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REPORT TO THE EMPLOYEE BENEFITS SECURITY ADMINISTRATION

EBSA FACED CHALLENGES ENFORCING COMPLIANCE WITH MENTAL HEALTH PARITY LAWS AND REQUIREMENTS

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BRIEFLY...

EBSA Faced Challenges Enforcing Compliance with Mental Health Parity Laws and Requirements

Why We Did the Audit

In accordance with Title I of the Employee Retirement Income Security Act of 1974 (ERISA), the Employee Benefits Security Administration (EBSA) is responsible for protecting workers' access to mental health and substance use disorder (mental health) benefits. This includes ensuring there is parity between mental health benefits and medical/surgical benefits.

EBSA enforces compliance with non-quantitative treatment limitation (NQTL) laws and requirements. However, in 2022 and 2023, EBSA reported that health plans and health insurance issuers were unprepared or provided insufficient information when EBSA requested a comparative analysis for review. EBSA also raised concerns about the complexity and challenges involved in its NQTL enforcement work.

Given these concerns, we performed an audit to answer the following question:

> To what extent did EBSA enforce compliance with mental health parity NQTL laws and requirements?

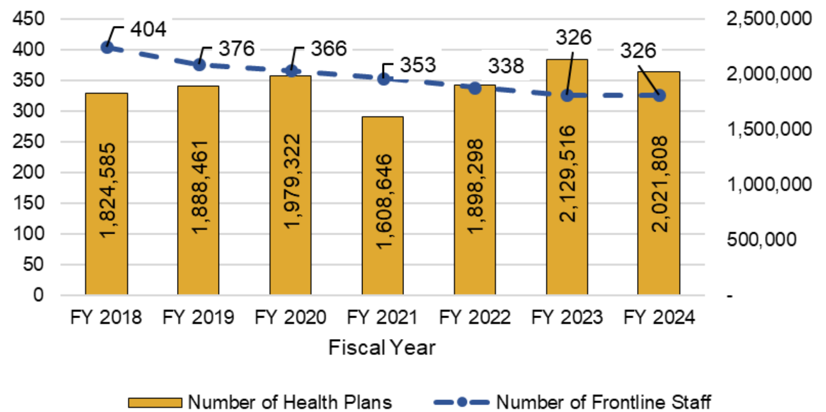
To answer our objective, we reviewed EBSA's NQTL comparative analysis review data. We also interviewed staff and surveyed stakeholders nationwide.

What We Found

Our audit identified challenges that limited EBSA's efforts to enforce compliance with mental health parity NQTL laws and requirements. Specifically, we found EBSA lacked critical tools to enforce compliance and deter parity violations, such as the ability to assess civil monetary penalties or bring actions against all responsible parties. EBSA did not use many of the enforcement tools within its authority to ensure health plans' compliance. It also took up to 3 years to complete NQTL comparative analysis reviews.

Many of these issues occurred because ERISA does not provide EBSA with the authority to assess and collect civil monetary penalties for parity violations or to bring enforcement actions against all responsible parties. EBSA also did not use many of its enforcement tools because it did not have a process to do so, or limitations deterred it from using them. The lack of statutory timeline requirements and diminishing resources, including staff, contributed to lengthy NQTL comparative analysis reviews (see Figure).

Figure: EBSA Frontline Staff Compared to Health Plans Subject to the Mental Health Parity and Addiction Equity Act



Source: OIG analysis of data provided by EBSA

EBSA's ability to enforce compliance with NQTL parity rules is diminished, which increases the risk of plan participants and beneficiaries paying expenses out-of-pocket for mental health treatments that should have been covered or not receiving these treatments altogether—treatments that are legally afforded to them.

What We Recommended

We made five recommendations for EBSA to pursue crucial legislative changes to increase authority, develop a referral process to help levy the excise tax, and provide NQTL guidance. EBSA largely agreed with and provided corrective actions in response to our five recommendations.

