity Consumer Web Portal

Depending on the type of group health plan, there may be more than one government agency, including both Federal and State agencies, that can help individuals obtain documents or understand the information that is provided. The Department has assisted HHS in developing a parity consumer web portal that can connect individuals to the appropriate agency. Individuals can go to www.hhs.gov/mental-health-and-addiction-insurance-help to identify the agency that can help. While different Federal and State agencies may be responsible for providing oversight for and assistance with respect to different plans, the agencies work together to ensure that any MHPAEA violations are corrected.

B. The 21st Century Cures Act

In December 2016, Congress enacted the 21st Century Cures Act, which made several reforms to the nation's behavioral health systems. Significantly, the Act required the Departments to take certain steps to promote understanding and compliance with MHPAEA. These steps include providing additional guidance regarding disclosure requirements and NQTLs, providing an opportunity for stakeholders to provide input, soliciting feedback on how disclosure processes can be improved, issuing a compliance program guidance document with "illustrative, de-identified examples of previous findings of compliance and non-compliance", and providing increased transparency with a public annual report to Congress that summarizes the Departments closed MHPAEA related investigations and enforcement actions with findings of any serious violation. The law also clarified that benefits for eating disorders are subject to the requirements of MHPAEA.

As discussed in more detail above, the Departments have been actively engaged in responding to these requirements through issuing FAQs regarding disclosure requirements and NQTLs, as well as developing model disclosure request forms for individuals and their authorized providers to use when requesting information from group health plans and insurance issuers.

The Department maintains a self-compliance tool on its website that plans may use to determine whether the plan is in compliance with Federal laws governing group health plans, including MHPAEA. This self-compliance tool is the same audit checklist that is used by the EBSA's investigators, and it has also been shared with HHS and State regulators. In response to the 21st Century Cures Act's instruction to provide a compliance program document, on April 23, 2018, EBSA released an updated self-compliance tool, with significantly more comprehensive

guidance regarding NQTLs and disclosure along with additional examples of what parity is – and what it is not.

Additionally, in January 2017, the Department issued a MHPAEA Enforcement Fact Sheet that summarized the Department’s enforcement activities in fiscal year 2016. The fact sheet was a follow-up to another fact sheet the Department had issued in 2016 that summarized the Department’s enforcement activities in the years since MHPAEA became effective. Going forward, the Department will release enforcement fact sheets each year that summarize its enforcement results achieved in the prior fiscal year. In addition, section 13003 of the Cures Act requires the Assistant Secretary of Labor of EBSA, in collaboration with the Administrator for the Centers for Medicare & Medicaid Services (CMS) and the Secretary of the Treasury to submit to the Committee on Energy and Commerce of the United States House of Representatives and the Committee on Health, Education, Labor, and Pensions of the United States Senate an annual report summarizing the results of all closed Federal investigations completed during the preceding 12-month period with findings of any serious MHPAEA violations. On December 12, 2017, CMS issued its first enforcement report.¹⁴

1. HHS Stakeholder Meeting

The 21st Century Cures Act 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 also directed HHS to produce an Action Plan based on input received from the public meeting as well as the recommendations the Parity Task Force made in its final report. The Action Plan identifies strategic approaches on how Federal and State governments can collaborate to share information, provide education, and improve enforcement of parity requirements. The Action Plan was released on April 23, 2018, and is available at www.hhs.gov/parity.

The Department, as well as other Federal agencies, assisted HHS in convening a public listening session on July 27, 2017. In addition to this meeting, HHS accepted written comments from interested parties. Stakeholders who provided comments and attended the public meeting consisted of employer associations, issuers, patients and patient advocacy groups, health care providers and provider organizations. Some of the major issues and concerns touched on transparency and disclosure, improved enforcement, consumer and provider education, further clarification on NQTLs, and guidance about new and experimental types of treatment.

¹⁴ Department of Health and Human Services (HHS) Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Enforcement Report, available at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HHS-2008-MHPAEA-Enforcement-Period.pdf>

C. The President’s Commission on Combating Drug Addiction and the Opioid Crisis

On March 29, 2017, President Trump signed an Executive Order establishing the President's Commission on Combating Drug Addiction and the Opioid Crisis (Commission) to study the Federal response to this issue and make recommendations for improvement. The mission of the Commission included identifying and describing federal funding used to combat drug addiction, identifying best practices for addiction prevention, reviewing educational messages, identifying and evaluating existing Federal programs to prevent and treat drug abuse, and making recommendations to the President.

