



# MENTAL HEALTH AND SUBSTANCE USE

## State and Federal Oversight of Compliance with Parity Requirements Varies

Accessible Version

December 2019

## Why GAO Did This Study

MHPAEA requires large group health plans that offer MH/SU benefits to ensure parity between MH/SU and medical/surgical benefits. To meet the essential health benefits requirements of the Patient Protection and Affordable Care Act, certain issuers offering small group and individual plans must comply with MHPAEA's MH/SU parity requirements.

The 21st Century Cures Act included a provision for GAO to review federal and state oversight of MH/SU parity requirements and the extent to which health plans comply with these requirements. This report, among other objectives, (1) examines how DOL, HHS, and states oversee health plan compliance with MH/SU parity requirements; and (2) describes what is known about the extent to which health plans are complying with MH/SU parity requirements.

For this report, GAO reviewed DOL and HHS policies, guidance, and reports; conducted a survey and received responses from all 50 states and the District of Columbia about oversight practices; interviewed officials from DOL, HHS, and selected states; interviewed national and state stakeholders; and reviewed available research studies regarding health plan compliance with MH/SU parity.

## What GAO Recommends

GAO is recommending that DOL and HHS evaluate whether relying on targeted oversight is effective for ensuring compliance with MH/SU parity requirements or whether alternative approaches are needed. DOL and HHS concurred with GAO's recommendations.

# MENTAL HEALTH AND SUBSTANCE USE

## State and Federal Oversight of Compliance with Parity Requirements Varies

### What GAO Found

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally requires that coverage for mental health and substance use disorder (MH/SU) be no more restrictive than coverage for medical/surgical services. State agencies and the Departments of Labor (DOL) and Health and Human Services (HHS) share responsibility for overseeing compliance with these MH/SU parity requirements among group and individual health plans. These oversight practices vary.

- While nearly all of the state officials who responded to GAO's survey reported that they perform some review of group and individual insurance plans for compliance with MH/SU parity requirements before they are approved to be sold to consumers, states vary in the frequency and type of reviews they conduct after consumers enroll in plans. For example, officials from 12 states reported that they conducted a targeted review of specific MH/SU parity concerns in 2017 and 2018, with the number of reviews ranging from one to 22 reviews per state.
- DOL and HHS conduct targeted reviews of certain employer-sponsored group plans when they receive information—such as consumer complaints—about possible noncompliance with MH/SU parity requirements or other federal health care requirements. Unlike states, these reviews only occur after consumers enroll in these plans. For example, in fiscal years 2017 and 2018, DOL completed 302 reviews that included a review of MH/SU parity compliance in its oversight of 2.2 million plans. Nearly all these reviews originated from complaints or other information about potential noncompliance with federal health care laws unrelated to MH/SU parity.

According to DOL and HHS officials, the departments have not analyzed whether relying on targeted reviews alone increases the risk of noncompliance with MH/SU parity requirements in employer-sponsored group plans. Without such an evaluation, DOL and HHS do not know if their oversight is effective or whether they need to adopt additional strategies.

While states, DOL, HHS, and the research GAO reviewed identified some instances of noncompliance with MH/SU parity requirements, the extent of compliance with these requirements is unknown. States, DOL, and HHS have identified some noncompliance with MH/SU parity requirements based on consumer complaints and other information about potential noncompliance. For example, DOL reported citing 113 violations of MH/SU parity requirements through its reviews in 2017 and 2018. The available research studies GAO reviewed also identified noncompliance with some of the requirements by reviewing plan documentation and benefit data, among other methods. However, according to stakeholders GAO interviewed, complaints are not a reliable indicator of the extent of noncompliance because consumers may not know about MH/SU parity requirements or may have privacy concerns related to submitting a complaint.

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### Abbreviations

ABP	Alternative Benefit Plans
CHIP	State Children’s Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DOL	Department of Labor
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
MCO	managed care organization
MH/SU	mental health and substance use disorder
MHPA	Mental Health Parity Act of 1996
MHPAEA	Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
NAIC	National Association of Insurance Commissioners
NQTL	non-quantitative treatment limitation
PPACA	Patient Protection and Affordable Care Act
QTL	quantitative treatment limitation
Treasury	Department of the Treasury

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December 13, 2019

The Honorable Chuck Grassley  
Chairman  
The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate

The Honorable Lamar Alexander  
Chairman  
The Honorable Patty Murray  
Ranking Member  
Committee on Health, Education, Labor and Pensions  
United States Senate

The Honorable Frank Pallone  
Chairman  
The Honorable Greg Walden  
Republican Leader  
Committee on Energy and Commerce  
House of Representatives

As of 2018, approximately 19.1 percent of U.S. adults were diagnosed with a mental illness and approximately 15.0 percent received mental health services. Further, among individuals aged 12 and over, an estimated 7.8 percent had a substance use disorder, with approximately 1.4 percent receiving substance use treatment.<sup>1</sup> Congress has taken steps to ensure that individuals seeking mental health and substance use disorder (MH/SU) treatment do not face discrepancies in coverage. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires large group health plan sponsors, including employers, that choose to offer MH/SU benefits to ensure that coverage of MH/SU treatment is no more restrictive than coverage for

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<sup>1</sup>See Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health*, PEP19-5068 (Rockville: August 2019).

medical/surgical treatment.<sup>2</sup> Generally, this means that the requirements or limitations imposed on MH/SU benefits—such as copayment amounts, number of annual visit allowed, or preauthorization of services—must be in parity with those imposed on medical/surgical benefits. The Patient Protection and Affordable Care Act (PPACA) extended these parity requirements to most small group and individual health plans.<sup>3</sup>

At the federal level, the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (Treasury) share joint responsibilities for overseeing compliance with MHPAEA and have jointly developed related regulations and guidance. Throughout this report, we will refer to MHPAEA requirements—contained in both laws and regulations—as MH/SU parity requirements. States are generally responsible for enforcing MH/SU parity requirements through their oversight of health insurance companies (known and hereafter referred to as issuers) that sell group and individual health plans in their states.<sup>4</sup>

In recent years, questions have been raised about disparities in coverage and access to MH/SU services despite the MH/SU parity requirements under MHPAEA. For example, a 2017 study from the consulting firm Milliman found that consumers used an out-of-network provider for a substantially higher proportion of MH/SU care than they did for medical/surgical care.<sup>5</sup> This could lead to higher out-of-pocket costs for individuals using out-of-network MH/SU services. Similar issues have

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<sup>2</sup>Pub. L. No. 110-343, Div. C, Tit. V, Sub. B, §§ 511-512, 122 Stat. 3765, 3881-3893 (Oct. 3, 2008). MHPAEA, passed as part of the Emergency Economic Stabilization Act of 2008, expands the parity requirements established by the Mental Health Parity Act of 1996 (MHPA) (Pub. L. No. 104-204, Tit. VII, §§ 701-702, 100 Stat. 2874, 2944-2950 (Sept. 26, 1996)). MHPAEA amended the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986.

<sup>3</sup>Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010).

<sup>4</sup>An issuer is an insurance company, insurance service, or insurance organization that is required to be licensed to engage in the business of insurance in a state.

<sup>5</sup>Stephen P. Melek, Daniel Perlman, and Stoddard Davenport, *Addiction and Mental Health vs. Physical Health: Analyzing Disparities in Network Use and Provider Reimbursement Rates* (Seattle: Milliman, December 2017).

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also been identified by stakeholder coalitions, a presidential taskforce, and consumer lawsuits.<sup>6</sup>

The 21st Century Cures Act includes a provision for us to review certain aspects of state and federal oversight of MH/SU parity requirements and to describe the extent to which plans comply with these requirements. This report

1. examines how states and responsible federal agencies oversee group and individual health plans for compliance with MH/SU parity requirements;
2. describes what is known about the extent to which these plans comply with MH/SU parity requirements; and
3. describes how responsible federal agencies coordinate their oversight to support states.

In appendix I we also provide information on MH/SU parity requirements in Medicaid and the State Children’s Health Insurance Program.

To examine how states oversee compliance with MH/SU parity requirements, we administered a survey to all 50 states and the District of Columbia (hereafter referred to as “states”). We asked states to report information about how they review health insurance plans for compliance with MH/SU parity requirements and to identify any related enforcement activities in 2017 and 2018. We also asked about coordination between the states and federal agencies. We conducted the survey from April 2019 to August 2019 and received responses from all states. For some questions, a few states either did not respond or told us they had no basis on which to respond. We did not independently verify the information reported by the states in the survey, but reviewed responses and followed up with state officials when reported information appeared inconsistent or needed clarification. We interviewed an official and reviewed

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<sup>6</sup>For example, the following two reports were authored by coalitions of advocacy and research organizations, and identify issues with MH/SU parity enforcement based on an analysis of states’ statutes and a consumer survey: Megan Douglas et al., *Evaluating State Mental Health and Addiction Parity Statutes: A Technical Report* (The Kennedy Forum: 2018); and Parity at 10 Campaign, *Consumer Health Insurance Knowledge and Experience Survey: Report of Findings* (February 2019). The following report from the White House Mental Health and Substance Use Disorder Parity Task Force identifies issues such as barriers to parity and implementation and enforcement based on information gathered from stakeholders: Executive Office of the President. *The Mental Health and Substance Use Disorder Parity Task Force Final Report* (October 2016).



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documentation from the National Association of Insurance Commissioners (NAIC) to provide additional national context to state responses.<sup>7</sup>

We also selected three states to illustrate aspects of, and variations in, state oversight of MH/SU parity requirements. These states were selected based on recommendations by stakeholders—both federal officials and national advocacy groups—and to represent geographic diversity across the United States. Using these criteria, we selected Maryland, Massachusetts, and Washington. We interviewed officials responsible for overseeing health insurance plans in each of these states and reviewed documentation related to MH/SU parity oversight. We also interviewed consumer advocacy groups in the selected states. We also spoke to officials in Wyoming to obtain the perspective of one of the four states where HHS, rather than the state insurance department, is enforcing federal MH/SU parity requirements. To examine how relevant federal agencies—HHS, DOL, and Treasury—oversee MH/SU parity compliance, we reviewed relevant laws, regulations, and sub-regulatory guidance; reviewed agency reports on enforcement activities; and interviewed relevant officials. We compared HHS and DOL oversight activities and related policies and procedures with the federal internal control standards related to risk assessment.<sup>8</sup>

To describe what is known about the extent to which plans comply with MH/SU parity requirements, we interviewed officials from HHS and DOL and reviewed the agencies' reports on parity enforcement activities for fiscal years 2017 and 2018. These were the most recent reports available at the time of our review. For more information on the types of violations of MH/SU parity requirements that federal agencies identified in these reports, we reviewed the letters DOL sent issuers or plans identifying noncompliance for cases closed in fiscal years 2017 and 2018. We used information from our state survey on state identified noncompliance and

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<sup>7</sup>NAIC is a voluntary association of the chief insurance regulators from all 50 states, the District of Columbia, and five U.S. territories. NAIC coordinates the regulation of multistate insurers, develops standards for state insurance regulation, and publishes model laws, regulations, and guidelines that state regulators can use as resources for developing their laws and regulations. In addition, NAIC provides a forum for states to share information and state-developed tools, as well as to discuss issues with federal regulators.

<sup>8</sup>See GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's management, oversight body, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

enforcement actions taken by the states in 2017 and 2018, and from interviews and documentation from the three selected states, to provide additional examples.

We interviewed representatives from several stakeholder groups, including seven advocacy groups (focusing on substance use, mental health, or both), four groups representing the insurance industry, one group representing medical providers, and NAIC, to gain an understanding of what is known about compliance with MH/SU parity requirements both nationally and locally. We also performed a literature review of studies that assessed MH/SU parity compliance. See appendix II for a description of the methodology used and results of the literature review. We also identified Mercer's *National Survey of Employer-Sponsored Health Plans* as a source of information about employer-sponsored group plan health benefits, including information about compliance with MH/SU parity compliance.<sup>9</sup> We assessed the reliability of the Mercer data through a review of the methodology for Mercer's employer surveys and a discussion with a Mercer official knowledgeable of the survey methodology. We determined that the data were sufficiently reliable for the purposes of our reporting objective.

To describe how responsible federal agencies (HHS, DOL, and Treasury) coordinate their oversight to support states, we reviewed federal regulations, guidance, documents, and websites. This included a review of the HHS Action Plan and a review of proposed guidance. We interviewed officials from HHS and DOL on the guidance they have published or proposed and about their coordination with states. We interviewed officials from Treasury about their oversight related to MH/SU parity and coordination with HHS and DOL. We used information from our 51 state survey on coordination with federal agencies and use of federal guidance for MH/SU parity enforcement. We also used information from our interviews with officials from the three selected states and stakeholder groups.

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<sup>9</sup>Mercer, *National Survey of Employer-Sponsored Health Plans: 2018 Survey Report* (New York: Mercer, LLC, 2019). Mercer is a consulting firm that has conducted the *National Survey of Employer-Sponsored Health Plans* annually since 1986. The 2018 survey included responses from 2,409 private and government employers that offer employer-sponsored group health plans and is nationally representative of plans with 10 or more members.

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We conducted this performance audit from December 2018 to December 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

The majority of Americans receive their health coverage through private health insurance, either by purchasing health coverage directly or receiving coverage through their employer. Many of those with private coverage are enrolled in plans purchased from state-licensed or state-regulated issuers. Others are covered by plans where their employer sets aside funds to pay for employee health care, known as self-funded plans. In general, those who obtain private health coverage do so in one of three market segments: individual, small group, or large group. Enrollees in the individual market purchase private health insurance plans directly from a state-regulated issuer—not in connection with a group health plan. In the small group and large group markets, enrollees generally obtain health insurance coverage through a group health plan offered through a plan sponsor (typically an employer).<sup>10</sup>

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## MH/SU Parity Requirements

Health benefits commonly include plan design features that require enrollees to pay for a portion of their health care, limit the amount or number of treatments enrollees can receive, and limit the scope or duration of treatments that enrollees may receive. Prior to the implementation of the MHPAEA, health plans offered through employers covering MH/SU often used plan design features that were more restrictive or provided lower levels of coverage for MH/SU benefits than for medical/surgical benefits. For example, prior to MHPAEA, an employer's plan could cover unlimited hospital days and outpatient office visits and require 20 percent coinsurance for outpatient office visits for medical/surgical treatment while, for MH/SU, that same plan could cover

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<sup>10</sup>Federal law defines a small employer as having an average of one to 50 employees during the preceding calendar year; however, states may apply this definition based on an average of one to 100 employees. See 42 U.S.C. §§ 300gg-91(e)(4), 18024(b)(2)-(3).

only 30 hospital days and 20 outpatient office visits per year and impose 50 percent coinsurance for outpatient office visits.

Congress passed MHPAEA in 2008 to help address discrepancies in health care coverage between mental illnesses and physical illnesses. MHPAEA both strengthened and broadened federal parity requirements enacted in 1996, including extending parity to cover the treatment of substance use disorders.<sup>11</sup> MHPAEA requires coverage for MH/SU services—when those services are offered by group health plans sponsored by large employers (generally employers with more than 50 employees)—be no more restrictive than coverage for medical/surgical services.<sup>12</sup> PPACA extended MH/SU parity requirements to individual insurance plans and some small group health plans.<sup>13</sup> See figure 1 for a timeline of the laws and regulations establishing federal parity requirements and the types of plans affected.