Read the Full Report

For more information, go to: https://www.oig.dol.gov/public/reports/oa/2025/09-25-001-12-001.pdf.

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U.S. Department of Labor

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INSPECTOR GENERAL'S REPORT

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This report presents the results of the U.S. Department of Labor (DOL) Office of Inspector General's (OIG) audit of the Employee Benefits Security Administration's (EBSA) efforts to enforce compliance with non-quantitative treatment limitation (NQTL) laws and requirements. NQTLs are non-numerical limits on the scope or duration of benefits for treatment, such as preauthorization requirements.

EBSA is responsible for administering and enforcing the fiduciary, reporting, and disclosure provisions of Title I of the Employee Retirement Income Security Act of 1974 (ERISA). These responsibilities include protecting more than 156 million workers, retirees, and their families who are covered by approximately 801,000 private retirement plans, 2.6 million health plans, and 514,000 other welfare benefit plans. EBSA's responsibilities also include protecting access to mental health and substance use disorder[1] (hereafter referred to as "mental health") benefits. Specifically, EBSA is charged with ensuring large group health plans[2] (plans) and health insurance issuers[3] (issuers) that offer mental health benefits provide coverage that is comparable to medical/surgical benefit coverage.

[1] According to the Substance Abuse and Mental Health Services Administration, substance use disorders are characterized by impairment caused by the recurrent use of alcohol or other drugs, or both. This includes "health problems, disability, and failure to meet major responsibilities at work, school, or home."
[2] A large group health plan is generally more than 50 employees. A group health plan is established or maintained by an employer or by an employee organization (such as a union), or both, that provides medical care for participants or their dependents directly or through insurance, reimbursement, or otherwise.
[3] A health insurance issuer is generally an insurance company, insurance service, or insurance organization that is required to be licensed to engage in the business of insurance in a state and is subject to state law that regulates insurance. It is not a group health plan.

Starting in 2021, plans and issuers were required to demonstrate parity between mental health benefits and medical/surgical benefits by documenting and performing a comparative analysis on the design and application of NQTLs. EBSA was also given the authority to request and review these comparative analyses. In 2022 and 2023, EBSA raised concerns about the complexity and challenges with enforcing the NQTL requirements and plans' and issuers' lack of preparedness and support to prove they were in compliance, among other issues.

Given these concerns, we conducted this audit to determine the following:

> To what extent did EBSA enforce compliance with mental health parity NQTL laws and requirements?

Based on the results of our audit work, we determined that challenges limited EBSA's efforts to enforce compliance with mental health parity NQTL laws and requirements. To answer our objective, we reviewed EBSA's NQTL comparative analysis data and relevant documentation for Fiscal Year (FY) 2018 through FY 2024. We reviewed related statutes, policies, and procedures and interviewed EBSA management and staff. We also met with and surveyed stakeholders nationwide representing consumers, providers, employers, issuers, unions, and state partners related to EBSA's enforcement of mental health parity, which included NQTL parity. See Appendix A for additional details on scope and methodology.

History of Mental Health Parity

Federal mental health parity protections were first enacted through the Mental Health Parity Act of 1996 and expanded in 2008 when Congress passed the Mental Health Parity and Addiction Equity Act (the Act). Neither act requires plans or issuers to provide mental health benefits. However, if they do, the financial requirements and treatment limitations applied to mental health benefits cannot be more restrictive than those applied to medical/surgical benefits. This is referred to as "parity."

For example, if a health plan charges a $50 copay to see an in-network psychiatrist and charges a $25 copay to see an in-network primary care provider, the higher copay for the psychiatrist would most likely violate mental health parity

rules, since both providers are in the same classification (i.e., outpatient, in-network).[4]

Mental health benefits are generally benefits to treat mental health conditions, for example, prescription medications and psychotherapy to treat depression. In 2008, among other changes, the Act expanded parity protections to cover substance use disorder benefits. These benefits may include behavioral therapy or medication to treat opioid, alcohol, and nicotine addiction.