Given the Department’s oversight responsibilities for group health plans and its role in implementing and enforcing MHPAEA, the Department was actively engaged in the Commission’s work. The Department attended several of the Opioid Commission meetings and expressed support for the recommendations included in the Commission’s Interim Report.

The Commission’s Interim Report included the specific recommendation to “Enforce the Mental Health Parity and Addiction Equity Act (MHPAEA) with a standardized parity compliance tool to ensure health plans cannot impose less favorable benefits for mental health and substance use diagnoses versus physical health diagnoses.” The Department’s comments on the Interim Report noted that not providing real parity is already illegal and recommended that the Commission urge the Administration to direct the Secretary of Labor to continue to enforce MHPAEA aggressively through expanded audit capacity. In addition, to advance the Commission’s goal of increased enforcement, Secretary Acosta recommended in his testimony to the Commission that the Administration support legislation that would provide the Department with civil monetary penalty authority for MHPAEA violations as a more meaningful deterrent against noncompliance.

On November 1, 2017 the Commission delivered its Final Report to President Trump, which discussed in detail the importance of enforcing MHPAEA to address the opioid crisis, noting that:

“MHPAEA has been the impetus for much progress towards parity for behavioral health coverage; plans and employers have, by and large, done away with policies that are clear violations; provisions such as dollar-limits, visit limits, and outright prohibitions on certain treatment modalities that exist only on behavioral health benefits. However, what remains are violations that are murkier and harder for regulators to discern, for example, non-quantitative treatment limits (NQTLs). These hurdles include medical necessity reviews that are more stringent on the behavioral health side than the medical/surgical side, limited provider networks, and onerous prior authorization requirements. In reality, it is often difficult to discern when a behavioral health benefit is ‘on par’ with a

medical/surgical benefit as different care settings and diagnoses have different policies regarding benefits, providers, and authorizations.”

The report went on to recommend that the Department be given authority to enhance its enforcement efforts, consistent with recommendations made in Secretary Acosta’s testimony. Specifically, the report stated that:

Legislative changes providing DOL with the ability to impose a civil monetary penalty, such as those provided for violations of the Genetic Information Nondiscrimination Act (GINA), would encourage private insurance companies, and employers, to satisfy their legal obligations under MHPAEA and in turn, ensure they are adequately doing their part to address the country's opioid epidemic.¹⁵

As part of its final recommendations, the report stated that “[b]ecause the Department of Labor (DOL) regulates health care coverage by many large employers, the Commission recommends that Congress provide DOL increased authority to levy monetary penalties on insurers and funders, and permit DOL to launch investigations of health insurers independently for parity violations.” The Department concurs with these recommendations as positive changes that will enable the Department to more effectively enforce MHPAEA.

¹⁵ See The President’s Commission on Combating Drug Addiction and the Opioid Crisis Final Report, available at https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf.

IV. CONCLUSION

Since the enactment of MHPAEA and as described in this report, the Department has been committed to enforcing the law, promoting compliance, assisting consumers, and conducting investigations. The Department is committed to leveraging all available resources, and collaborating with its Federal and State partners, to increase access to meaningful coverage for mental health and substance use disorders. At the same time, the Department acknowledges that there is more work to be done. The Department believes that through robust education of and outreach to consumers, providers, plan sponsors, and insurance companies, the Department can facilitate a greater understanding of the parity requirements that can result in more individuals realizing the benefit of full parity. The Department also understands that robust enforcement can not only protect individuals' parity rights, but can protect individuals from future harm. As access to quality health coverage for mental health and substance abuse is an issue for all sectors of the health insurance market, the Department values its Federal and State partnerships, and is constantly looking for ways to further its efforts through collaboration. 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.

V. APPENDICES

Appendix A: [Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program](#)

Appendix B: [DOL MHPAEA Enforcement Fact Sheets](#)

Appendix C: [HHS Enforcement Fact Sheet](#)

Appendix D: [FAQs About Affordable Care Act Implementation and Mental Health And Substance Use Disorder Parity Implementation Parts V, XVII, XXIX, 31, 34, 38](#)

Appendix E: [Consumer Guide to Disclosure Rights: Making the Most of Your Mental Health and Substance Use Disorder Benefits](#)

Appendix F: [Warning Signs: Plan or Policy Non-Quantitative Treatment Limitations \(NQTs\) that Require Additional Analysis to Determine Mental Health Parity Compliance](#)

Appendix G: [Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits](#)

Appendix H: [Self-Compliance Tool for Part 7 of ERISA: Health Care-Related Provisions](#)