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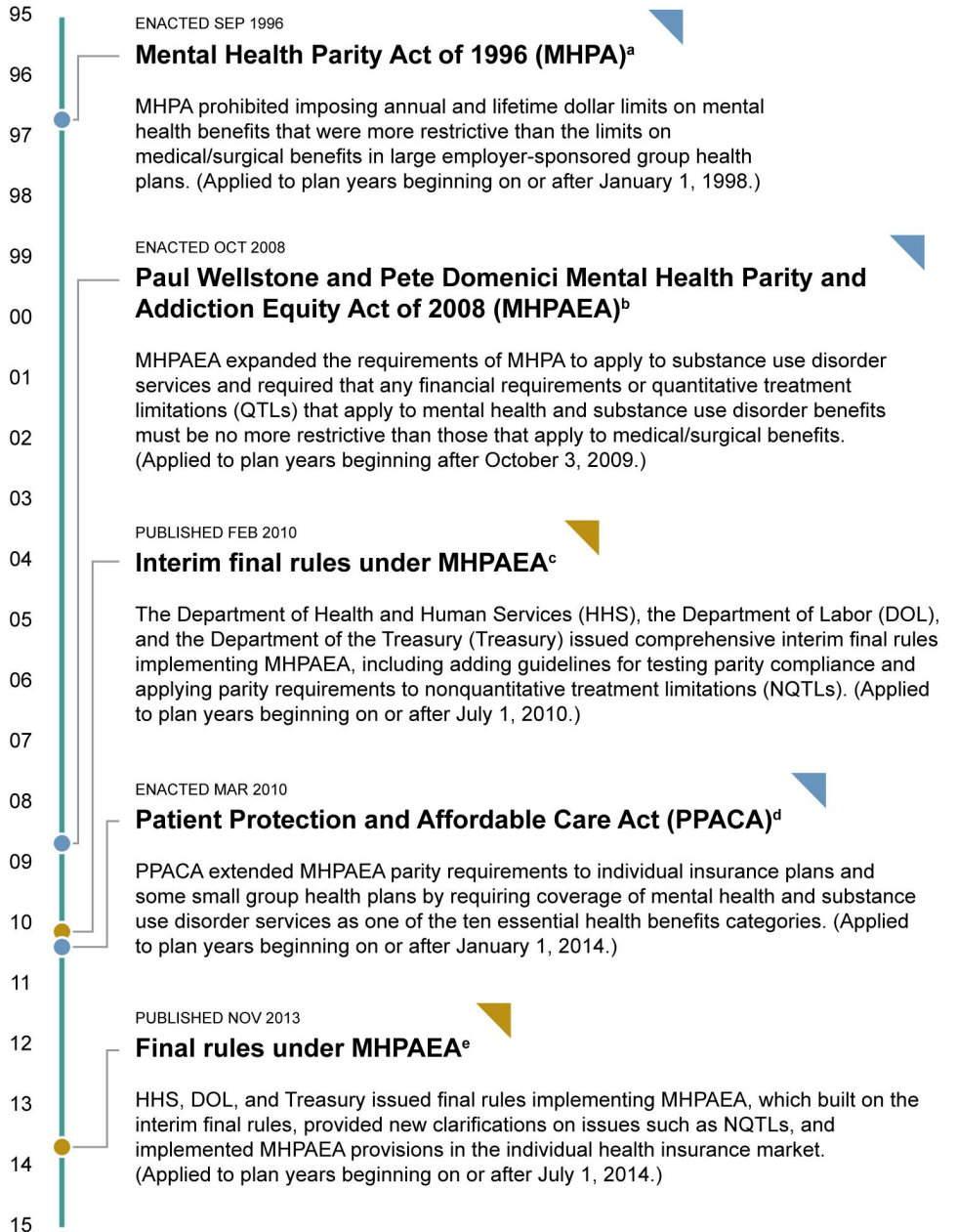
<sup>11</sup>Enacted in 1996, MHPA required parity in annual and aggregate lifetime dollar limits in employer-sponsored, large group health plans. In addition to extending parity requirements to cover the treatment of substance use disorders, MHPAEA applied parity requirements more broadly to financial requirements and treatment limitations.

<sup>12</sup>MHPAEA requirements do not apply to self-funded, employer-sponsored, small group plans or retiree-only plans. MHPAEA also contains an increased cost exemption to group plans that meet certain requirements. Additionally, plans for state and local government employees that are self-funded may opt-out of MHPAEA's requirements if certain administrative steps are taken.

<sup>13</sup>MHPAEA contains exemptions for group health plans sponsored by small employers (generally defined as 50 or fewer employees). However, MHPAEA requirements apply to small group health plans through PPACA's inclusion of MH/SU benefits as one of the ten essential health benefits categories that non-grandfathered, fully-insured, small group and individual plans—both those sold through the health insurance marketplaces, known as exchanges, and outside the marketplaces—must cover. HHS clarified through rulemaking that the MH/SU benefits offered through these plans as one of the ten essential health benefits must comply with MHPAEA requirements. 45 C.F.R. § 156.115(a)(3) (2019).

**Figure 1: Timeline of Mental Health and Substance Use Disorder Parity-Related Laws and Regulations**

Calendar years



Source: GAO review of federal laws and rules. | GAO-20-150

<sup>a</sup>Pub. L. No. 104-204, Tit. VII, § 701-702, 100 Stat. 2874, 2944-50 (Sept. 26, 1996).

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<sup>b</sup>Pub. L. No. 110-343, Div. C, Tit. V, Sub. B, §§ 511-512, 122 Stat. 3765, 3881-93 (Oct. 3, 2008).

<sup>c</sup>75 Fed. Reg. 5410 (Feb. 2, 2010).

<sup>d</sup>Pub. L. No. 111-148, §§ 1201, 1302, 1311(j), 124 Stat. 119, 161, 163-64, 181 (Mar. 23, 2010).

<sup>e</sup>78 Fed. Reg. 68,420 (Nov. 13, 2013).

In general, MHPAEA requires that the financial requirements and treatment limitations imposed on MH/SU benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits.

**Financial requirements.** The most common types of financial requirements include: (1) deductibles, which are required payments of a specified amount made by enrollees for services before the issuer begins to pay; (2) copayments, which are payments made by enrollees and are a specified flat dollar amount—usually on a per-unit-of-service basis—with the issuer reimbursing some portion of the remaining charges; (3) coinsurance, which is a percentage payment made by enrollees after the deductible is met and until an out-of-pocket maximum is reached; and (4) out-of-pocket maximums, which are the maximum amounts enrollees have to pay per year for all covered medical expenses.

**Quantitative treatment limitations (QTL).** QTLs are treatment limitations that can be expressed numerically, such as annual, episode, and lifetime day and visit limits. For example, QTLs include annual limits on the number of office visits an enrollee can make for a certain condition and lifetime limits on the coverage of benefits for a certain type of treatment.

**Non-quantitative treatment limitations (NQTL).** NQTLs are non-numerical limitations on the scope or duration of MH/SU services. Common NQTLs include (1) medical management standards that limit or exclude benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; (2) refusal to pay for higher-cost therapies until it can be shown that lower cost therapy is not effective—known as fail first or step therapy protocols; (3) exclusions based on failure to complete a course of treatment; (4) standards for providers to be admitted to participate in a network, including the factors used to set provider reimbursement rates; and (5) requiring pre-authorization of services—the requirement that an enrollee receives prior approval for care.

The MH/SU parity regulations established a two-part analysis to determine if the financial requirements or QTLs in a plan are in compliance with MH/SU parity requirements.<sup>14</sup> The first test determines if a particular type of financial requirement or QTL (such as a copay) applies to substantially all medical/surgical benefits in the relevant classification of benefits (e.g., inpatient in-network or outpatient out-of-network). Generally, a financial requirement or QTL is considered to apply to “substantially all” medical/surgical benefits if it applies to at least two-thirds of the medical/surgical benefits in the classification, according to the regulations. Once the first test is met, the second test checks for parity in the level or magnitude of the requirement (e.g., copay of \$15 or \$20 or treatment limit of 21 or 30 inpatient days per episode). Specifically, by regulation, the financial requirement or QTL cannot exceed the predominant level—that is, the level that applies to more than half of the medical/surgical benefits subject to the financial requirement or QTL in the classification. For example, if at least two-thirds of outpatient, in-network, medical/surgical benefits are subject to a copay, and 75 percent (i.e. more than half) of outpatient, in-network visits involving medical/surgical benefits are subject to a copay of \$30, the copay for outpatient, in-network visits involving MH/SU benefits cannot exceed \$30.

The MH/SU parity regulations extended parity requirements to NQTLs and establish a different test for assessing parity of NQTLs between medical/surgical and MH/SU benefits.<sup>15</sup> Under the regulations, a plan generally cannot apply an NQTL on an MH/SU benefit unless—both as written and in operation—it is comparable to and applied no more stringently than the NQTL applied to medical/surgical benefits.<sup>16</sup> According to guidance issued by HHS, DOL, and Treasury, the NQTL analysis in the regulations focuses on the underlying factors (such as

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<sup>14</sup>See 29 C.F.R. § 2590.712(c)(2)-(3) (2019). The parity analysis is conducted on a classification-by-classification basis in six specific classifications of benefits. The six 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. Outpatient benefits can be sub-classified into office visits and other outpatient services.

<sup>15</sup>See 29 C.F.R. § 2590.712(c)(4) (2019).

<sup>16</sup>29 C.F.R. § 2590.712(c)(4)(i) (2019). Specifically, a plan cannot impose an NQTL on an MH/SU benefit 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/SU benefits in a classification are comparable to, and 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.

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processes, strategies, and evidentiary standards) used to apply the NQTL and ensuring there are not arbitrary or discriminatory differences in how a plan or issuer applies those factors to MH/SU benefits as compared to medical/surgical benefits.<sup>17</sup>

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## MH/SU Parity Oversight

HHS, DOL, and Treasury share joint oversight responsibilities for certain federal laws applicable to private health coverage, including MHPAEA.<sup>18</sup> The oversight of plans and issuers for compliance with MHPAEA is split between the states, HHS, DOL, and Treasury, depending on the type of coverage and whether the plan is self-funded or fully insured.

**Individual and fully insured group plans sold by issuers.** States have primary responsibility for regulating insurance, and health insurance products sold within a state must meet both federal and state requirements, including MH/SU parity requirements. States oversee health insurance sold by issuers (1) in the individual market, where individuals purchase private health insurance plans directly from an issuer or through an exchange; and (2) in the group market, where a plan sponsor (typically an employer) purchases coverage from an issuer.<sup>19</sup> Of the estimated 216 million Americans who were enrolled in private health insurance in 2016, the estimated enrollment in these state-regulated markets was 17.3 million in the individual market, 14.2 million in the small

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<sup>17</sup>For example, a plan requires prior authorization for both inpatient medical/surgical and MH/SU treatment. In practice, inpatient benefits for medical/surgical care are routinely approved for 7 days before requiring additional documentation, as compared to MH/SU treatment, which is routinely approved for only 1 day. While the written prior authorization requirement appears to be in parity, it violates MH/SU parity requirements because in practice, the NQTL is applied more strictly to MH/SU benefits than the medical/surgical benefits. See 29 C.F.R. § 2590.712(c)(4)(iii), Example 1 (2019).

<sup>18</sup>HHS, DOL, and Treasury develop and jointly issue regulations under parallel provisions, consistent with the tri-agency memorandum of understanding that implements section 104 of the Health Insurance Portability and Accountability Act of 1996. 64 Fed. Reg. 70.164 (Dec. 15, 1999).

<sup>19</sup>Health insurance exchanges are marketplaces that operate within each state's overall individual and small group market where eligible consumers and small employers can compare and select among qualified insurance plans offered by participating issuers.



group market, and 42.9 million in the large group market.<sup>20</sup> State oversight of health insurance applies only to fully insured health plans offered by state-licensed issuers. Because self-funded plans are financed directly by the plan sponsor, these plans are generally not subject to state law or oversight.

With respect to health insurance issuers selling products in the individual and fully insured group market, HHS has primary enforcement authority over MH/SU parity requirements in two instances: (1) when a state notifies HHS that it does not have the authority to enforce MH/SU parity requirements or the state notifies HHS that it is not otherwise enforcing the requirements, or (2) when HHS determines the state failed to substantially enforce MH/SU parity requirements. States falling into these categories are known as direct enforcement states, and, in these states, the Centers for Medicare & Medicaid Services (CMS) within HHS assumes the responsibility for directly enforcing federal MH/SU parity requirements and other federal health laws covered by PPACA with respect to issuers. CMS is currently responsible for enforcing MH/SU parity requirements against issuers in four states: Missouri, Oklahoma, Texas, and Wyoming. While CMS enforces MH/SU parity requirements and other PPACA requirements for these direct-enforcement states, these states maintain enforcement authority over issuers for state-level regulatory requirements.

**Employer-sponsored group plans.** DOL has enforcement authority for MH/SU parity requirements for most group health plans sponsored by private employers. This includes both fully insured plans (where the employer purchases coverage from a state-regulated issuer) and self-funded plans (where the employer pays for employee health care benefits directly, bearing the risk for covering medical benefits generated by beneficiaries). Collectively, we refer to group health plans (both large and small group) provided by an employer as employer-sponsored group

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<sup>20</sup>For the estimated enrollment by market, see GAO, *Private Health Insurance: Enrollment Remains Concentrated among Few Issuers, including in Exchanges*, [GAO-19-306](#) (Washington, D.C.: Mar. 21, 2019). The estimated enrollment numbers for state regulated small group and large group markets are from fully insured plans only. These estimates do not include enrollment data for self-funded plans, which is how most large employers provide at least some of their employee health benefits.

For the estimate of overall enrollment in private health plans in 2016, see U.S. Census Bureau, *Coverage Numbers and Rates by Type of Health Insurance: 2013 to 2016*, Current Population Survey, 2014 to 2017 Annual Social and Economic Supplements, table 1.

plans.<sup>21</sup> In fiscal year 2018, there were 131.6 million enrollees in private, employer-sponsored group plans. While states oversee the issuers of these fully insured, private employer-sponsored group plans and the products they offer, DOL oversees the plans themselves for compliance through its Employee Benefits Security Administration (see table 1).<sup>22</sup> DOL does not have the authority to enforce MH/SU parity requirements directly against issuers to correct noncompliant health policies that are designed, marketed, and sold by the issuer to numerous employers for the purposes of offering health plans to their employees. DOL has primary authority for overseeing compliance with MH/SU parity requirements for self-funded, private employer-sponsored group plans, as states generally do not have authority over these plans. The Internal Revenue Service (IRS) within Treasury is authorized to impose an excise tax on employers that sponsor private group plans that are not in compliance with MH/SU parity requirements.<sup>23</sup>

Similarly, HHS has primary authority for MH/SU parity requirements over employer-sponsored plans for state and local governments—known as non-federal governmental plans.<sup>24</sup> Within HHS, CMS oversees both fully insured and self-funded non-federal governmental plans.<sup>25</sup> In 2017, an estimated 13 million state and local government employees enrolled in these plans.<sup>26</sup> Sponsors of self-funded, non-federal governmental plans may elect an exemption from, or “opt-out” of, certain federal health care

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<sup>21</sup>Employer-sponsored group plans include plans provided by an employer, an employee organization (such as a union), or multiple employers through a multiple employer welfare arrangement.

<sup>22</sup>Throughout the report we use DOL to refer to the MH/SU parity-related activities performed by its Employee Benefits Security Administration.

<sup>23</sup>For multi-employer plans, IRS can also impose an excise tax on the plan itself, according to officials from Treasury.

<sup>24</sup>HHS officials told us that states can choose to regulate self-funded, non-federal governmental plans.

<sup>25</sup>Throughout the report we use CMS to refer to the MH/SU parity oversight that occurs within CMS—both in states where CMS directly enforces MH/SU parity for issuers and for employer-sponsored, non-federal governmental plans. We refer to HHS for department-level activities and activities performed by multiple components of HHS—such as issuing regulations or developing and approving guidance.

