Department of Health and Human Services (HHS) Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Enforcement Report

Current as of December 2017

The Centers for Medicare & Medicaid Services (CMS) is publishing this report to increase transparency with respect to enforcement of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Although CMS has taken action to ensure compliance with MHPAEA since its enactment in 2008, this report only includes MHPAEA investigations completed in 2016 and beyond. It will be updated periodically as additional cases are closed.[1]

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

The Public Health Service Act (PHS Act) section 2791(d)(8)(C) defines the term "non-Federal governmental plan" as a governmental plan that is not a Federal governmental plan. Non-Federal governmental plans are group health plans that are sponsored by states, counties, school districts, and municipalities for their employees. Sponsors of self-funded, non-Federal governmental plans may opt out of certain requirements of Title XXVII of the PHS Act, including MHPAEA.[2] The Patient Protection and Affordable Care Act (PPACA) limited the number of provisions from which self-funded, non-Federal governmental plans may opt-out. CMS, a component of the Department of Health and Human Services (HHS), has primary enforcement authority with respect to MHPAEA and other applicable Federal laws over non-Federal governmental plans (including both insured and self-funded coverage). CMS investigates, for compliance with MHPAEA, non-Federal governmental plans that have not opted out of MHPAEA when complaints with respect to MHPAEA are filed with CMS.[3] As noted in the table below, since the beginning of 2016, CMS has completed five investigations of non-Federal governmental plans. CMS has the authority to initiate a market conduct examination to determine whether a non-Federal governmental plan is out of compliance with MHPAEA.[4]

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[1] Section 13003 of the 21st Century Cures Act (Cures Act) (Pub. L. 114-255) also requires the Assistant Secretary of Labor of the Employee Benefits Security Administration, in collaboration with the Administrator of 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 violation regarding compliance with mental health and substance use disorder coverage requirements under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

[2] For more information about the provisions from which non-Federal governmental plans may opt-out, visit https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/nonfedgovplans.html.

[3] See 45 CFR 150.303 for CMS' authority to initiate an investigation of a potential violation of applicable Federal law by issuers and non-Federal governmental plans.

[4] See 45 CFR 150.313 for CMS' authority to initiate a market conduct examination to determine whether a non-Federal governmental plan is out of compliance with applicable Federal law.

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With respect to health insurance issuers selling products in the individual and fully-insured group markets, CMS has primary enforcement authority with respect to MHPAEA only when a state elects not to enforce or fails to substantially enforce MHPAEA. Currently, CMS is enforcing MHPAEA with respect to issuers in four states: Missouri, Oklahoma, Texas, and Wyoming. In these states, CMS reviews policy forms of issuers in the individual and group markets for compliance with MHPAEA prior to the products being offered for sale in the states. Through this process, numerous parity issues are identified by CMS reviewers and corrected by the issuers before individuals and groups enroll in the products. CMS has also created a market conduct examination process where health insurance issuers in states where CMS is directly enforcing federal reforms are audited for compliance with applicable Federal law.[5] CMS additionally conducts market conduct examinations of issuers in states that have a collaborative enforcement agreement with CMS if the state requests such an examination in order to obtain issuer compliance with a Federal requirement. CMS will enter into a collaborative enforcement agreement with any state that is willing and able to perform regulatory functions but lacks enforcement authority. If the state finds a potential violation and is unable to obtain voluntary compliance from an issuer, it will refer the matter to CMS for possible enforcement action. As noted in the table below, since the beginning of 2016, CMS has finalized one market conduct examination.

Table: Overview of HHS MHPAEA Investigations

Type of Coverage	Source of Information/Complaint	Type of Investigational Action	MHPAEA Issue	Date Closed
Self-funded, non-Federal governmental plan – state plan	Consumer complaint	Non-Federal Governmental plan investigation	Non-Quantitative Treatment Limitations (NQTL) (precertification)	February 24, 2016
Self-funded, non-Federal governmental plan – school district	Plan review following a late MHPAEA opt-out submission	Invalid HIPAA opt-out	Quantitative Treatment Limitations (QTL) (potential impermissible annual day limit)	June 3, 2016
Self-funded, non-Federal governmental plan – state plan	Consumer inquiry	Non-Federal Governmental plan investigation	NQTL (fail-first policy)	June 24, 2016
Self-funded, non-Federal governmental plan – city plan	Consumer complaint	Non-Federal Governmental plan investigation	NQTL (age limitation)	October 5, 2016

[5] Id.