In addition, per the Act, DOL, the Department of Health and Human Services (HHS), and the Department of the Treasury (Treasury)—hereafter referred to collectively as "the Departments"—were tasked with developing, implementing, and enforcing key elements of the Act's mental health parity rules. The Act also required DOL to submit a biennial report to Congress on compliance with the Act. The Departments and states jointly enforce the mental health parity provisions of the Act:

- EBSA has jurisdiction for over 2.0 million ERISA-covered group health plans that are subject to the Act's requirements.
- HHS has jurisdiction over self-funded public sector group health plans, referred to as "self-funded non-Federal governmental plans."
- Treasury has the authority to impose an excise tax on employers that sponsor group health plans that are not in compliance with parity requirements.
- States have jurisdiction over issuers. If a state fails to substantially enforce the Act, HHS can then directly enforce the Act's requirements.

Mental health parity was amended again in December 2016 through the 21st Century Cures Act (Cures Act). The Cures Act required the Departments to solicit feedback and issue guidance regarding the disclosure and NQTL requirements of the Act. The Cures Act also required the Departments to issue clarifying information and illustrative examples of compliance and non-compliance to assist plans' and issuers' compliance with the Act.

[4] This example comes from a plain language explanation of the Act's rights for consumers. A complete analysis of the plan design in the example requires more information. Under the Act, the parity analysis applies to health benefits under different classifications. The six classifications used for purposes of the mental health parity rules are: (1) inpatient, in-network; (2) outpatient, in-network; (3) inpatient, out-of-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

What is an NQTL?

NQTLs are limitations that do not have a numerical value.

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An example of an NQTL is requiring approval from the health plan provider prior to administering care.

In December 2020, the 2021 Consolidated Appropriations Act (CAA) provided the Departments with additional authority to enforce compliance with NQTLs. The CAA required plans or issuers to perform and document comparative analyses of the design and application of NQTLs and, beginning on February 10, 2021, make them available to the Departments upon request.[5] In addition, the CAA required the Departments to:

- determine whether the plan or issuer: (1) provided sufficient information to review the comparative analysis and (2) complied with the NQTL requirements;
- determine whether noncompliant plans' or issuers' corrective actions will result in compliance; and
- issue an annual report to Congress[6] with the NQTL comparative analysis review results.

In April 2021, the Departments issued Frequently Asked Questions for the implementation of the CAA.[7] These Frequently Asked Questions, among other things, explained: (1) when NQTL comparative analyses must be made available to the Departments upon request, (2) what information should be included in the comparative analyses, (3) examples of reasons why the Department might conclude that comparative analyses are insufficient, and (4) the types of documents plans and issuers should be prepared to make available to support a comparative analysis.

Shortly after the passage of the CAA, EBSA created a dedicated Mental Health Parity and Addiction Equity Act NQTL Task Force (Task Force). The Task Force is comprised of experienced investigators, health policy experts, technical experts from EBSA's regional and national offices, and attorneys from DOL's

[5] The Departments are required to request no fewer than 20 comparative analyses each year.
[6] The CAA requires DOL to submit an annual, publicly available report to Congress no later than October 1st of each year. The report includes a summary of requested comparative analyses and identifies plans and issuers with a final determination of noncompliance, among other items.
[7] FAQs About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45, issued April 2, 2021, last accessed on November 25, 2024, available at: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/faqs-about-mental-health-parity-implementation-and-consolidated-appropriations-act-2021-part-45.pdf

Office of the Solicitor (SOL). Its main goals were to increase the number of impactful results from NQTL reviews and ensure EBSA complies with its Congressional reporting requirements. Initially, the Task Force provided intensive support to gather sufficient information and make NQTL compliance determinations. In 2022, as EBSA's NQTL-related experience grew, the Task Force's role shifted to more of a coordination, consultation, and secondary review role.