<sup>26</sup>This estimation is based on the Agency for Healthcare Research and Quality's 2017 Medical Expenditure Panel Survey. It reflects the number of employees that are enrolled in health coverage through state and local government jobs and does not include dependents.

requirements, including MH/SU parity requirements. If a plan elects to opt-out of MH/SU parity requirements, CMS also reviews the plan’s election to ensure they meet requirements for doing so.<sup>27</sup>

**Table 1: Selected Health Plan Types and Oversight Authorities for Compliance with Mental Health and Substance Use Disorder (MH/SU) Parity Requirements**

Plan type	Plan size	Employer sector	Issuer level oversight	Plan level oversight
Fully insured, employer-sponsored plans (Employer pays premiums to an issuer to purchase a health plan)	Large group (>50 employees)	Private	State department of insurance <sup>a</sup>	Department of Labor (DOL)
Fully insured, employer-sponsored plans (Employer pays premiums to an issuer to purchase a health plan)	Large group (>50 employees)	Non-federal government	State department of insurance <sup>a</sup>	Department of Health and Human Services (HHS)
Fully insured, employer-sponsored plans (Employer pays premiums to an issuer to purchase a health plan)	Small group (50 or fewer employees)	Private	State department of insurance <sup>a</sup>	None <sup>b</sup>
Fully insured, employer-sponsored plans (Employer pays premiums to an issuer to purchase a health plan)	Small group (50 or fewer employees)	Non-federal government	State department of insurance <sup>a</sup>	HHS
Self-funded, employer-sponsored plans (Employer pays for the plan’s covered health expenses directly, rather than purchasing a plan from an issuer)	Large group (>50 employees)	Private	None <sup>c</sup>	DOL
Self-funded, employer-sponsored plans (Employer pays for the plan’s covered health expenses directly, rather than purchasing a plan from an issuer)	Large group (>50 employees)	Non-federal government	None	HHS <sup>d</sup>
Self-funded, employer-sponsored plans (Employer pays for the plan’s covered health expenses directly, rather than purchasing a plan from an issuer)	Small group plans <sup>e</sup> (50 or fewer employees)	Private	None	None

<sup>27</sup>As of June 2019, 207 plans opted out of MH/SU parity requirements.

Plan type	Plan size	Employer sector	Issuer level oversight	Plan level oversight
Self-funded, employer-sponsored plans (Employer pays for the plan's covered health expenses directly, rather than purchasing a plan from an issuer)	Small group plans <sup>e</sup> (50 or fewer employees)	Non-federal government	None	None
Individual plans (Fully insured plans generally sold to individual consumers lacking access to group coverage)	N/A	N/A	State department of insurance <sup>a</sup>	None

Source: GAO analysis of Congressional Research Service, DOL, and HHS documents. | GAO-20-150

<sup>a</sup>HHS has direct enforcement authority in four states that are not enforcing federal MH/SU parity requirements: Missouri, Oklahoma, Texas, and Wyoming.

<sup>b</sup>DOL does not oversee fully insured, small group plan compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), because it is the issuer that is required to comply with MHPAEA, through the essential health benefits provision of the Patient Protection and Affordable Care Act, not the plan. DOL does not oversee issuers.

<sup>c</sup>State insurance laws generally do not apply to self-funded, large group plans.

<sup>d</sup>HHS officials told us that states can choose to regulate self-funded, non-federal governmental plans.

<sup>e</sup>Self-funded, small group plans are not required to comply with federal MH/SU parity requirements.

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## Practices for Overseeing Compliance with MH/SU Parity Requirements Vary among State and Federal Agencies

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### Nearly All States Reported Some Review of Fully Insured Group and Individual Plans for MH/SU Parity Compliance before Consumers Enroll; Post-Enrollment Reviews Vary

Through our survey and interviews with officials from the three selected states, we found that nearly all states conduct some type of review for MH/SU parity compliance as part of their oversight of issuers selling fully insured large and small group plans and individual plans.<sup>28</sup> The reported type and frequency of these reviews vary, particularly for the reviews conducted after consumers enroll in plans.

**State oversight before consumers enroll in plans.** Nearly all states reported in our survey that they review issuer documentation for compliance with MH/SU parity requirements before they approve the issuer's plans for sale to consumers in their state.<sup>29</sup> Details of these state reviews include the following:

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<sup>28</sup>An official from California informed us that two state agencies are responsible for enforcing compliance with MH/SU parity requirements—the California Department of Insurance and the California Department of Managed Health Care. We received separate responses from both agencies. We combined the agencies' responses into one survey response to represent statewide information throughout the report. We note any instances where the response (such as a count of complaints) was primarily driven by one of the agencies.

<sup>29</sup>According to the NAIC Product Filing Review Handbook, insurance companies typically file policies, member handbooks, and explanations of benefits with the state during this initial review. State regulators typically review this issuer documentation at the product level, on which the plans sold to consumers are based. States can also allow insurers to submit variable language in their documentation which can allow the regulators to review common policy provisions in an efficient manner. Some provisions of PPACA require review on a plan-by-plan basis.

A product is a discrete package of health insurance coverage benefits that are offered using a particular product network type (e.g., health maintenance organization or preferred provider organization) within a service area. Issuers then sell plans to consumers by pairing health insurance coverage benefits with a particular cost sharing structure, provider network, and service area.

- **Review of financial requirements and QTLs.** States review issuer documentation to ensure that the type and level of the financial requirements and QTLs an issuer applies to MH/SU benefits are comparable to those applied to medical/surgical benefits, such as an annual limit on visits. Officials from one of the three selected states in our review described the initial review process as (1) examining how the issuer projects plan payments and determines MH/SU parity compliance, (2) reviewing the compliance testing methodology and results of the issuer’s compliance testing, and (3) determining how service categories—such as inpatient and outpatient services—are classified as benefits, among other things. States can use templates or tools to conduct these reviews in a consistent manner, and most states use an HHS mental health parity tool to assist in these reviews, according to an NAIC official, though the tool is not yet available to issuers. The tool imports data directly from plan documentation into a spreadsheet and flags possible compliance issues with some MH/SU parity requirements.
- **Review of NQTLs.** Forty-two states reported in our survey they review issuers’ documentation to determine that at least one type of NQTL meets MH/SU parity requirements before consumers enroll in plans. More than half of states reported they review for specific NQTLs, such as restrictions based on geographic location, facility type, and provider specialty. However, officials we spoke with from NAIC and two of the three selected states told us it is difficult to identify NQTL noncompliance based on issuer documentation. An NAIC official told us this is because NQTLs may not be listed in the documentation or may be hard to compare because they are not defined by quantitative data. The NAIC official also told us that most NQTL violations would be identified through state oversight after consumers enroll in a plan. Additionally, according to CMS officials, the HHS mental health parity tool is not designed to facilitate an evaluation of NQTLs due to the nature of reviewing NQTLs.

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The only two states that did not report that they conduct reviews for MH/SU parity compliance before products are approved for sale in their states are Missouri and Wyoming, which are two of the four states where CMS is directly enforcing MH/SU parity requirements. In the four direct enforcement states, CMS conducts reviews of issuer policies and documentation for compliance with federal MH/SU parity requirements before products are approved for sale in the states. The two other states—Texas and Oklahoma—reported in our survey that they review products for state-level MH/SU parity compliance; however, CMS maintains primary authority for reviewing products for compliance with federal MH/SU parity requirements in those states.

**State oversight after consumers enroll in plans.** In addition to the review they conduct prior to consumers enrolling in plans, 27 states reported in our survey they have conducted some type of review related to MH/SU parity after consumers enroll.<sup>30</sup> The types of reviews states conduct vary. These review types include: targeted reviews based on consumer complaints or other information, random audits, and conducting broad routine reviews of issuers' compliance with state and federal health insurance laws—called market conduct examinations.<sup>31</sup> Through our interviews of states and stakeholders we identified additional enforcement activities some states are using to assess the issuer compliance with MH/SU parity requirements after consumers enroll. These reviews and additional enforcement activities are described below:

- **Conducting targeted reviews.** Twenty states reported in our survey that they had conducted a targeted review that focused on specific issuers or particular MH/SU parity compliance concerns, while other states reported they had never performed such a review. Consumer complaints were most commonly identified as the reason—at least in part—that these 20 states conducted targeted reviews to assess compliance with MH/SU parity requirements. Thirty-eight states reported in our survey that they track MH/SU parity complaints, which can be submitted by consumers, providers, or advocates.<sup>32</sup> For

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<sup>30</sup>While state departments of insurance are responsible for overseeing and regulating health insurance at the state level, some state attorneys general have used their authority to investigate and prosecute issuers for noncompliance related to MH/SU parity. According to officials we spoke with in one state's office of the attorney general, the authority of attorneys general to work in this area varies by state and typically falls under their oversight of state consumer protection laws.

<sup>31</sup>CMS officials told us that in the four direct-enforcement states where they have authority over issuers for MH/SU parity compliance, they do not have the authority to require ongoing reporting or to conduct any routine or random reviews of plans after consumers enroll. However, they told us they can carry out market conduct examinations based on a complaint or other information about possible noncompliance. In these four states, CMS identified one MH/SU parity-related complaint and did not finalize any market conduct exams between fiscal years 2017 and 2018. As of October 2019, CMS officials told us they have 16 ongoing market conduct exams in these direct enforcement states.

<sup>32</sup>Not all complaints will result in a targeted review of an issuer. For example, a complaint may be resolved informally by a state or the issue in the complaint may not violate parity requirements. Additionally, multiple complaints could lead to a single targeted examination if the complaints relate to the same issue.

An official from NAIC told us most states use NAIC's complaint codes to identify the subject of the complaint—such as those related to MH/SU parity. However, the NAIC official told us complaints may not always be accurately coded, and officials from one state told us they manually review all mental health complaints to determine if they are related to MH/SU parity.

example, after receiving consumer complaints, Massachusetts examined the accuracy of the information on behavioral health services—services that address mental health or substance use issues—contained in issuers’ provider directories and compared this to the accuracy of medical/surgical provider information in a 2018 report. Officials from another state told us they frequently use targeted reviews in response to complaints because these focus on a specific issue, rely on more recent data, and are less time consuming than more comprehensive market conduct examinations that review an issuer’s compliance with all state health requirements. States reported additional reasons for starting targeted reviews related to MH/SU parity requirements, including reviews initiated after receiving referrals from other departments, reviews driven by predictive analytics or market analyses, and reviews in response to media attention. In 2017 and 2018, the frequency of receiving MH/SU parity-related complaints and conducting targeted reviews varied across states. (See table 2).

**Table 2: State-Reported Oversight Activities Specific to Mental Health and Substance Use Disorder (MH/SU) Parity after Consumer Enrollment in Plans in 2017 and 2018**

Category	States	Range	Median	Total from all states
Tracked parity-related complaints	38	0-523 complaints <sup>a</sup>	4 complaints	<b>988 complaints</b>
Conducted targeted reviews	12	1-22 reviews	2 reviews	<b>70 targeted reviews</b>

Source: GAO survey of state departments of insurance. | GAO-20-150

Note: We administered a survey to officials responsible for overseeing compliance with MH/SU parity in all 50 states and DC.

<sup>a</sup>One state—California—reported receiving 523 complaints in 2017 and 2018, representing over half of all complaints that states reported they received during these years. The California Department of Insurance received 501 complaints and the California Department of Managed Health Care received 22 complaints. Officials from the California Department of Insurance told GAO that the vast majority of these complaints came from treatment facilities and providers regarding the handling and payment of claims by an insurer.



- **Market conduct examinations.** Nearly all states conduct market conduct examinations and states have not routinely included a review for MH/SU parity compliance as part of the examinations. Market conduct examinations are a review of an insurer's marketplace practices. The examination is an opportunity for the state to verify data provided by the insurer and to confirm that companies' internal controls and operational processes result in compliance with state laws and regulations. Eighteen states reported in our survey that they routinely conduct market conduct examinations (ranging from every 3 or 5 years), and, of those, nine states reported that they usually or always include a review of MH/SU parity compliance. Twenty-nine states reported that their market conduct examinations are not routine; they are conducted on an as-needed basis or in response to risk factors, such as market analysis or complaints.<sup>33</sup> In order to assist states' ongoing oversight of MH/SU parity compliance, NAIC developed guidance on MH/SU parity for its Market Regulation Handbook, which most states use to guide their market conduct examinations, an NAIC official told us. The guidance includes a data collection tool for mental health parity analysis. While the guidance was finalized in August 2019, an NAIC official told us most states were already using the guidance to conduct their market conduct examinations while it was in draft form.
- **State-wide comprehensive reviews of issuers.** Officials we interviewed from two of the three selected states told us they have conducted reviews of all issuers in their state as part of their oversight of MH/SU parity compliance after consumers enroll in plans. For example, as requested by its state legislature, Maryland conducted three annual MH/SU parity surveys with the state's major issuers. Maryland officials told us the first two surveys focused on MH/SU parity compliance in the issuers' plan documentation, and the last survey assessed compliance in plan practices and operations. Maryland officials told us the review of all issuers in the state will give them a baseline understanding of issuer compliance with MH/SU parity requirements reviewed. Officials from Washington told us they are using a CMS grant to evaluate issuer claims data and to understand issuers' NQTLs in operation, which officials say will enable them to identify statewide MH/SU parity-related concerns.

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<sup>33</sup>The other four states reported in our survey that they do not regularly perform market conduct examinations or did not provide enough information for us to determine how frequently these examinations are conducted.

- **Annual compliance reporting.** At least eight states have established annual requirements for issuers to demonstrate their MH/SU parity compliance through data reporting or self-certifications, according to officials from one of the three selected states in our review and a provider organization. To fulfill the states' requirements, issuers submit information such as the percentage of claims paid for in-network and out-of-network MH/SU services compared to those paid for medical/surgical services and the number of consumers denied prior authorizations for MH/SU services. For example, in 2012, Massachusetts began requiring issuers to submit annual reports certifying that their plans comply with federal and state MH/SU parity requirements and instructing issuers to compare denials of care for MH/SU and medical/surgical services, among other things.<sup>34</sup> These certifications must be signed by the issuer's chief executive officer and chief medical officer, which Massachusetts officials told us ensures that issuer leadership is aware of the MH/SU parity requirements. Additionally, an official from NAIC told us that NAIC now includes data reporting requirements related to MH/SU parity, such as requiring information on prior authorizations and denials of care, in its annual nationwide collection of issuers' post-enrollment information.<sup>35</sup> An NAIC official told us states can use these data to compare information on MH/SU and medical/surgical services and examine issuers that operate in multiple states.

In their survey responses, 47 states identified enforcement actions they can take if they find, through a review, that an issuer violated MH/SU parity requirements. States reported that these enforcement actions include: financial penalties, license termination, orders to pay claims or interest, and orders to pay restitution.<sup>36</sup> However, an official from NAIC told us that in the majority of cases, issuers voluntarily come into compliance after state regulators identify an issue or parity violation.

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<sup>34</sup>211 Mass. Code Regs. 154 (2013).

<sup>35</sup>NAIC collects annual data from issuers through its Market Conduct Annual Statement, which includes market conduct information on multiple lines of business, including health insurance. An NAIC official noted that while the health data, which includes data related to MH/SU parity, is available to state regulators, it has not yet been made public due to inconsistencies in issuer reporting.

<sup>36</sup>While 47 states identified available enforcement actions that they could take against an issuer if a violation of MH/SU parity requirements was identified through a review, three states did not identify available enforcement actions to bring issuers into compliance with MH/SU parity requirements. One state did not respond to this question.

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## DOL and CMS Conduct Targeted Oversight of Employer-Sponsored Group Plans after Receiving Information and Complaints about Possible Noncompliance

Both DOL and CMS oversee employer-sponsored group plans to ensure their compliance with MH/SU parity requirements. Specifically, the agencies conduct what are known as targeted reviews after consumers enroll in these plans. The agencies initiate these reviews after they receive complaints or other information regarding possible noncompliance with either MH/SU parity requirements or other, unrelated issues, such as a plan failing to provide a document explaining the health benefits covered. Unlike states, the agencies do not conduct any type of review of employer-sponsored plans before consumers enroll and do not have the authority to conduct such a review, according to DOL and CMS officials.

**DOL oversight.** DOL's targeted reviews are triggered by inquiries, including complaints, or other information that identifies possible noncompliance with MH/SU parity requirements or other applicable federal health care laws.<sup>37</sup> These targeted reviews can also originate from additional techniques DOL uses to target plans for review, such as reviewing bankruptcy filings or financial and operational information filed annually by employers. According to DOL's enforcement manual, DOL investigators generally identify the reasons for starting each review, obtain relevant information from the plan or issuer, and conduct a full review of compliance with applicable federal health care laws.<sup>38</sup> These

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<sup>37</sup>DOL uses "inquiries" as an umbrella term for the requests for assistance it receives from the public, including both complaints and general requests for information about the legal requirements for private, employer-sponsored group plans. DOL officials told us that most of the MH/SU parity-related inquiries they receive are complaints from plan members about denied claims. For consistency with the rest of the report, we use the term complaints to refer to these inquiries. Examples of the other types of information that DOL may use to identify possible noncompliance with MH/SU parity requirements or other federal health care laws are media reports, referrals from advocacy groups, and private litigation.