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Type of Coverage	Source of Information/Complaint	Type of Investigational Action	MHPAEA Issue	Date Closed
Fully-insured health insurance issuer in a state	Consumer complaint	Market Conduct Examination	NQTL (coverage exclusion)	June 2, 2017
Self-funded, non-Federal governmental plan – city plan	Professional association complaint	Non-Federal Governmental plan investigation	NQTL (preauthorization)	June 16, 2017

In addition to the MHPAEA investigations, policy form reviews, and market conduct examinations, CMS provides technical assistance in response to numerous complex questions from states, issuers, and plans. CMS also provided further clarification regarding MHPAEA requirements through the Substance Abuse and Mental Health Services Administration's Commercial Parity Policy Academy, stakeholder listening sessions, and the publication of numerous guidance documents. In conjunction with the Departments of Labor and the Treasury, CMS published the Mental Health and Substance Use Disorder Parity Compliance Assistance Materials Index, which serves as a compilation of sub-regulatory guidance and compliance assistance materials that aim to assist plans, issuers, and third party administrators as they work to ensure compliance with MHPAEA.

The issues and subsequent enforcement actions discussed below are intended to summarize results obtained in CMS' closed investigational actions completed since the beginning of 2016 with respect to MHPAEA. The enforcement actions taken in these cases are based on specific details in each investigational action and are not determinative of future enforcement actions by CMS or other Federal agencies.

Increased coverage for treatment for opioid addiction

CMS conducted a market-conduct examination of all mental health/substance use disorder (MH/SUD) benefits in all classifications and found that the issuer did not cover methadone for opioid addiction though methadone is covered for pain management. The issuer failed to demonstrate that the processes, strategies, evidentiary standards, and other factors used to develop the methadone treatment exclusion for opioid addiction are comparable to and applied no more stringently than those used for medical/surgical conditions. The issuer re-evaluated the medical necessity of methadone-maintenance treatment programs. The issuer developed medical-necessity criteria to replace the methadone-maintenance treatment exclusion in the issuer's 2017 plans, which mirrors Federal guidelines for opioid treatment programs. The updated medical-necessity criteria is included in the plan year 2017 benefit booklet and was posted to the issuer's website with an effective date of 1/1/2017.

Additional visits provided without pre-certification

CMS found that a non-Federal governmental plan contained non-quantitative treatment limitations on certain MH/SUD benefits. Certification requests were required after 15 outpatient MH/SUD visits, but outpatient medical/surgical visits required certification after 20 visits. Ultimately, the plan raised the visit threshold for the certification request requirement to 20 for outpatient MH/SUD services and amended the plan documents to reflect the change.

ABA therapy treatment plan approved for plan enrollee

The plan denied claims for applied behavior analysis (ABA) therapy for the treatment of autism spectrum disorder, because the covered dependent was diagnosed after the age specified by the plan. It was not clear if and how the plan used a similar process to impose an age limitation for medical/surgical benefits in the same classification. The plan was asked to provide information about the processes, strategies, evidentiary standards, and other factors used to impose age limits to out-patient in-network medical/surgical benefits and MH/SUD benefits. Although CMS concluded the application of the non-quantitative treatment limitation with respect to outpatient, in-network MH/SUD benefits did not violate MHPAEA, the plan chose to approve the individual's ABA therapy for the treatment of autism. No enforcement action was taken.

Corrective action plan issued to clarify NQTLs in a plan document

CMS reviewed the plan's documents for compliance with MHPAEA and identified treatment limitations that were applied to MH/SUD benefits that were potentially more restrictive than those applied to medical/surgical benefits. The plan documents imposed a 120-consecutive-day limit on MH/SUD inpatient services and required concurrent review of certain inpatient mental health services. The plan's administrator confirmed that the 120-consecutive-day limit applied to both medical/surgical and MH/SUD inpatient services. The plan's administrator confirmed that all medical/surgical inpatient admissions are subject to concurrent review. CMS issued a corrective action plan directing the plan to clarify the language in the plan documents.