Furthermore, in August 2023, the Departments issued proposed rules to amend the Act and add new NQTL comparative analysis requirements. The Departments received approximately 9,500 comments due to strong public interest in the rules and access to mental health benefits. In September 2024, the Departments released final rules,[8] which clarified the following:

- the intent of the Act, including new requirements for plans and issuers for the design and application, as well as data evaluation, of NQTLs;
- minimum requirements for written NQTL comparative analyses; and
- new timeliness requirements for plans and issuers to provide requested comparative analyses and/or information, among other items.

The final rules are applicable to group health plans and group health insurance coverage for plan years beginning on or after January 1, 2025, with some requirements delayed until plan years beginning on or after January 1, 2026.

NQTL Comparative Analysis Review Process

EBSA's general process for reviewing NQTL comparative analyses is as follows:

1. EBSA requests NQTL comparative analyses and supporting documentation from plans or issuers with potential NQTL violations or complaints.

[8] Requirements Related to the Mental Health Parity and Addiction Equity Act, published September 23, 2024, last accessed October 16, 2024, available at: https://www.federalregister.gov/documents/2024/09/23/2024-20612/requirements-related-to-the-mental-health-parity-and-addiction-equity-act

2. EBSA assesses the sufficiency of the NQTL comparative analysis and information provided. If insufficient, EBSA issues an insufficiency letter, and the plan or issuer is given an opportunity to provide additional information.

3. EBSA determines the NQTL's compliance with the law. If the NQTL is in violation of parity laws and/or documentation was insufficient, EBSA issues an initial determination letter.

4. The plan or issuer has 45 days to provide EBSA with a corrective action plan and additional comparative analyses that address the violation.

5. EBSA reviews the submitted documentation to determine the plan's or issuer's compliance.

6. If EBSA determines the NQTL is still in violation of parity laws, a final determination letter is issued.

7. The plan or issuer must notify all participants and beneficiaries that it was not in compliance with the Act within 7 days of the final determination letter. In addition, EBSA names the violator in the annual report to Congress.

Despite EBSA's additional authority and new tool with the NQTL comparative analysis review process, there is still more that EBSA could do to improve parity.

RESULTS

Our audit identified challenges that limited EBSA's efforts to enforce compliance with mental health parity NQTL laws and requirements. Specifically, we found EBSA lacked critical tools to enforce compliance with and deter violations of the Act, such as the ability to assess civil monetary penalties, bring actions against issuers, or directly hold the responsible party accountable. We also determined EBSA did not use many of the enforcement tools within its authority to ensure plans' compliance. Finally, we found EBSA took up to 3 years, in some cases, to complete NQTL comparative analysis reviews.

These issues occurred because ERISA does not provide EBSA with the authority to assess and collect civil monetary penalties for parity violations or to bring enforcement actions against all responsible parties. Furthermore, EBSA did not have a process in place to refer plans to Treasury to levy an excise tax. Limitations also deterred EBSA from using its enforcement tools, or the

requirements to use the tool were not triggered. Finally, the lack of statutory timeline requirements and diminishing resources for enforcement contributed to lengthy NQTL comparative analysis reviews.

As a result, EBSA's ability to enforce plans' and issuers' compliance with NQTL parity requirements is diminished, which increases the risk of plan participants and beneficiaries paying expenses out-of-pocket for mental health treatments, such as applied behavior analysis therapy[9] and nutritional counseling,[10] that should have been covered or not receiving these treatments altogether—treatments that are legally afforded to them.[11]

EBSA's NQTL Enforcement Efforts Were Significantly Limited

We found EBSA faced challenges that limited its efforts to enforce compliance with mental health parity NQTL laws and requirements. Specifically, our work identified EBSA: (1) lacked critical tools, (2) did not use many of its existing enforcement tools, and (3) can take up to 3 years to complete NQTL comparative analysis reviews.

EBSA Cannot Assess Civil Monetary Penalties for Violations of the Act or Bring Action Against Health Plan Issuers

We found EBSA cannot assess civil monetary penalties for violations of the Act or bring action directly against issuers. Specifically, EBSA cannot assess civil monetary penalties to hold plans and issuers accountable for mental health parity violations, including NQTL violations.