<sup>38</sup>Per DOL's enforcement manual, DOL's reviews of employer-sponsored group plans include a compliance review of the Employee Retirement Income Security Act of 1974 group plan requirements under parts 6 and 7 relating to all applicable health laws, including: Health Insurance Portability and Accountability Act of 1996; MHPAEA; PPACA; Women's Health and Cancer Rights Act of 1998; Newborns' and Mothers' Health Protection Act of 1996; and Genetic Information Nondiscrimination Act of 2008.

reviews which are performed by DOL's 10 regional offices can focus on specific private, employer-sponsored group plans, service providers (such as third party administrators), or issuers; however, DOL does not have the authority to take direct enforcement actions against issuers for violations of MH/SU parity requirements.<sup>39</sup>

DOL reported that it completed 302 reviews of private, employer-sponsored group plans that included a review for compliance with MH/SU parity requirements in fiscal years 2017 and 2018.<sup>40</sup> According to DOL officials, these reviews can take 2 to 3 years to complete and investigators follow an extensive compliance checklist to conduct these reviews. The checklist includes specific questions to help determine compliance with all applicable requirements, including a section with questions on MH/SU parity. Because investigators complete the compliance checklist for every plan level health investigation, reviews not triggered by a parity complaint may still uncover a parity violation. For example, DOL might review a private employer-sponsored group plan in response to a consumer complaint about how long the plan covered a hospital stay for a mother and her newborn. The review would include a review of compliance with the related law (the Newborns' and Mothers' Health Protection Act of 1996), MH/SU parity-related requirements, and all other applicable federal health care requirements.

Nearly all DOL reviews that assess compliance with MH/SU parity requirements originate from sources unrelated to MH/SU parity, including complaints or other information about potential noncompliance with other

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<sup>39</sup>DOL does not have the authority to enforce MHPAEA directly against issuers to correct noncompliant health policies that are designed, marketed, and sold by the issuer to numerous employers for the purposes of offering health plans to their employees. As discussed in DOL's enforcement manual, DOL does have authority, however, over plans and service providers, such as third party administrators, including service providers that exercise discretionary authority or discretionary control respecting the management or administration of the plan. DOL can only take enforcement actions at the plan level to ensure that plans comply with MH/SU parity requirements and that fiduciaries and service providers that service many private, employer-sponsored plans do so according to plan terms and in accordance with applicable claims processing regulations. Additionally, DOL has been able to work with issuers in a number of cases to obtain voluntary corrections to MH/SU parity violations occurring at the issuer level.

<sup>40</sup>DOL reported that it completed a total of 632 health care investigations in fiscal years 2017 and 2018. In 330 of these investigations, MH/SU parity requirements did not apply to the employer-sponsored group plans. The MH/SU parity requirements under MHPAEA do not apply to self-funded employer-sponsored small group plans (less than 50 employees) or to large employer-sponsored group plans that choose not to cover MH/SU benefits.

federal health care laws and DOL reviews of the annual financial and operational information filed by employers, based on data provided by DOL on the reasons targeted reviews were opened. DOL received few MH/SU parity complaints and opened few reviews based on a potential MH/SU parity violation, compared to complaints related to other federal health requirements, in fiscal years 2017 and 2018 (see table 3).<sup>41</sup>

**Table 3: DOL Mental Health and Substance Use Disorder (MH/SU) Parity-Specific and Total Health Inquiries Received and Reviews Opened in Fiscal Years 2017 and 2018**

Category	Fiscal year 2017: MH/SU parity-specific <sup>a</sup>	Fiscal year 2017: Health <sup>b</sup>	Fiscal year 2018: MH/SU parity-specific <sup>a</sup>	Fiscal year 2018: Health <sup>b</sup>
Inquiries received	126	59,000	129	56,262
Inquiries referred for review	6	121	3	128
Reviews opened <sup>c</sup>	12	208	9	174

Source: Department of Labor (DOL) officials | GAO 20-150.

Note: DOL uses inquiries as an umbrella term for the requests for assistance it receives from the public, including both complaints and general requests for information on the legal requirements for private employer-sponsored group plans. MH/SU parity refers to the federal requirements that coverage for MH/SU services—when those services are offered by an employer—be no more restrictive than coverage for medical/surgical services.

<sup>a</sup>MH/SU parity-specific refers to inquiries or reviews where MH/SU parity is listed as a primary issue of the inquiry or review.

<sup>b</sup>Health refers to inquiries or reviews where Health is listed as a primary issue of the inquiry or investigation, including but not limited to MH/SU parity; the Health Insurance Portability and Accountability Act of 1996; the Women’s Health and Cancer Rights Act of 1998; and the Newborns’ and Mothers’ Health Protection Act of 1996. MH/SU parity-specific inquiries and reviews are included in the total numbers for Health.

<sup>c</sup>The number of reviews opened includes all the reviews DOL opened in the fiscal year with a particular lead issue (MH/SU parity or Health generally). This includes both reviews opened based on inquiries and on other sources of information. As a result, the number of reviews may be larger than the number of inquiries referred for review. DOL officials told us that statistics on the lead issue or primary reason for opening a review may change during the course of the review. DOL officials told us the final designation of the lead issue only occurs at the close of the case.

When DOL identifies a violation of MH/SU parity requirements through one of its reviews, investigators first seek to bring the private employer-sponsored group plan or issuer into compliance voluntarily, according to DOL officials. When that is not possible, DOL can sue the plan for equitable relief, which can result in the plan being required to reimburse

<sup>41</sup>According to the DOL’s standard operating procedures, DOL’s benefit advisors—staff who receive and respond to complaints and compliance inquiries—try to resolve identified issues voluntarily with private employer-sponsored group plans; however, the benefit advisors will make referrals to investigators when necessary, including when a practice appears to affect multiple plans or beneficiaries. As a result, not all complaints lead to investigations.

members whose claims were improperly denied. DOL can also request that the Treasury levy an excise tax on the non-compliant private employer-sponsored group plan, but DOL officials noted that the excise tax goes to the Treasury rather than toward payment of claims for plan members, and DOL's focus is on obtaining payment of claims. DOL officials told us they have never referred a plan to IRS to levy an excise tax based on an MH/SU parity violation. The 21st Century Cures Act requires DOL to conduct an audit of a private employer-sponsored group plan when DOL has identified five or more MH/SU parity violations; however, DOL officials told us the use of this authority has not been triggered, as of October 2019.<sup>42</sup>

DOL identified audit resources challenges faced by the agency given the universe of plans DOL oversees and reported that the agency is taking steps to better leverage its resources through targeted exams in its September 2019 enforcement report to Congress.<sup>43</sup> Specifically, DOL reported that DOL has less than one investigator for every 12,500 employee benefit plans the agency oversees, including private health, pension, life, and disability insurance. In light of these challenges, DOL officials said they are focusing their targeted reviews on issuers and other service providers to obtain voluntary corrections whenever possible so they can address noncompliance across multiple private employer-sponsored group plans.<sup>44</sup> To date, they have completed at least two investigations at the issuer level and brought an issuer into voluntary compliance after one investigation identified MH/SU parity noncompliance affecting over 4,000 private, employer-sponsored group plans and 7 million consumers. According to DOL officials, focusing on issuers will result in their opening fewer targeted reviews than in prior years, but will have more meaningful results. DOL officials also noted other efforts

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<sup>42</sup>The 21st Century Cures Act requires that the appropriate federal agency—HHS, DOL, or Treasury—audit plans or issuers that violated MH/SU parity requirements five or more times. DOL officials told us they have internal protocols to track these violations for private, employer-sponsored group plans. The officials told us DOL has enhanced its enforcement data systems to track MH/SU parity violations by violation type and plan characteristics, such as plan type and funding status. DOL officials told us their current approach to reviewing and resolving MH/SU parity violations limits the benefit of auditing plans or issuers with multiple violations. This is because a targeted review is not closed unless the agencies receive evidence of a correction of the violation, according to DOL officials.

<sup>43</sup>See Department of Labor, *FY 2018 MHPAEA Enforcement Fact Sheet* (Sept. 5, 2019).

<sup>44</sup>While DOL cannot take enforcement actions against an issuer, they can review issuers and bring them into voluntary compliance with MH/SU parity requirements.

underway to assist in MH/SU parity oversight. For example, the DOL's Kansas City Regional Office has convened a task force that focuses on parity in opioid use disorder treatment coverage. DOL officials told us they require senior advisors in each of the 10 regions to identify trends in the types of violations DOL identifies and to identify when a violation could be happening at the issuer level, rather than the individual employer-sponsored group plan level.

**CMS oversight.** CMS oversight of employer-sponsored, non-federal governmental plans for compliance with MH/SU parity requirements consists of targeted reviews.<sup>45</sup> Like DOL, these targeted reviews originate from complaints or information about noncompliance—about MH/SU parity or issues with other federal health care laws. The reviews are used to assess compliance with all applicable health requirements, and CMS officials told us CMS has broad authority to review or request information as a part of these reviews.<sup>46</sup> However, according to CMS officials, CMS has limited authority to review or request information from these plans outside of these targeted reviews. Specifically, CMS officials said CMS does not have the authority to conduct random audits, reviews, or examinations of employer-sponsored, non-federal governmental plans, or to require the plans to provide documentation to demonstrate compliance with MH/SU parity requirements. CMS officials also said they do not have the authority to review employer-sponsored, non-federal governmental plans for compliance with MH/SU parity requirements prior to enrollment.

While large, self-funded, employer-sponsored, non-federal governmental plans may opt-out of MH/SU parity requirements and certain other federal health requirements, CMS may identify MH/SU parity noncompliance if

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<sup>45</sup>While CMS officials told us they do not currently know the universe of non-federal governmental plans, they estimated that it is in the range of 10,000 plans.

<sup>46</sup>According to CMS guidance, these targeted reviews begin with a review of plan documentation and a fact-finding call with the plan related to the complaint raised. CMS officials told us that the contractors who conduct these targeted reviews require plans to complete a data worksheet and provide documentation that helps the contractor assess if the plan is out of compliance with MH/SU parity requirements. CMS officials told us the contractors review the data worksheet and documentation, including during reviews of complaints unrelated to MH/SU parity. If the initial review of the complaint indicates a plan might be out of compliance, CMS does a more comprehensive review of compliance with all federal requirements.

these plans did not properly opt-out.<sup>47</sup> CMS officials told us that they review documentation for all plans that elect to opt out of MH/SU parity requirements to ensure it was properly submitted. If CMS finds a plan may have opted-out incorrectly, CMS officials said they can request additional information from the plan and can ultimately decide the opt-out was invalid.

CMS reported that it closed five reviews related to MH/SU parity in fiscal years 2017 and 2018. Two targeted reviews originated from MH/SU parity complaints and three reviews were related to plans opting-out of MH/SU parity requirements. CMS officials told us that they received four complaints related to MH/SU parity in employer-sponsored, non-federal governmental plans in fiscal years 2017 and 2018. The officials told us all four complaints resulted in targeted reviews, two of which were ongoing as of September 2019.

When CMS identifies MH/SU parity noncompliance through one of these targeted reviews, the agency takes one of several actions: working with the plan to implement a corrective action plan; initiating a full market conduct examination of the plan; or imposing civil money penalties. Like DOL, the 21st Century Cures Act requires CMS to audit an employer-sponsored, non-federal governmental plan or issuer when CMS has identified noncompliance five or more times. According to CMS officials, as of November 2019, the use of this audit authority has not been triggered.

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### **DOL and CMS Do Not Have Assurance That Their Use of Targeted Reviews to Oversee MH/SU Parity Requirements Is Effective for Ensuring Parity**

Under DOL's and CMS's oversight through targeted reviews, self-funded employer-sponsored group plans do not undergo review for compliance with MH/SU parity requirements unless the agencies receive complaints or other information about potential noncompliance with an applicable federal health care law, or the review is opened as a result of a targeting

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<sup>47</sup>A plan must inform CMS and plan members on an annual basis that it is opting out of MH/SU parity requirements. A plan has opted out of MH/SU parity requirements improperly if it does not inform CMS or plan members prior to members enrolling in the plan. As of June 2019, 207 self-funded, employer-sponsored non-federal governmental plans opted out of MH/SU parity requirements.



technique unrelated to MH/SU parity—such as bankruptcy filing review.<sup>48</sup> Relying on the receipt of such information to trigger a targeted review of MH/SU parity is a concern given the low number of complaints DOL receives related to MH/SU parity when compared to other federal health requirements. For example, as we have noted, DOL received 129 complaints in fiscal year 2018, and most of the noncompliance with MH/SU parity requirements DOL identified was found through reviews triggered by complaints and information unrelated to MH/SU parity in fiscal years 2017 and 2018, based on our review of DOL data. Further, as discussed later in this report, consumer advocates have noted that there is a lack of consumer awareness about MH/SU parity requirements, which may result in fewer complaints than would otherwise be made if consumers understood the requirements.

Federal internal control standards state that agencies should identify, analyze, and respond to risks related to achieving their defined objectives.<sup>49</sup> DOL has stated that its defined objective is the full implementation of MH/SU parity requirements through vigorous compliance assistance and enforcement. HHS has stated that it is committed to enforcing MH/SU parity requirements through CMS and to providing the sponsors of employer-sponsored, non-federal governmental plans the information needed to ensure that the plans are fully compliant with MH/SU parity requirements.

DOL and CMS officials told us they have not completed any statistical analysis or study regarding the effectiveness of their targeted review approach to MH/SU parity compliance, nor whether this approach

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<sup>48</sup>DOL and CMS oversee both fully insured and self-funded employer-sponsored group plans. The issuers of fully insured, employer-sponsored group plans receive additional oversight by either the states or CMS in four states, including a review before an issuer can sell a product in a state. Self-funded, employer-sponsored group plans generally are not overseen by the state.

<sup>49</sup>[GAO-14-704G](#). According to federal internal control standards, risk assessment is the identification and analysis of risks related to achieving the defined objectives to form a basis for designing risk responses. The standards state that management should analyze identified risks to estimate the significance of their effect on achieving a defined objective.

increases the risk of noncompliance.<sup>50</sup> Specifically, they have not analyzed whether relying on targeted reviews alone increases the risk of noncompliance with MH/SU parity requirements in employer-sponsored group plans.<sup>51</sup> The risk of noncompliance may be increased because incentives for plans to comply are limited when investigations are initiated only after receiving complaints or information about noncompliance. DOL and CMS officials also said they have not analyzed whether additional strategies, such as the attestation or issuer documentation requirements used by some states, would reduce the risk of noncompliance. For example, such an evaluation could assess whether a sample of health plans reviewed for compliance identified similar types of noncompliance as those identified when plans were reviewed in response to MH/SU parity complaints. According to officials from a provider organization, one such strategy to improve compliance would be to require issuers or plans to affirm that (1) their plans comply with MH/SU parity requirements and (2) they have documentation showing that they analyzed their plans for compliance. According to these officials, requiring this documentation from plans and issuers can increase compliance, even if there is a low probability that a plan will be audited. DOL and CMS officials told us that they currently do not have the authority to conduct oversight activities of this type. Specifically, they told us that for self-funded private or non-federal governmental employer-sponsored group plans they do not

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<sup>50</sup>DOL officials, however, told us they analyze the effectiveness of their enforcement program by reviewing the results of their investigations and any findings related to MH/SU parity. They told us that the regional offices are required to submit voluntary compliance letters and closing letters related to MH/SU parity to the national Office of Enforcement for review prior to issuance. The review includes the technical accuracy of cited violations and the universe of participants affected and the extent of the harm, among other things. They told us that they review enforcement results on an annual basis as they develop the next year's operating plan and their MH/SU parity enforcement report. Officials noted that the results of this ongoing, qualitative review can be found in their most recent enforcement fact sheet. See Department of Labor, *FY 2018 MHPAEA Enforcement Fact Sheet*.

