In 2017, the Employee Benefit Security Administration (EBSA) investigated 187 health care plans for compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). EBSA found that 92 of those plans were in violation of MHPAEA, with about half of the violations involving so-called “nonquantitative” treatment limitations on mental health and substance abuse benefits. As a result of this investigation, and as more fully discussed below, EBSA has made available “benefits advisors” for participants to call for help when their claims for mental health or substance abuse benefits are denied. Plan sponsors, should be alert to and wary of a phone call from an EBSA benefits advisor, as such a phone call can lead to a full-blown EBSA investigation of the plan’s compliance with the MHPAEA.

MHPAEA Requirements

As background, the MHPAEA prohibits group health plans from imposing more stringent treatment requirements and limitations on mental health and substance abuse benefits than those placed on medical and surgical plan benefits. This prohibition includes both quantitative (e.g., number of visits per year) and nonquantitative treatment limitations. In fielding phone call inquiries to benefits advisors, EBSA is focusing on the following types of nonquantitative treatment limitations:

1. Excluding mental health or substance abuse treatments as “experimental”;

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2. Dosage limits and drug formularies for prescription drugs;
3. So-called “step therapy” or “fail first” protocols for approving more expensive, in-patient, or residential treatments; and
4. Inadequacy plan networks for mental health and substance abuse providers.

As part of its enforcement initiative, EBSA has released guidance in the form of Questions and Answers. See Proposed FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act. The guidance explains how EBSA will examine various types of nonquantitative treatment limitations for mental health and substance abuse conditions. The guidance also contains numerous examples of plan terms that violate the MHPAEA. Key examples of violations include:

- Denial of any mental health treatment with a “C” rating in a medical directory, but case-by-case approval of a physical treatment with a “C” rating in the same directory.
- Denial of Applied Behavioral Analysis treatment for children with autism as experimental, when the treatment meets the usual standard for approval of treatments for physical conditions (e.g., two randomized controlled trials support the treatment’s use for the physical condition).
- Using professionally-recognized treatment guidelines when setting dosage limits for prescription drugs for physical conditions, but setting a lower dosage limit than the professionally-recognized guidelines recommend for prescription drugs that are used to treat mental health conditions.
- Requiring only one unsuccessful attempt at outpatient treatment in the past 12 months to be eligible for in-patient treatment for a physical condition, but requiring two unsuccessful attempts at outpatient treatment in the past 12 months to be eligible for in-patient treatment for a substance abuse condition (unless the plan can demonstrate that evidentiary standards or other factors were used to develop these different standards for eligibility for in-patient treatment).

**Participant Requests for Plan Information and Benefits Advisor Phone Calls**

Section 104(b)(4) of ERISA gives plan participants the right to request and receive additional information about the documents that are used to determine eligibility for plan benefits. To assist participants, EBSA has posted on its website a model form for participants to use when requesting additional information about the plan’s mental health and substance abuse benefits. This model form contains very detailed and specific requests for information, such as “identify the factors used in the development of the [nonquantitative treatment] limitation (examples of factors include, but are not limited to, excessive utilization, recent medical cost escalation, high variability in cost for each episode of care, and safety and effectiveness of treatment)” and
“provide any evidence and documentation to establish that the [nonquantitative treatment] limitation is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.”

EBSA also has hired “benefits advisors” to assist participants in overturning denied claims for mental health and substance abuse benefits that may be a violation of the MHPAEA. Plan administrators will receive an initial phone call (not a letter) from an EBSA benefits advisor if a participant has requested assistance. Plan administrators should be cordial, but should refer the benefits advisor to legal counsel. A phone call from an EBSA benefits advisor can be a precursor to a full-blown EBSA investigation of the plan. According to the EBSA, “if the inquiry suggests the problem may affect multiple participants and the Benefits Advisor is unable to obtain voluntary compliance, the Benefits Advisor will refer the issue for investigation.”

If you have any questions related to benefit plans in general, or the Mental Health Parity and Addiction Equity Act in particular, please contact a member of Koley Jessen’s Employment, Labor and Benefits Practice Group.