[9] Applied behavior analysis therapy is delivered by a behavioral specialist and often involves multiple sessions a week over the course of months or years. For example, it is used to treat autism spectrum disorder, which is a developmental disability that can cause significant life-long social, communication, and behavioral challenges.
[10] Nutritional counseling is for those suffering from eating disorders such as anorexia nervosa, bulimia nervosa, and binge-eating disorder. Eating disorders are serious and often fatal illnesses associated with severe disturbances in people's eating behaviors and related thoughts and emotions.
[11] Plans or issuers are not required to provide mental health benefits. However, if they do, the financial requirements and treatment limitations applied to mental health benefits cannot be more restrictive than those applied to medical/surgical benefits.

EBSA is statutorily barred from bringing enforcement actions against state-licensed health insurance issuers when they violate the Act. Specifically, ERISA Section 502(b)(3) states the Secretary of Labor does not have civil enforcement authority to enforce the mental health parity provisions "against a health insurance issuer offering health insurance coverage in connection with a group health plan."

ERISA instead focuses on the plan's responsibility for parity and NQTL compliance with the Act. However, EBSA officials told us the plan is not always responsible for, or even aware of, the design and application of impermissible NQTLs. Plans are often dependent on service providers, such as third-party administrators, administrative services only providers, and issuers for the design and administering of plans.

In contrast, HHS, which is responsible for enforcing mental health parity over self-funded, non-federal governmental plans,[12] has civil monetary penalty authority when these plans violate the Act, including the NQTL requirements. According to HHS officials, if these plans do not come into compliance once a final determination letter is issued, HHS can use its civil monetary penalty authority to enforce compliance.

What is a Service Provider?

This general term includes any entity that provides services to a plan. Third-Party Administrators, Administrator Services Only Providers, and Health Insurance Issuers all fall under the definition of a service provider.

Third-Party Administrator or Administrative Services Only Provider

A company that provides:
(1) operational services (i.e., claims processing, sending out participant notices, and/or managing an online portal for participants and beneficiaries to obtain plan information);
(2) adjudication services (i.e., making claim determinations and paying claims); and/or (3) plan design services (i.e., offering a template health plan or designing plan terms).

Health Insurance Issuer

An insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a state, is subject to state laws regulating insurance, and is acting as the issuer. The issuer may provide a group health insurance policy to an insured plan and may also serve as a third-party administrator or administrative services only provider to a self-insured plan.

The ability to assess a penalty directly against a plan or issuer is a powerful sanction and deterrent. Civil monetary penalties provide federal agencies with the ability to punish willful and egregious

[12] HHS is also responsible for enforcing parity over issuers in states with insurance departments that are not substantially enforcing the Act's requirements.

violators, deter future violations, and enforce regulatory policies.[13] EBSA officials acknowledged its lack of civil monetary penalty authority creates a gap with what plans are willing to do for each Department. Without consequences for violating the Act, plans and issuers do not have an incentive to cooperate with investigations or bring plans into compliance.

Without this authority, EBSA is limited to the CAA process, "voluntary compliance"[14] methods, and litigation to correct violations. In the CAA process, after the initial determination letter is received, the plan or issuer is required to submit a corrective action plan outlining how they intend to correct the violation(s). EBSA will also engage in voluntary compliance by asking follow-up questions, seeking additional evidence, performing further assessment, and affording opportunities for explanation. Through these efforts, plans may reprocess claims for benefits denied or revise plan documents to remove NQTLs, such as improper exclusions of benefits.

If the plan is still not brought into compliance, EBSA will issue a final determination letter to the plan. The plan must send a notice to all participants and beneficiaries within 7 days stating that the plan and issuer were not in compliance with the Act. The plan and issuer are then named in the Departments' publicly available annual report to Congress. In the 2023 report, EBSA noted three plans were not in compliance.[15] While EBSA officials told us it can continue to pursue uncorrected NQTL violations, the CAA process concludes, even if the plan has not corrected the violation.