<sup>51</sup>DOL and CMS have conducted special projects that assessed group health plan compliance with MH/SU parity requirements or other federal health laws. These special projects reviewed a sample of plans. In 2001, DOL reviewed 1,267 group health plans for compliance with 42 specific requirements of new health care laws, including MHPA. DOL reported on noncompliance rates for the health laws reviewed and found 8 percent of plans were cited with a violation of MHPA. DOL attributed this relatively low violation rate to the narrow scope of MHPA's provision and relatively simple changes that plans made to come into compliance. To streamline its compliance review process for requirements related to the Health Insurance Portability and Accountability Act of 1996, CMS completed a volunteer pilot program that reviewed documentation from a small number of health plans and clearing houses in 2018. According to CMS, this information is being used to inform its broader compliance review program, which includes periodic reviews of randomly selected entities to assess compliance.

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currently have the authority to: (1) review plans for compliance with MH/SU parity requirements before coverage is offered to consumers, (2) require plans to develop documentation to demonstrate compliance with MH/SU parity requirements, and (3) monitor or examine plans for compliance with MH/SU parity requirements outside of an investigation.

Without evaluating the effectiveness of their targeted review approach, DOL and CMS do not know whether their oversight is adequate for ensuring compliance with MH/SU parity requirements, or whether they need to adopt additional strategies and seek new authorities, if needed.

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## Enforcement Activities and Research Identified Some Health Plans Not Compliant with MH/SU Parity Requirements, but the Extent of Compliance Is Unknown

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### States, DOL, CMS, and Available Research Identified Some Noncompliance with MH/SU Parity Requirements

States, DOL, and CMS identified some plan or issuer noncompliance with specific MH/SU parity requirements in 2017 and 2018 through their various oversight efforts. Specifically, after consumers enrolled in plans:

- Seventeen of the 51 states that responded to our survey reported identifying noncompliance a total of 254 times among issuers of individual plans and fully insured, employer-sponsored group plans.<sup>52</sup>

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<sup>52</sup>One state identified noncompliance 100 times. Three states did not provide a response to this survey question. Thirty-one states reported that they did not identify any instances of noncompliance in 2017 or 2018.

In fiscal year 2017, CMS identified one instance of noncompliance in a direct enforcement state. The issuer was found to have an NQTL that was not compliant with MH/SU parity requirements, because the plan covered methadone for pain management but not opioid addiction. The issuer agreed to correct its policy and made the necessary change effective in 2017. CMS identified this instance of noncompliance through a market conduct exam.

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- DOL reported identifying noncompliance 113 times among private, employer-sponsored group plans or the issuers of these plans.<sup>53</sup>
  - CMS reported identifying noncompliance two times among employer-sponsored, non-federal governmental plans.<sup>54</sup>

Both states and DOL most commonly identified noncompliance with MH/SU parity NQTL requirements. Eleven of the 14 states that provided information on the types of MH/SU parity noncompliance in our survey reported that the noncompliance they found was related to NQTLs half the time or more. Similarly, DOL reported that 55 percent of noncompliance the agency found in fiscal year 2018 was related to NQTLs, while 40 percent was related to financial requirements or QTLs.<sup>55</sup> Through our review of DOL letters informing plans of noncompliance, we found that the most common types of noncompliance with MH/SU parity requirements were related to (1) copayments or coinsurance, such as a higher copayments for MH/SU treatment than those generally applied to equivalent medical/surgical treatment (a financial requirement); (2) prior authorizations, such as requiring approval in advance for MH/SU treatment but not requiring it for equivalent medical/surgical treatment (an NQTL); and (3) the total number of treatments allowed, such as a limit on inpatient hospital days for MH/SU treatment that is not applied to equivalent medical/surgical treatment (a QTL).

The scope of noncompliance with MH/SU parity requirements identified by states, DOL, and CMS in 2017 and 2018 varied—both in terms of the number of consumers affected and the steps needed to come into

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<sup>53</sup>These 113 violations of MH/SU parity requirements were identified in 66 of the 302 reviews closed by DOL in fiscal years 2017 and 2018 that included a review of MH/SU parity requirements. See Department of Labor, *FY 2017 MHPAEA Enforcement Fact Sheet* and Department of Labor, *FY 2018 MHPAEA Enforcement Fact Sheet*. We found that 54 of the 66 reviews also identified at least one violation of a federal health care law unrelated to MH/SU parity through our review of DOL letters informing plans of noncompliance.

<sup>54</sup>CMS numbers were reported to Congress through HHS's annual enforcement reports for fiscal years 2017 and 2018. In both cases of noncompliance, the plans failed to properly opt-out of MH/SU parity requirements.

See Department of Health and Human Services, *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Enforcement Report* (Dec. 12, 2017) and Department of Health and Human Services, *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Enforcement Report for the 2018 Federal Fiscal Year* (Mar. 29, 2019).

<sup>55</sup>The remaining 5 percent of noncompliance DOL found was noncompliant annual and lifetime dollar limits and benefit coverage requirements.

compliance. While MH/SU parity requirements apply to plans, regulators may identify and seek to correct noncompliance in the underlying health policies that issuers use to design, market, and sell as health plans to numerous employers. For example, DOL letters show one particularly widespread violation affected more than 7 million enrollees. Most plans or issuers resolved the noncompliance identified by regulators voluntarily. For example, DOL officials told us that plans or issuers resolved all instances of noncompliance voluntarily. Nine states reported in our survey taking a total of 20 enforcement actions to bring plans or issuers into compliance in 2017 and 2018. See table 4 for examples of noncompliance and steps required to come into compliance.

**Table 4: Examples of Mental Health and Substance Use Disorder (MH/SU) Parity Noncompliance Identified by State and Federal Regulators in 2017 and 2018**

Regulator	Plan(s) type and scope	Description of MH/SU parity noncompliance	Steps required to come into compliance
Department of Labor (DOL)	Both self-funded and fully insured employer-sponsored plans  More than 7 million enrollees	A blanket preauthorization requirement for MH/SU services—a provider must request authorization from the issuer prior to providing any MH/SU services to an enrollee.  Preauthorization was not required for many medical/surgical benefits.	Remove the preauthorization policy from MH/SU benefits. The change had to be made to both medical provider contracts and plan documents provided to consumers.
DOL	Self-funded, employer-sponsored plan  Approximately 60,000 enrollees	The plans were charging two copayments for one MH/SU office visit.  Two copayments were not being charged for one medical/surgical office visit.	Review all the claims affected by the noncompliance and provide appropriate repayment to plan members.
DOL	Fully insured, employer-sponsored plan  Approximately 900 enrollees	The plan limited the hours of therapy it would cover for people diagnosed with autism spectrum disorder.  This limit on the hours of service covered was not applied to medical/surgical treatment.	Review all the claims affected by the noncompliance and provide appropriate repayment to plan members.
Centers for Medicare & Medicaid Services (CMS)	Self-funded, non-federal governmental plan  One plan covering a school district	The plan did not appropriately inform CMS that it intended to opt-out of MH/SU parity requirements before the first day of the plan year.	<ol style="list-style-type: none"> <li>1. Retroactively apply MH/SU parity requirements for the entire plan year to which the opt-out otherwise would have applied.</li> <li>2. Notify plan enrollees of the benefits they have a right to under MH/SU parity requirements.</li> <li>3. Allow enrollees to retroactively file claims for benefits not received.</li> <li>4. Review previously denied claims and make appropriate claim payments.</li> </ol>

Regulator	Plan(s) type and scope	Description of MH/SU parity noncompliance	Steps required to come into compliance
State	An issuer	<p>The issuer required MH/SU facilities to undergo a review of medical malpractice history before admitting them into the plan network.</p> <p>A review of medical malpractice history was not required of medical/surgical facilities.</p>	<p>Remove the standard it used for MH/SU facilities but not medical/surgical facilities.</p> <p>Pay a penalty of \$2,000 to the state department of insurance.</p>

Source: GAO review of DOL, CMS, and state information. | GAO 20-150

Additionally, while the literature we reviewed suggested that the individual, small group, and large group plans assessed by the studies were generally compliant with MH/SU parity requirements assessed by the studies, the studies identified some noncompliance or possible noncompliance.<sup>56</sup> For example:

- One case study found that, in 25 percent of the total products offered on two state-based health insurance exchanges between October 2013 and March 2014—the first year of operation for the exchanges established by PPACA—the financial requirements and certain NQTLs reviewed appeared to be noncompliant with MH/SU parity requirements. The study also found variation in the types of noncompliance in each of the states.<sup>57</sup> The case study concluded that on one exchange more than half the products appeared inconsistent with MH/SU parity requirements, particularly the NQTLs reviewed; on the other exchange, 11 percent of the products had a financial requirement that violated MH/SU parity requirements.<sup>58</sup>

<sup>56</sup>In total, we reviewed 10 articles that contained information about compliance by individual, small group, and large group plans with MH/SU parity requirements, either by assessing compliance, by comparing MH/SU plan benefits and requirements to medical/surgical benefits, or by assessing changes in MH/SU plan benefits over time. See appendix II for a description of our literature review methodology, and a summary of the methodologies and key findings of the 10 articles. Seven of the 10 research studies we reviewed found possible noncompliance with MH/SU parity by plans but did not draw a conclusion about whether or not the plans were compliant.

<sup>57</sup>Health insurance exchanges are marketplaces that operate within each state’s overall individual and small group market where eligible consumers and small employers can compare and select among qualified insurance plans offered by participating issuers. These plans are required to comply with MH/SU parity requirements as part of the ten essential health benefits categories that individual and small group plans must cover under PPACA.

<sup>58</sup>Kelsey N. Berry, et al. “A Tale of Two States: Do Consumers See Mental Health Insurance Parity When Shopping on State Exchanges?” *Psychiatric Services*, vol. 66, no. 6 (2015): p. 565–567.

- One study found that 18 percent of benchmark plans were not compliant with MH/SU parity requirements for substance use disorder benefits specifically.<sup>59</sup> For example, five plans had limits on the number of inpatient and/or outpatient visits for substance use disorder services only.<sup>60</sup> (See app. II for additional information about the studies we reviewed.)

Each of the studies we reviewed were limited because they evaluated only selected requirements, with the authors of four studies noting there was insufficient information in plan documents to evaluate additional MH/SU parity requirements.<sup>61</sup> As such, none of the studies could determine the extent of issuer compliance with all MH/SU parity requirements.

A 2018 survey of employer-sponsored group plans suggests that there could be employer-sponsored plans that have not come into compliance with MH/SU parity requirements. Specifically, this nationally representative survey of employers that offer employer-sponsored group plans found that 61 percent of large and midsized employers reported they had taken steps to address compliance with MH/SU parity requirements—such as reviewing plan documents. An additional 13 percent of large and midsized employers reported that they planned to take action to come into compliance and some plans may have already been in compliance.<sup>62</sup>

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<sup>59</sup>A benchmark plan is a plan designated as the standard for the ten essential health benefits offered by individual and small group plans sold on health insurance exchanges. Plans sold on the exchanges are required to comply with MH/SU parity requirements regardless of the benchmark plan's compliance.

Center on Addiction, *Uncovering Coverage Gaps II: A Review and Comparison of Addiction Benefits in ACA Plans* (New York: March 2019), 3.

<sup>60</sup>Center on Addiction, *Uncovering Coverage Gaps II*, 10.

<sup>61</sup>The authors of the studies we reviewed identified other limitations including the use of survey responses without independent verification of the responses and the use of data from a single issuer.

<sup>62</sup>Mercer, *National Survey of Employer-Sponsored Health Plans: 2018 Survey Report*, 37. Mercer defined large and midsized employers as those with 500 employees or more and 1,620 of these employers responded to the Mercer survey. The remaining one-quarter of employers reported that MH/SU parity regulation compliance was not a priority for them.

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## Stakeholders and Research Reviewed Indicate the Full Extent of Compliance with MH/SU Parity Requirements is Not Known

According to advocacy groups and state and federal officials we interviewed and some of the research we reviewed, the full extent of compliance with MH/SU parity requirements is not known. As NAIC and consumer advocacy stakeholders have reported, regulators often rely on both individual complaints and aggregate consumer complaint statistics to identify problem issuers and problem areas for additional oversight. However, stakeholders from eight consumer advocacy groups told us that complaints are not a good measure of whether MH/SU parity issues exist and do not accurately reflect the number of enrollees facing problems with parity. Further, CMS, DOL, and state officials, as well as stakeholders and researchers, also noted the complexity of assessing plans for MH/SU parity compliance for NQTLs in particular, which may result in inconsistent identification of MH/SU parity violations or the inability to fully assess compliance.

**Limitations of relying on complaints to trigger enforcement activities.** Stakeholders and state officials reported on the limitations of relying on complaints to trigger enforcement activities—which contribute to the challenges in determining the full extent of compliance with parity requirements. Stakeholders from eight consumer advocacy groups told us that if regulators rely on complaints to identify possible noncompliance after consumers enroll in plans, they will not know the full extent of compliance with MH/SU parity requirements. These stakeholders identified several reasons complaints do not accurately reflect the number of consumers facing problems related to plan or issuer compliance with MH/SU parity requirements:

- Consumers may not be aware of MH/SU parity requirements, such as how to determine if the treatment challenge they are experiencing is a potential parity violation, how to file a parity-related complaint, or which entity they should contact to file a complaint, according to five consumer advocacy stakeholders we spoke to and one professional organization. For example, while a consumer would be aware of a denial for a particular treatment for a mental health condition because the issuer did not consider it to be medically necessary, the consumer could not easily determine if this standard was applied more stringently than to similar



medical/surgical benefits and thus signaled a parity issue.<sup>63</sup> Further, in our survey, officials from 21 states reported they do not provide any public information to consumers about MH/SU parity requirements, which may contribute to a general lack of consumer awareness in these states.<sup>64</sup>

- Consumers may decide not to file a complaint due to the stigma associated with MH/SU treatment, three consumer advocacy stakeholders and state officials in one state told us. One stakeholder also noted that consumers expect substance use disorder services to be treated differently than medical services and are therefore less likely to file a complaint if they receive disparate treatment.<sup>65</sup>
- Consumers may be hesitant to file a complaint that includes sensitive personal details, such as a mental illness diagnosis, two stakeholders told us. One of these stakeholders told us consumers in need of substance use disorder services in particular may not want to raise a complaint that documents their participation in illegal activities, such as drug misuse. In addition, two stakeholders and state officials in one state stated that individuals or families experiencing an immediate crisis associated with MH/SU conditions may not be well-equipped to navigate the complaint process or wait for a complaint resolution.
- Providers face barriers helping consumers file complaints or appeals related to MH/SU parity requirements, four consumer advocacy stakeholder groups and one professional organization told us. The barriers identified by these stakeholders include: providers being unable

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<sup>63</sup>Under MH/SU parity regulations, a plan may not impose an NQTL—such as limiting or excluding benefits based on a medical necessity determination—unless, under the plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SU benefits are comparable to, and applied no more stringently, than those used in applying the limitation with respect to medical/surgical benefits. See C.F.R. § 2590.712(c)(4)(i) (2019).

<sup>64</sup>This lack of consumer awareness was reflected in a 2018 advocacy group survey of consumers in five states that found that less than half of consumers surveyed were aware of MH/SU parity requirements. The Consumer Health Insurance Knowledge and Experience Survey Report of Findings was produced by the Parity at 10 Campaign, which is a coalition of advocacy groups in Illinois, Maryland, New Jersey, New York, and Ohio with the goal of increasing access to MH/SU services through enforcement of MH/SU parity requirements. See Parity at 10 Campaign, *The Consumer Health Insurance Knowledge and Experience Survey*, 3 and 17.

<sup>65</sup>The Parity at 10 consumer survey found that 93 percent of consumers were likely to challenge a medical/surgical treatment denial of coverage, while 78 percent of consumers were likely to challenge an MH/SU treatment denial of coverage. See Parity at 10 Campaign, *The Consumer Health Insurance Knowledge and Experience Survey*, 15.

to file complaints on behalf of consumers in some states; the time consuming nature of the appeals or complaint processes; and provider fear that an issuer will drop them from their network if they file a complaint. Two consumer advocacy groups have identified that providers may be in a better position to understand a denial decision and justify a consumer's need for treatment, but noted that barriers discourage providers from filing an appeal or complaint. One of these consumer advocacy groups reported that providers might be unaware of what issuer actions would violate MH/SU parity requirements.<sup>66</sup>

Officials from the three selected states provided examples of specific efforts taken that may address stakeholder identified challenges consumers face in understanding parity requirements and filing related complaints. For example, Maryland officials told us they developed a webinar to help consumers with filing complaints related to substance use disorder treatment.<sup>67</sup> Officials from Massachusetts told us they review for parity violations any complaint related to coverage of mental health-related services, regardless of whether the consumer indicates that the complaint might be a parity violation. While this process is still dependent on a consumer to make a complaint, it does not rely on the consumer having an in-depth understanding of parity requirements for their complaint to be reviewed for potential noncompliance. In light of concerns about consumers not filing complaints, officials from Washington told us their statewide comprehensive review includes an assessment of how issuers implemented state and federal MH/SU parity requirements and aims to help them assist consumers who are not reaching out directly. Additionally, 30 states reported in our survey that they provide public information—such as frequently asked questions or brochures—for consumers about MH/SU parity requirements.

**Complexity of assessing NQTLs for MH/SU parity compliance.** CMS, DOL, NAIC, and state officials, as well as some stakeholders and researchers, identified complexities in assessing NQTLs for compliance

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<sup>66</sup>Findings from a 2018 advocacy group survey of over 750 providers in five states suggest that providers have limited knowledge and awareness of MH/SU parity requirements and lack confidence in their knowledge. As a result, providers face barriers assisting their patients in responding to issues related to MH/SU parity requirements. See Parity at 10 Campaign, *Provider Parity Act Knowledge and Practice Survey: Report of Findings* (Feb. 11, 2019).

<sup>67</sup>See *Maryland's Opioid Crisis and How the Maryland Insurance Administration Can Help* (Maryland Insurance Administration), accessed October 23, 2019, <https://insurance.maryland.gov/Consumer/Pages/Webinar-Meetings.aspx>

with MH/SU parity requirements. As a result, regulators may fail to identify noncompliance, or may not always identify noncompliance, making current numbers on noncompliance with MH/SU parity requirements an unreliable indicator of the extent of noncompliance.

- **Difficult to assess plan implementation of NQTLs.** Officials from three states reported in our survey or interviews that it is challenging to determine how an NQTL described in plan documents is actually being implemented and experienced by consumers in practice. This can make it difficult to determine both if noncompliance has occurred and the extent of any noncompliance.<sup>68</sup> Further, some state regulators do not conduct the types of detailed analyses necessary to determine if an NQTL is in compliance with MH/SU parity requirements, according to one consumer advocacy group. Finally, four studies we reviewed identified that researchers were unable to observe the plans' implementation of NQTLs. Thus, they were unable to draw conclusions about whether or not the way plans implemented the NQTLs complied with MH/SU parity requirements. To address the complexities of these analyses for their own reviews, DOL officials told us that for its targeted reviews of MH/SU parity compliance, DOL uses seasoned investigators, early litigation support, technical guidance from DOL's regulations office, and outreach to other federal and state agencies.
- **Lack of documentation on medical/surgical NQTLs.** A lack of documentation on the factors used to apply NQTLs to medical/surgical benefits makes it difficult for issuers to demonstrate compliance with MH/SU parity requirements, according to two industry officials. They told us that information on NQTLs—such as when to require prior authorization—has to be created for medical/surgical benefits so that the information can then be compared to the application of NQTLs to MH/SU benefits to assess compliance with MH/SU parity requirements. One industry official noted that this poses an additional hurdle when MH/SU benefits are carved out or separately managed from the rest of a health plan. This lack of explicit information about medical/surgical benefits and difficulty drawing parallels between medical/surgical and MH/SU care also makes it difficult for regulators to determine parity compliance, officials from one of the three selected states told us.

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<sup>68</sup>For example, DOL officials told us that a plan document may require a pre-admission certification for inpatient MH/SU treatment. However, in practice, the plan might cover the treatment, regardless of whether or not the consumer had pre-admission certification. They told us that while in practice the NQTL is not a barrier to care, it can still be considered a barrier or violation as consumers may not have sought treatment at all due to the language in the plan document.

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- **Lack of resources.** Eight states reported in our survey that lack of staff resources, staff training, or clinical expertise are additional challenges to assessing compliance with MH/SU parity requirements. Further, states may hesitate to determine an issuer violated federal MH/SU parity requirements due to a lack of confidence or clarity in applying the federal laws and may cite state laws instead, according to officials from one of our three selected states and a provider organization. Officials from the provider organization told us this could result in an undercount of MH/SU parity violations if a state cites a potential violation of an MH/SU parity requirement as a violation of a state law unrelated to federal MH/SU parity requirements. One state official identified consumer protection laws as an alternative to pursuing possible MH/SU parity requirement violations. Officials from one state told us some state laws have more clear cut standards than federal MH/SU parity requirements, due to the lack of clarity regarding federal MH/SU parity requirements. However, different strategies were used in three states to obtain the needed clinical expertise to review NQTLs, including regular meetings with clinicians from the state mental health department and using grant money to contract with physicians with clinical expertise to help with compliance reviews.

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## HHS, DOL, and Treasury Jointly Develop Guidance and Provide Support to States for Enforcing MH/SU Parity Requirements

HHS, DOL, and Treasury have coordinated on oversight of MH/SU parity requirements by providing support and jointly developing guidance for state regulators, insurance industry officials, providers, and consumers. HHS described several recent and planned coordination activities in its public action plan to improve state and federal coordination of the oversight of MH/SU parity requirements. This plan was required by the 21st Century Cures Act.<sup>69</sup> Recent and ongoing support and coordination activities include:

- **Formal agreements with states.** HHS and DOL officials told us they have established formal agreements—such as collaborative enforcement agreements—with states to help coordinate, share information about, or assist states with MH/SU parity enforcement activities. For example, DOL officials told us they have general enforcement and common interest agreements with nearly 40 states that allow them to share information related to MH/SU parity enforcement. HHS officials told us they have collaborative enforcement agreements with six states that allow HHS to intervene if a state’s efforts to bring an issuer into compliance with MH/SU parity requirements are unsuccessful. In response to our survey, state officials reported few formal referrals between the states and HHS or DOL.
- **Informal communication with states.** HHS and DOL officials told us that state regulators can contact regional coordinators and individuals in their respective headquarters for assistance with MH/SU parity enforcement outside of formal agreements. HHS and DOL officials told

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<sup>69</sup>As required by the 21st Century Cures Act, HHS, in coordination with DOL, Treasury, and the Office of Personnel Management, held a public listening session with stakeholders—including state government officials, issuers, and MH/SU service providers—to develop a public action plan to improve state and federal coordination of MH/SU parity. The resulting action plan highlighted recent and planned actions to maintain momentum on parity enforcement and implementation. DOL officials told us that the plan generally contained information about enforcement activities that had already been completed, rather than describing future activities.

See Department of Health and Human Services, *21st Century Cures Act: Section 13002 Action Plan for Enhanced Enforcement of Mental Health and Substance Use Disorder Coverage* (Apr. 23, 2018).

us that referrals of specific complaints are informal and infrequent, noting that if a complainant contacted their office by mistake they would provide the contact information for the appropriate state or federal agency.

- **Technical assistance and outreach.** HHS and DOL jointly conduct technical assistance for state regulators and have conducted outreach with stakeholders, including consumers, consumer advocates, providers, issuers, and employers, to improve compliance with MH/SU parity requirements. DOL officials told us that they meet regularly with state regulators and NAIC to provide technical assistance and foster implementation and enforcement coordination. For example, in 2017, HHS and DOL held a commercial market parity policy academy—technical assistance for teams of state officials on strategies to advance MH/SU parity compliance and lessons learned from other states' implementation efforts. According to the HHS action plan, representatives from 20 states and territories attended. Additionally, DOL held a roundtable discussion with stakeholders to discuss NQTLs, disclosure, and federal-state coordination in January 2019.
- **Grant funding.** HHS has also awarded funding, provided by PPACA, to states to help improve oversight of MH/SU parity requirements. In 2016, CMS awarded \$9.3 million to 20 states specifically for enforcement and oversight related to MH/SU parity.<sup>70</sup> Maryland, for example, used these funds to create a position specific to MH/SU parity oversight, which the state made permanent after the funding period ended. In 2018, CMS awarded funding through the State Flexibility to Stabilize the Market Grant Program that focused on supporting state implementation and planning around several PPACA market reforms and consumer protections. Washington, for example, is using this grant to review issuer's implementation of state and federal MH/SU parity requirements and to assess access to MH/SU treatment.

HHS, DOL, and Treasury also coordinate with state regulators and NAIC to issue guidance for stakeholders in an effort to increase understanding of and compliance with MH/SU parity requirements. From December 2010 to September 2019, the three agencies issued 10 guidance documents that included 58 frequently asked questions and answers specific to MH/SU parity requirements. These guidance documents cover a range of topics, including describing the types of plans covered by

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<sup>70</sup>HHS awarded over \$25 million to 23 states to enforce and oversee issuer compliance with key insurance market reforms and consumer protections in PPACA in 2016. MH/SU parity was one of the market reforms for which states could receive funding above the minimum baseline amount included in the grant.

MH/SU parity requirements, providing definitions of QTLs and NQTLs, and using specific scenarios to show if a practice—such as requiring prior authorization for certain medications to treat a substance use disorder—is permissible under the law.

HHS, DOL, and Treasury have also developed guidance or support on MH/SU parity aimed specifically at consumers. For example, as part of HHS's action plan, HHS developed a web-based portal to assist consumers in identifying, based on the consumer's insurance type, the appropriate entity to contact for filing a parity-related complaint—HHS, DOL, or state insurance regulators.<sup>71</sup> See appendix III for examples of guidance published by the agencies and the target audience.

States have reported that existing guidance and support from the agencies helped states in their reviews of issuers for compliance with MH/SU parity requirements; however, some states and other stakeholders have identified a need for additional guidance. Specifically, officials from 43 states reported in our survey that guidance or other support from the agencies has helped inform state reviews of plans or issuers for compliance with MH/SU parity requirements, and officials from 24 states reported in our survey that additional guidance or support is needed. In written survey responses, state officials most commonly identified the need for additional guidance around reviewing NQTLs. In their comments for the 2017 HHS public listening session, some stakeholders identified the need for additional compliance information. Similarly, two industry stakeholders and one consumer advocacy organization also told us that additional guidance around NQTLs would be helpful to improve compliance with MH/SU parity requirements.

HHS, DOL, and Treasury issued additional guidance after seeking public comment, as required by the 21st Century Cures Act. This guidance covers the types of information plans must release to consumers or providers related to MH/SU parity, known as disclosure requirements, and NQTL requirements. Specifically, the guidance document contains (1) answers to 11 additional frequently asked questions on NQTLs and

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<sup>71</sup>The Mental Health and Addiction Insurance Help page was developed as part of the HHS action plan to improve state and federal coordination of MH/SU parity enforcement.

Department of Health and Human Services, *Mental Health and Addiction Insurance Help*, accessed September 19, 2019, <https://www.hhs.gov/programs/topic-sites/mental-health-parity/mental-health-and-addiction-insurance-help/index.html>.

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disclosure requirements and (2) a disclosure template consumers can use to request MH/SU parity-related information from their employer-sponsored health plans and issuers of individual plans. Released in September 2019, the guidance may address the concerns identified by states and stakeholders.

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## Conclusions

Employer-sponsored group plan and issuer compliance with federal MH/SU parity requirements is important to ensure that individuals seeking MH/SU treatment do not face discriminatory practices. DOL's and CMS's oversight of employer-sponsored group plan compliance with federal health care laws is driven by information and complaints they receive about potential noncompliance; however the agencies receive relatively few consumer complaints about MH/SU parity and DOL refers a small percentage of those complaints to its investigators. DOL's and CMS's reviews of compliance with relevant federal health care laws—including those related to MH/SU parity even when the origin of the investigation was unrelated to MH/SU parity concerns—has enabled the agencies to identify some plan and issuer violations of MH/SU parity requirements. However, the frequency with which compliance issues are identified in these reviews suggests that noncompliance with MH/SU parity requirements may be common.

Given stakeholder-identified concerns with relying on complaints for MH/SU parity, the complexity of MH/SU parity requirements, and the limited complaints received in this area, DOL and CMS may not be identifying and responding to the risks posed by the agencies' oversight approach. As a result, consumers may be enrolled in plans that fail to comply with MH/SU parity requirements. Until DOL and CMS evaluate whether the current approach of targeted oversight in response to information received is effective for identifying compliance issues with MH/SU parity, they will not know whether this approach is effective or whether additional strategies are needed to help ensure that their oversight meets their commitment to full implementation of MHPAEA.

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## Recommendations for Executive Action

We are making a total of two recommendations, including one to DOL's Employee Benefits Security Administration and one to HHS's CMS. Specifically:



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The Assistant Secretary of Labor for the Employee Benefits Security Administration should evaluate whether targeted oversight in response to information received is effective for ensuring compliance with MH/SU parity requirements. If this evaluation determines the current targeted oversight approach results in significant program risks, the Employee Benefits Security Administration should develop a plan to more effectively enforce MH/SU parity requirements and if necessary seek additional oversight authority, as warranted. (Recommendation 1)

The Administrator of CMS should evaluate whether targeted oversight in response to information received is effective for ensuring compliance with MH/SU parity requirements for non-federal governmental plans. If this evaluation determines the current targeted oversight approach results in significant program risks, CMS should develop a plan to more effectively enforce MH/SU parity requirements and if necessary seek additional oversight authority, as warranted. (Recommendation 2)

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## Agency Comments and Our Evaluation

We provided a draft of this report to DOL, HHS, and Treasury for review and comment. DOL and HHS both concurred with our recommendations. DOL's comments are reproduced in appendix IV and discussed below. HHS's comments are reproduced in appendix V and discussed below. DOL, HHS, and Treasury also provided technical comments, which we incorporated as appropriate.

In its written comments, DOL elaborated on its current strategy to review its health enforcement program. Specifically, DOL noted that it reviews all MH/SU parity-related investigation findings and case closings, and all health plan investigations include a review of MH/SU parity requirement compliance, regardless of the source or reason for the investigation. DOL also stated that its current enforcement strategy to identify violations at the plan level and seek corrections of systemic violations at the service provider level has been successful. However, as explained in our report, DOL has not analyzed whether relying on targeted reviews alone increases the risk of noncompliance with MH/SU parity requirements in private, employer-sponsored group plans. Such an evaluation could help DOL identify and determine if additional enforcement strategies related to MH/SU parity requirements are needed.

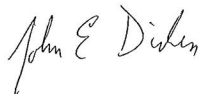
In its comments, DOL also noted its resource limitations. Specifically, DOL stated that despite the Employee Benefits Security Administration's

small size and limited resources, it is responsible for overseeing 2.4 million health plans, among other things. DOL noted that it will consider GAO's recommendation in light of its resource constraints. Given these constraints, an evaluation could help ensure DOL's resources are most efficiently targeted.

In its comments, HHS stated that it is committed to enforcing MH/SU parity requirements. HHS described its responsibilities for enforcement and noted that it works with plans and issuers to help them understand and comply with MHPAEA. HHS also stated that it collaborates with state regulators, DOL, and Treasury in an effort to increase understanding and compliance.

We are sending copies of this report to the appropriate congressional committees, the Secretaries of Health and Human Services, Labor, and Treasury, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or [DickenJ@gao.gov](mailto:DickenJ@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VI.



John E. Dicken  
Director, Health Care

# Appendix I: Mental Health and Substance Use Disorder Parity Requirements in Medicaid and the State Children's Health Insurance Program (CHIP)

In 2016, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services, issued a final rule addressing the application of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to Medicaid managed care organizations (MCO), Medicaid Alternative Benefit Plans (ABP), and CHIP.<sup>1</sup> Under this final rule, all beneficiaries enrolled in Medicaid MCOs, ABPs, and CHIP are entitled to mental health and substance use disorder (MH/SU) benefits that comply with certain MH/SU parity requirements of MHPAEA, which generally requires that

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<sup>1</sup>Medicaid is a joint federal-state health care program for low income and medically needy individuals. States contract with Medicaid MCOs to offer Medicaid services to Medicaid beneficiaries in exchange for a payment per beneficiary. MHPAEA does not apply to beneficiaries who receive fee-for-service Medicaid only, or who are enrolled in a Prepaid Inpatient Health Plan, Prepaid Ambulatory Health Plan, or Primary Care Case Management Plan but not also enrolled in an MCO. These plans are types of plans that cover limited benefits or that are not fully responsible for the cost of Medicaid beneficiaries' medical care. States are required to use ABPs to cover the Patient Protection and Affordable Care Act (PPACA) Medicaid expansion population and may choose to cover other populations using an ABP.