The following example demonstrates the challenges EBSA has experienced in its past investigations of plans and issuers.

Investigation Example

> In January 2020, EBSA opened an investigation of a self-funded plan and discovered the plan's service provider—in this case its claims processor or administrative services only provider—was automatically denying claims for drug testing when tied to a substance use disorder diagnosis. It did not do the same for claims that were unrelated to a substance use disorder diagnosis. As a result, the plan was cited for an NQTL violation. EBSA

[13] Government Accountability Office, "Civil Monetary Penalties: Federal Agencies' Compliance with the 2023 Annual Inflation Adjustment Requirements," GAO-24-107193 (April 18, 2024), available at: https://www.gao.gov/assets/gao-24-107193.pdf

[14] According to EBSA officials, "voluntary compliance" is the general term for corrective action that takes place without litigation.

[15] The 2022 and 2023 Reports to Congress are available at: https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/reports.

worked with the plan to correct the violation even though the responsible party for the violation was at the service-provider level.

EBSA suspected the service provider was handling drug testing claims in the same way for its other 30 self-funded plan clients, which covered over 170,000 participants and dependents. Although the service provider corrected the violation for the 1 plan above, it refused to correct the same violation in the other 30 plans. The service provider also indicated the plans control the terms of coverage and are responsible for their own compliance with the Act.

As a result, EBSA opened an investigation focused on the service provider's operations, which confirmed the same practice was being used for all 30 of its client plans. However, EBSA could not cite the service provider directly for the NQTL violation. Instead, EBSA had to request comparative analyses from all 30 plans, then discuss the topic of correction so the plans could push the service provider to correct the violation. Most of the plans were unaware of the service provider's practice to deny drug testing claims for substance use disorders.

From case opening to full correction, the service provider investigation took over 2,100 hours of work, spread across more than 20 investigators over a 33-month period (January 2020 to September 2022). If EBSA had authority to cite the service provider for noncompliance, EBSA may have obtained corrective action more quickly and directly, resulting in over 170,000 plan participants and their dependents having access to drug testing as part of the substance use disorder treatment years sooner.

Source: EBSA

This investigation highlights EBSA's limitations as a result of ERISA. ERISA does not provide EBSA with the authority to assess civil monetary penalties for violations of the Act or bring action against issuers or against all responsible parties. Since 2016, EBSA, in its reports and budget submissions to Congress, also known as Congressional Budget Justifications, has regularly requested increased authority to ensure compliance.[16] In addition, in 2016, the White House Mental Health and Substance Use Disorder Parity Task Force[17] and, in 2017, the

[16] EBSA requested these authorities in its 2016, 2018, 2022, and 2023 Reports to Congress and in its 2023, 2024 and 2025 Congressional Budget Justifications.
[17] This task force was created on March 29, 2016, to improve access to high quality behavioral health care. The task force consisted of the Director of the U.S. Domestic Policy Council and the heads (or designees) of the Departments of the Treasury, Defense, Justice, Labor, HHS, and Veterans Affairs; the Office of Personnel Management; and the Office of National Drug Control Policy.

President's Commission on Combating Drug Addiction and the Opioid Crisis[18] similarly recommended EBSA have increased authority. Despite these efforts, EBSA has not been granted these authorities.

Stakeholders that we solicited feedback from, including consumers, providers, employers, issuers, unions, and state partners were generally in favor of EBSA having civil monetary penalty authority, with caveats. Some stakeholders explained that if EBSA had the authority, it would be an additional deterrent against potential violations and help safeguard the interests of plan participants and beneficiaries. However, stakeholders also specified if EBSA were given this authority, the civil monetary penalties should be assessed against those parties responsible for the violations and when they acted in "bad faith." Some stakeholders also said additional NQTL comparative analysis guidance and understanding is needed before EBSA is allowed these authorities.