CHIP is a joint federal-state program that provides health insurance to low-income children and pregnant woman who are not eligible for Medicaid. All MH/SU parity requirements apply to CHIP when MH/SU benefits are offered regardless of how the state provides CHIP benefits, such as through an MCO or fee-for-service, when the state CHIP plan covers MH/SU benefits.

MH/SU benefits be no more restrictive than medical or surgical benefits when MH/SU benefits are offered.<sup>2</sup>

The CMS final rule defines the role of the states in evaluating overall compliance of state Medicaid and CHIP programs with MH/SU parity requirements. The final rule establishes the processes by which states must assess and document that their Medicaid and CHIP programs comply with MH/SU parity requirements. CMS guidance provides detailed information to help states assess their compliance with MH/SU parity requirements.<sup>3</sup> These processes vary by program type, as described below.

**Medicaid MCOs.** The final rule requires either the state or the Medicaid MCO to complete a parity analysis, depending on how Medicaid benefits are provided. In general, CMS guidance requires states or MCOs to assess if a plan’s MH/SU benefits are no more restrictive than medical or surgical benefits for the following items: aggregate lifetime/annual dollar limits, financial requirements, quantitative treatment limitations (QTL), and non-quantitative treatment limitations (NQTL).<sup>4</sup> The MCO must complete this analysis when it provides all Medicaid benefits—both medical and MH/SU benefits. The state must complete the parity analysis if the benefits are provided through multiple delivery systems, such as through multiple MCOs or the state’s fee-for-service Medicaid program, and

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<sup>2</sup>Through the final rule, CMS clarified that states had to provide MHPAEA-compliant benefits to any beneficiary who receives some part of their Medicaid benefits through an MCO, even if the beneficiary does not receive MH/SU benefits through the MCO. States that provide Medicaid benefits through MCOs may contract with separate companies to manage medical and MH/SU benefits, often referred to as “carving out” MH/SU benefits, or may cover some or all MH/SU benefits on a fee-for-service basis, where the state pays providers for each covered service. Further, if any benefit is carved out of the MCO, the state must complete a parity analysis.

<sup>3</sup>CMS has provided a variety of guidance materials including, the Parity Compliance Toolkit, the Parity Implementation Roadmap, multiple webinars, a fact sheet, and two sets of frequently asked questions.

<sup>4</sup>Aggregate lifetime and annual dollar limits are restrictions on the total amount spent on a particular benefit during a lifetime or year. Because MH/SU benefits are considered an essential health benefit under PPACA, ABPs are not permitted to have any annual or lifetime dollar limits on MH/SU benefits. Financial requirements include copayments, coinsurance, deductibles, and out-of-pocket maximums. QTLs are numerical restrictions on benefits, such as the number of days or visits. NQTLs are policies that limit the scope or duration of benefits, such as medical management standards limiting or excluding benefits based on medical necessity or the refusal to pay for higher-cost therapies until a lower-cost therapy has not been effective.

provide the parity analysis to CMS for review. States are also required to make the documentation of compliance with the final rule available to the general public.

The final rule also requires states to include contract provisions requiring compliance with MH/SU parity requirements in all MCO and other applicable contracts.<sup>5</sup> CMS guidance encourages states to consider including provisions in their contracts with MCOs to ensure adequate oversight of the MCO's parity-related monitoring and compliance activities, such as ensuring the state can see the MCO's parity analysis.

**ABPs and CHIP.** The final rule requires states to document that their ABP and CHIP plans comply with MH/SU parity requirements in the comprehensive state plans that describe the state's Medicaid and CHIP programs.<sup>6</sup> CMS guidance requires that states conduct a parity analysis demonstrating this compliance as part of the documentation the states submit to CMS to request a change to the state plan, known as a state plan amendment.

In certain CHIP programs and ABPs, the state does not have to complete the full parity analysis, known as deemed compliance. A plan may be deemed to be in compliance with MH/SU parity requirements for plan members aged 20 and under if Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits are provided to those individuals, because EPSDT benefits include MH/SU services.<sup>7</sup> CMS guidance requires that states demonstrate that EPSDT benefits are covered by

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<sup>5</sup>When parity requirements apply to Prepaid Inpatient Health Plan and Prepaid Ambulatory Health Plan contracts because they provide coverage to MCO enrollees, states must include contract provisions requiring compliance with MH/SU parity requirements in those applicable contracts.

<sup>6</sup>States with CHIP programs that are separate from their Medicaid programs and offer MH/SU benefits must document compliance with parity requirements in the state child health plan through state plan amendments. If CHIP funding is used to cover Medicaid-eligible children through the state's Medicaid program, compliance with parity requirements is shown through the state or MCO parity analysis.

<sup>7</sup>EPSDT benefits are a set of comprehensive and preventive benefits that must be provided to categorically eligible individuals aged 20 and under who are enrolled in Medicaid. The EPSDT benefit is defined in federal law to include screening, vision, dental, and hearing services, as well as other necessary services identified in section 1905(a) of the Social Security Act to correct or ameliorate any condition discovered through screening, regardless of whether such service is covered under the state Medicaid plan. Medicaid ABPs must also provide EPSDT benefits, and states that operate CHIP plans separately from their Medicaid program have the option to provide EPSDT benefits.

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**Appendix I: Mental Health and Substance Use Disorder Parity Requirements in Medicaid and the State Children's Health Insurance Program (CHIP)**

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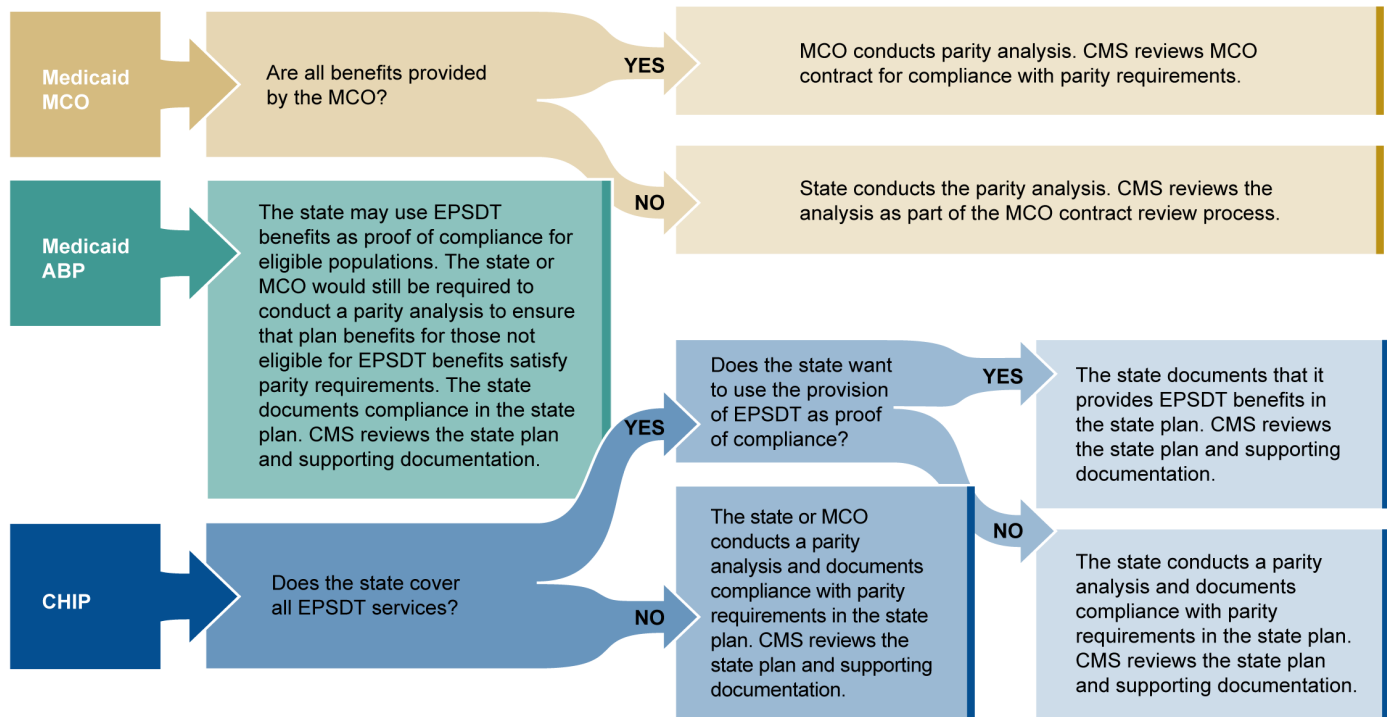
their CHIP plans through documents such as member handbooks. (The state or MCO would still be required to conduct a parity analysis to ensure that plan benefits for those not eligible for EPSDT benefits satisfy parity requirements.)

To ensure state Medicaid and CHIP benefits comply with MH/SU parity requirements, CMS must review states' documentation of compliance. For Medicaid managed care, CMS must review state contracts with managed care plans to ensure they are compliant with CMS requirements. CMS reviews the parity provisions in MCO contracts and the state's parity analysis as part of the normal contract review process. Additionally, for states in which some but not all benefits are provided by an MCO, CMS reviews documentation of the state's parity analysis to ensure the full scope of services being provided complies with MH/SU parity requirements. For ABP and CHIP, CMS staff are required to review the state plan amendments submitted by the states and supporting documentation for compliance with MH/SU parity requirements.

See figure 2 for a map of the parity compliance review process by program type.

**Appendix I: Mental Health and Substance Use Disorder Parity Requirements in Medicaid and the State Children’s Health Insurance Program (CHIP)**

**Figure 2: The Medicaid/CHIP MH/SU Parity Compliance Review Process by Program Type**



ABP Alternative Benefit Plan  
 CHIP State Children’s Health Insurance Program  
 CMS Centers for Medicare & Medicaid Services  
 EPSDT Early and Periodic Screening, Diagnostic and Treatment  
 MCO Managed care organization  
 MH/SU Mental health/substance use disorder

Source: GAO analysis of CMS information. | GAO 20-150

Notes: A state plan documents how a state and CMS have agreed the state’s Medicaid and CHIP programs will be run. The state may provide Medicaid benefits through an MCO and must provide Medicaid benefits through an ABP for some Medicaid populations. A state’s CHIP program may be considered compliant with MH/SU parity requirements for individuals under age 19 if it provides EPSDT benefits to those individuals. EPSDT benefits include MH/SU benefits.

## Appendix II: Literature Review

We conducted a literature review to identify information about compliance with federal mental health/substance use disorder (MH/SU) parity requirements by individual and employer-sponsored small and large group health plans. We identified literature through keyword searches of several bibliographic databases, including ProQuest, MEDLINE, Scopus, and WorldCat. We focused our review on literature published between January 2011 and May 2019. Of the 828 study citations we identified, we reviewed 77 full studies; of those, we determined there were six relevant studies. We also identified four additional studies through web searches, interviews with stakeholders, and citations included in the literature we reviewed. Our review included studies that contained information collected about compliance by individual and employer-sponsored group health plans with federal MH/SU parity requirements by assessing compliance, comparing MH/SU plan benefits and requirements to medical/surgical benefits, or by assessing changes in MH/SU plan benefits over time. Our review excluded studies that focused on the effects of federal MH/SU parity requirements on consumer utilization of MH/SU services, consumer spending on MH/SU services, and plan spending on MH/SU services. The 10 studies are described in more detail below.

Berry, Kelsey N., et al. "A Tale of Two States: Do Consumers See Mental Health Insurance Parity When Shopping on State Exchanges?" *Psychiatric Services*, vol. 66, no. 6 (2015): pp. 565–567.

- **Methodology:** The case study reviewed documents for all small group and individual health insurance products offered on two state health insurance exchanges between October 2013 and March 2014 and assessed compliance with observable quantitative treatment limitations (QTL) and non-quantitative treatment limitations (NQTL).<sup>1</sup>

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<sup>1</sup>State health insurance exchanges are marketplaces within each state's overall individual and small group market where eligible consumers and small employers can compare and select among qualified insurance plans offered by participating issuers. These plans are required to comply with MH/SU parity requirements as part of the essential health benefits categories that individual and small group plans must cover under the Patient Protection and Affordable Care Act.



- **Examples of key findings:** The case study found that for 75 percent of products offered, the financial requirements and certain NQTLs reviewed appeared to be compliant with MH/SU parity requirements, but compliance varied by state. On one state health insurance exchange (with fewer products) more than half the products appeared inconsistent with the parity requirements reviewed, particularly the NQTLs. On the other state health insurance exchange, 11 percent of the products contained a financial requirement that violated MH/SU parity requirements. The case study was not able to assess all aspects of NQTL requirements because the available documents did not provide information about all NQTLs, such as whether or not a specific MH/SU treatment would be considered medical necessary.

Cowell, Alexander J., et al. *Changes in Individual and Small Group Behavioral Health Coverage Following the Enactment of Parity Requirements: Final Report*. A report prepared for the United States Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy. January 2017.

- **Methodology:** The study reviewed plan documents for a sample of individual and small group plans and assessed changes in MH/SU and medical/surgical benefits before implementation of MH/SU parity requirements in 2013 and after implementation in 2014.
- **Examples of key findings:** The study found that in 2014 most plans' financial requirements and QTLs were compliant with MH/SU parity requirements. However, the plans included different limits on the quantity of prescription drugs covered for medications used for MH/SU treatments and those used for other chronic health conditions. This difference indicated possible noncompliance with MH/SU parity requirements for NQTLs, and the study noted that differences in NQTLs between MH/SU and other health conditions is an issue in need of additional study. The study stated that plan documents did not contain all information necessary to fully assess NQTLs.

Friedman, Sarah, et al. "The Mental Health Parity and Addiction Equity Act Evaluation Study: Impact on Mental Health Financial Requirements among Commercial 'Carve-In' Plans." *Health Services Research*, vol.51, no. 1 (2018) pp.366-388.

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A product is a set of health insurance plans that have the same benefits.

- **Methodology:** The study analyzed a sample of health benefit design data from 2008 to 2013. This data on large group plans was obtained from a managed behavioral health organization and was analyzed for changes in cost-sharing requirements for plan members before and after parity requirements were implemented.<sup>2</sup>
- **Examples of key findings:** The study found that there were both increases and decreases in cost-sharing after MH/SU parity requirements went into effect. For example, among plans that covered both in-network and out-of-network benefits and required coinsurance for inpatient stays, the likelihood of using coinsurance increased by 4 percentage points, and the coinsurance rate increased by .75 percentage points. However, outpatient copayments were reduced by \$3.88 among plans that offered only in-network benefits.

Goplerud, Eric. *Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*. A report prepared for the United States Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy. November 2013.

- **Methodology:** The study summarized the results of multiple assessments of compliance with MH/SU parity between 2009 and 2011 based on both plan data available from private databases and the Department of Labor, and survey data and interviews with health plan representatives.
- **Examples of key findings:** The study found that between 2009 and 2011 large group health plans made substantial changes to their plan designs to meet the parity requirements. By 2011, most large group health plans had removed most financial requirements that did not meet MH/SU parity requirements, although 20 percent still had a non-compliant copayment for outpatient services. Nearly all had eliminated the use of separate deductibles for MH/SU treatment and medical/surgical treatment. The study also noted that assessing consistency with NQTLs was difficult based on document reviews.

Hodgkin, Dominic, et al. "Federal Parity and Access to Behavioral Health Care in Private Health Plans." *Psychiatric Services*, vol. 69, no. 4, (2018): pp. 396–402.

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<sup>2</sup>Cost-sharing is the amount a plan member is required to pay for treatment, including deductibles, copayments, and coinsurance.

- **Methodology:** The study reported results of surveys of senior executives at commercial health plans regarding changes to MH/SU benefits over time. The surveys were conducted between September 2010 and June 2011, and again between August 2014 and April 2015. The study did not independently verify the self-reported data from senior executives.
- **Examples of key findings:** The study did not find significant noncompliance with MH/SU parity requirements. It found that fewer plans required prior authorization for outpatient MH/SU treatment than medical treatment. This suggests compliance with the requirement that NQTLs applied to MH/SU treatment be no more restrictive than those for medical/surgical treatment. The study also found that 6 percent of products used coinsurance for MH/SU treatment and copayments for other medical care. While this is not necessarily noncompliant, this could result in noncompliant higher cost-sharing for MH/SU treatment than other medical care in some cases, because coinsurance may result in higher cost-sharing than a copayment.

Horgan, Constance M., et al. "Health Plans' Early Response to Federal Parity Legislation for Mental Health and Addiction Services." *Psychiatric Services*, vol. 67, no. 2 (2016): pp. 162–168.

- **Methodology:** The study reported results of surveys of senior executives at commercial health plans regarding changes to MH/SU benefits over time. The surveys were conducted between September 2010 and June 2011. The study did not independently verify the self-reported data from senior executives.
- **Examples of key findings:** The study found that plans complied with MH/SU parity requirements by lifting QTLs that only applied to MH/SU benefits, although 4 percent of plans had QTLs that applied to mental health treatment that did not apply to medical/surgical treatment. This study also found that fewer plans had prior authorization requirements for outpatient MH/SU treatment than outpatient medical treatment, which suggests compliance with the requirement that NQTLs applied to MH/SU treatment be no more restrictive than those for medical/surgical treatment. The study was not able to assess if prior authorization requirements were implemented differently between MH/SU and medical/surgical treatment.

Huskamp, Haiden A., et al. "Coverage of Medications That Treat Opioid Use Disorder and Opioids for Pain Management in Marketplace Plans, 2017." *Medical Care*, vol.56, no 6(2018) pp.505-509.

- **Methodology:** The study compared coverage for medications used to treat opioid use disorder (an MH/SU benefit) and opioids used to

treatment pain management (a medical/surgical benefit) in 2017 health insurance marketplace exchange plans, using publicly available data for a sample of 100 plans.

- **Examples of key findings:** The study found that most plans covered at least one of the four primary medications intended for opioid use disorder treatment, while 100 percent of plans cover short-acting opioid pain medications. For example, 80 percent of plans cover a generic combination of buprenorphine and naloxone for treatment of opioid use disorder, while 100 percent of plans cover the generic version of Oxycodone and Fentanyl for treatment of pain disorder. The study states that additional monitoring is needed to ensure that plan coverage of MH/SU medications complies with MH/SU parity requirements.

Thalmayer, Amber Gayle, et al. "The Mental Health Parity and Addiction Equity Act Evaluation Study: Impact on Nonquantitative Treatment Limits for Specialty Behavioral Health Care." *Health Services Research*, vol. 53, no. 6 (2018): pp. 4584–4608.

- **Methodology:** The study analyzed a sample of health benefit design data from 2008 to 2013. This data on large group plans was obtained from a managed behavioral health organization and was analyzed for changes in NQTL requirements for plan members before and after parity requirements were implemented.
- **Examples of key findings:** The study found plans were less likely to require NQTLs, such as prior authorization and financial penalties for failure to obtain prior authorization for MH/SU treatments after MH/SU parity requirements were implemented, among plans that manage MH/SU benefits separately from other medical benefits. However, the study also found that plans were more likely to include a penalty for failing to obtain prior authorization for MH/SU treatments after MH/SU parity requirement implementation if the MH/SU benefits were managed by the same plan that managed other health benefits. The study was limited in that it did not assess how NQTLs were implemented by plans and so could not determine if there were differences in how MH/SU and medical requirements were applied.

Thalmayer, Amber Gayle, et al. "The Mental Health Parity and Addiction Equity Act (MHPAEA) Evaluation Study: Impact on Quantitative Treatment Limits." *Psychiatric Services*, vol. 68, no. 5 (2017): pp. 435–42.

- **Methodology:** The study analyzed a sample of health benefit design data from 2008 to 2013. This data on large group plans was obtained from behavioral health organizations and was analyzed for changes in

QTL requirements for plan members before and after MH/SU parity requirements were implemented

- **Examples of key findings:** The study found that QTLs were nearly eliminated after MH/SU parity requirements were implemented. This suggests that plans became compliant with parity requirements because if a QTL does not exist it cannot be more stringent than a medical/surgical QTL. The study noted that plans that continued to have QTLs might be noncompliant with MH/SU parity requirements, but did not assess that.

Center on Addiction, *Uncovering Coverage Gaps II: A Review and Comparison of Addiction Benefits in ACA Plans*, (New York: March 2019).

- **Methodology:** The study reviewed plan documents to assess compliance with MH/SU parity requirements from a sample of 2017 benchmark plans and plans sold on health insurance exchanges.<sup>3</sup>
- **Examples of key findings:** The study identified nine benchmark plans and 10 states that sold plans that were not compliant with MH/SU parity requirements (where this could be identified through plan documents). The study was able to identify non-compliant financial requirements in three benchmark plans and non-compliant QTLs in six benchmark plans, and found one state that sold a plan to with a possible non-compliant QTL. The study also identified two benchmark plans that had possibly noncompliant NQTLs, and 21 states that had either NQTL violations or indications of possible NQTL violations that could not be fully assessed with the available information. The study noted that plan documentation did not contain sufficient information to fully assess compliance with MH/SU parity requirements related to NQTLs.

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<sup>3</sup>A benchmark plan is a plan designated by a state as the standard for the ten essential health benefits offered by individual and small group plans sold on health insurance exchanges.

# Appendix III: Examples of Mental Health and Substance Use Disorder Parity-Related Guidance from HHS, DOL, and Treasury

**Table 5: Examples of Mental Health and Substance Use Disorder (MH/SU) Parity-Related Guidance Released by the Department of Health and Human Services (HHS), Department of Labor (DOL), and the Department of the Treasury (Treasury)**

Document title	Target audience	Summary
Consumer Guide to Disclosure Rights: Making the Most of Your Mental Health and Substance Use Disorder Benefits	Consumers	This October 2016 publication provides an overview of federal disclosure laws affecting private-sector, employer-sponsored group health plans and health insurers.
Frequently Asked Questions about Mental Health Parity Implementation	Consumers, providers, issuers, and state regulators	Between December 2010 and September 2019, the three agencies issued 10 guidance documents with 58 frequently asked questions about MH/SU parity requirements. These frequently asked questions are designed to help people understand the law, and benefit from it as intended through examples that illustrate the requirements. Topics include the types of plans covered by MH/SU parity requirements and specific examples of how to determine if a practice or policy is permissible under the law.
Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits	Consumers	This June 2016 brochure gives a high-level overview of MH/SU parity requirements and lists common limits placed on MH/SU services that are subject to parity.
Action Plan for Enhanced Mental Health and Substance Use Disorder Parity Coverage	Consumers, issuers, state regulators, and other stakeholders	This April 2018 action plan released by HHS covers recent and planned actions related to HHS, DOL, and Treasury's implementation of MH/SU parity requirements. The plan, required by the 21st Century Cures Act, includes information about a public listening session the agencies held in July 2017.
Parity of Mental Health and Substance Use Benefits with Other Benefits: Using Your Employer-Sponsored Health Plan to Cover Services	Consumers	This February 2016 publication describes MH/SU parity requirements for people with employer-sponsored health plans who need MH/SU treatment. It describes why some MH/SU benefit claims are denied and how to file a claim, the denial of a claim, and the appeals process.

**Appendix III: Examples of Mental Health and  
Substance Use Disorder Parity-Related  
Guidance from HHS, DOL, and Treasury**

<b>Document title</b>	<b>Target audience</b>	<b>Summary</b>
Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)	Issuers, plans sponsors, and state regulators	DOL issued this self-compliance tool in April 2018 to help both issuers and regulators determine if a plan or issuer complies with MH/SU parity requirements and other related federal health care laws.
Warning Signs: Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance	Consumers, issuers, state regulators, and other stakeholders	In May 2016, DOL and HHS published this brief guide of examples of plan provisions that—absent similar restrictions on medical/surgical benefits—could be “red flags” that a plan or issuer may be imposing an NQTL that is out of compliance with MH/SU parity requirements and should be reviewed.

Source: GAO analysis of HHS, DOL, and Treasury information. | GAO 20-150

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# Appendix IV: Comments from the Department of Labor



**Appendix IV: Comments from the Department  
of Labor**

**U.S. Department of Labor**

Assistant Secretary for  
Employee Benefits Security Administration  
Washington, D.C. 20210



NOV 20 2019

John E. Dicken  
Director, Health Care  
Government Accountability Office  
Washington, DC 20548

Dear Mr. Dicken:

Thank you for the opportunity to review the Government Accountability Office's draft report entitled "Mental Health and Substance Use: States and Federal Oversight of Compliance with Parity Requirements Varies" (GAO-20-150). The draft report contained one recommendation for the Department of Labor (DOL). Specifically, you recommend that the Assistant Secretary of Employee Benefits Security Administration (EBSA) should evaluate whether targeted oversight in response to information received is effective for ensuring compliance with MH/SU parity requirements. Further, if this evaluation determines the current targeted oversight approach results in significant program risks, EBSA should develop a plan to more effectively enforce MH/SU parity requirements and if necessary seek additional oversight authority, as warranted. While EBSA concurs with the recommendation, we would like to again note and clarify our current strategy and our resource limitations.

The report's recommendation suggests that DOL does not review the effectiveness of its targeted approach to ensuring compliance with MH/SU parity requirements in employer-sponsored group plans. However, EBSA does review the effectiveness of its health enforcement program and health enforcement results. It does so through (1) the careful and regular review of every MHPAEA investigation finding, (2) the annual development of the upcoming year's Program Operating Plan, and (3) the annual review of fiscal year case closings to prepare the annual MHPAEA Enforcement Factsheet. Further, EBSA reviews all health plan investigations for MH/SU requirement compliance, regardless of the source or the reason for the investigation. For example, a case may be opened due to a complaint or referral on potential violations of the Affordable Care Act emergency services provisions; however, as part of the investigation, the investigator will also conduct a MHPAEA compliance review. The use of common service providers (health insurance issuers and ASO providers) among plans across the country provides EBSA with assurance of capturing the widespread noncompliance by commercially popular providers. Further, it is EBSA's current enforcement strategy to identify violations at plan level cases and other sources, and then seek corrections of systemic violations at the service provider level. EBSA has been successful in this approach that seeks global widespread compliance with the plan service providers to achieve the best results for participants and beneficiaries.

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**Appendix IV: Comments from the Department  
of Labor**

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Despite its small size and limited resources, EBSA is responsible for overseeing nearly 154 million workers, retirees and their families covered by approximately 710,000 private retirement plans, 2.4 million health plans, and similar numbers of other welfare benefit plans holding approximately \$10.6 trillion in assets. Nevertheless, we will carefully consider the GAO's recommendations in light of the resource constraints indicated above.

Thank you again for sharing your draft report and recommendation. Please be assured that we are focused on solutions that serve the best interests of America's workers.

Sincerely,



Preston Rutledge  
Assistant Secretary

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# Appendix V: Comments from the Department of Health and Human Services

Appendix V: Comments from the Department  
of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

NOV 22 2019

John Dicken  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Mr. Dicken:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*MENTAL HEALTH AND SUBSTANCE USE: States and Federal Oversight of Compliance with Parity Requirements Varies*" (GAO-20-150).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in blue ink, appearing to read "Sarah Arbes".

Sarah Arbes  
Acting Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MENTAL HEALTH AND SUBSTANCE USE: STATES AND FEDERAL OVERSIGHT OF COMPLIANCE WITH PARITY REQUIREMENTS VARIES (GAO-20-150)**

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report. HHS is committed to enforcing mental health and substance use disorder parity requirements in the areas in which it has authority.

HHS has primary enforcement authority with respect to The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and other applicable Federal laws, over non-Federal governmental plans. Non-Federal governmental plans are group health plans that are sponsored by public employers other than the Federal government, such as 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 Public Health Service (PHS) Act, including MHPAEA. HHS reviews self-funded, non-Federal governmental plans' opt-out elections to ensure compliance with the requirements for opting out of the applicable PHS Act provisions, including MHPAEA. HHS has the authority to investigate, for compliance with MHPAEA, non-Federal governmental plans that have not opted out of MHPAEA when HHS receives information that indicates potential noncompliance with respect to MHPAEA or other applicable laws. In addition, HHS has the authority to initiate a market conduct examination to determine whether a non-Federal governmental plan that has not filed a valid MHPAEA opt-out is out of compliance with MHPAEA.

HHS' MHPAEA enforcement authority with respect to health insurance issuers selling health insurance products in the individual and group markets extends only to states that elect not to enforce or the Secretary determines are failing to substantially enforce MHPAEA. HHS is currently enforcing MHPAEA with respect to issuers in four states: Missouri, Oklahoma, Texas, and Wyoming. In general, HHS reviews health insurance policy forms of issuers in the individual and group markets for compliance with MHPAEA and other Federal requirements prior to the products being offered for sale in these states. Through this process, parity issues are identified by HHS reviewers and are addressed and corrected by the issuers before individuals and groups enroll in the products. HHS additionally may conduct market conduct examinations of issuers in these states, as well as in states that have a collaborative enforcement agreement with HHS if the state requests such an examination in order to obtain issuer compliance with a Federal requirement. HHS will enter into a collaborative enforcement agreement with any state that is willing and able to perform regulatory functions but lacks enforcement authority.

In addition to enforcing MHPAEA requirements, HHS also works with plans and issuers to help them understand and comply with MHPAEA and ensure that individuals receive the benefits to which they are entitled. HHS also collaborates with State regulators, both individually and through the National Association of Insurance Commissioners (NAIC), as well as with the Departments of Labor and the Treasury, to issue guidance to address frequently asked questions from stakeholders and provide technical assistance in an effort to increase understanding and compliance. Compliance assistance is a high priority for HHS, and HHS emphasizes the importance of assisting plans and issuers that are working to comply with MHPAEA requirements.

**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MENTAL HEALTH AND SUBSTANCE USE: STATES AND FEDERAL OVERSIGHT OF COMPLIANCE WITH PARITY REQUIREMENTS VARIES (GAO-20-150)**

In collaboration with the Department of Labor, HHS has published numerous FAQs and other guidance documents intended to better educate consumers, issuers, group health plans, state regulators, and other stakeholders on how to identify potential violations of the Non-Quantitative Treatment Limitations (NQTLs) requirements of MHPAEA. This guidance includes examples of plan or policy language that could be considered a red flag that an issuer or plan may be imposing impermissible NQTLs.

GAO's recommendation and HHS' response are below.

**Recommendation 1**

The Administrator of CMS should evaluate whether targeted oversight in response to information received is effective for ensuring compliance with MH/SU parity requirements for non-federal governmental plans. If this evaluation determines the current targeted oversight approach results in significant program risks, CMS should develop a plan to more effectively enforce MH/SU parity requirements and if necessary seek additional oversight authority, as warranted.

**HHS Response**

HHS concurs with the GAO's recommendation. HHS will evaluate whether targeted oversight in response to information received is effective for ensuring compliance with MH/SU parity requirements for non-federal governmental plans, in conjunction with other efforts to promote understanding and compliance with the law. HHS will also evaluate whether seeking additional oversight authority and resources is warranted.

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# Appendix VI: GAO Contact and Staff Acknowledgments

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## GAO Contact

John E. Dicken at (202) 512-7114 or [dickenj@gao.gov](mailto:dickenj@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Kristi Peterson (Assistant Director); Summar C. Corley (Analyst-in-Charge); Kerry Casey; and Eric J. Schwab made key contributions to this report. Also contributing were Leia Dickerson, Cynthia Khan, Laurie Pachter, Ethiene Salgado-Rodriguez, and Emily Wilson Schwark.

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# Appendix VII: Accessible Data

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## Agency Comment Letters

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### Accessible Text for Appendix IV Comments from the Department of Labor

#### Page 1

NOV 20 2019

John E. Dicken

Director, Health Care

Government Accountability Office

Washington, DC 20548

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Assistant Secretary

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Accessible Text for Appendix V Comments from the  
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Sarah Arbes

Acting Assistant Secretary for Legislation

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