Without the ability to assess civil monetary penalties for violations of the Act or hold the responsible party accountable, EBSA lacks powerful deterrents for future violations, placing participants and beneficiaries at increased risk of paying out-of-pocket for mental health treatments that should have been covered or not receiving mental health treatments that are legally afforded to them at all.

EBSA Did Not Use Many of the Enforcement Tools Available to the Agency

Although EBSA does not have the authority to assess civil monetary penalties for the Act and NQTL violations or hold the responsible party accountable, it has other tools that, when used in the appropriate circumstances, may motivate plans to correct violations. These tools include referring plans to Treasury to levy an excise tax, pursuing litigation through DOL's SOL, and performing Cures Act audits. EBSA did not use these tools because it did not have a process in place to do so, limitations deterred EBSA from using them, or the requirements to use the tool were not triggered.

By EBSA not using its existing tools, plans that offer mental health benefits may have little incentive to comply with NQTL parity requirements. This may result in thousands of participants and beneficiaries paying out-of-pocket for mental health treatments that should have been covered or not receiving mental health treatments.

[18] On March 29, 2017, the Commission was established and served as an advisory board and provided recommendations regarding policies and practices for combating the addiction, specifically the opioid, crisis. The Commission was comprised of a mix of governors, congressmen, and attorneys.

Referrals to Treasury to Levy an Excise Tax

Treasury is authorized to impose an excise tax on employer sponsors of group health plans or multiemployer group health plans that are not in compliance with mental health parity requirements.[19] The excise tax is equal to $100 per day per affected individual under the plans. However, we found EBSA has never referred a plan to Treasury to levy this tax.

EBSA officials told us there are limitations with levying the Treasury excise tax. First and foremost, the excise tax is not applicable to issuers. Instead, the excise tax is levied against employers who sponsor a covered plan. However, the employer may not be the responsible party for the parity violation cited. Additionally, an extremely large excise tax could be potentially levied against an employer-sponsored or a multiemployer plan, which could increase the risk of the employer or plan no longer offering mental health benefits at all, as there is no federal requirement to offer them. EBSA also stated it cannot guarantee how quickly Treasury will issue the tax. For these reasons, EBSA believes it has the greatest beneficial impact by engaging with the plans or service providers to restore benefits through its voluntary compliance methods. However, EBSA also acknowledged that assessing the excise tax, which would require issuing a notice for a monetary penalty, may bring attention to consequences for violating the Act.

Although there are limitations with the excise tax, EBSA also did not have a process in place to refer health plans to Treasury. While EBSA and Treasury established a Memorandum of Understanding in 2023, the memorandum did not specifically address enforcement of the Act or excise tax referrals. It is mainly used for issues related to prohibited retirement plan transactions.

Even with these limitations, the excise tax provides EBSA with a tool that can be used, in the appropriate circumstances, as a deterrent, absent civil monetary penalty authority. A number of stakeholders also recognized EBSA did not use the tool that may enhance EBSA's ability to deter violations and motivate plans to come into compliance.

Pursuing Litigation with SOL

ERISA provides potential remedies in healthcare cases through its civil enforcement provisions.[20] While participants and beneficiaries may file a suit to recover benefits due under the terms of a plan, EBSA can pursue litigation through SOL for violations of ERISA's fiduciary standards and claims processing

[19] Internal Revenue Code, Title 26, Subtitle D, Chapter 43, Subsection 4980D
[20] ERISA Section 502(a); 29 U.S.C. § 1132(a)

rules with respect to plan administrators. EBSA officials told us it can also pursue violations of the Act's requirements with respect to group health plans.

SOL can pursue litigation against an issuer. However, it can only do so if the issuer is a fiduciary[21] and a fiduciary breach has been identified by EBSA. Additionally, taking legal action against an issuer for breaching its fiduciary duty does not hold the issuer directly responsible for violations of the Act, regardless of egregiousness or evidence that shows they are responsible.

According to EBSA officials, some parties, like third party administrators and network administrators, go to great lengths to not be treated as a fiduciary. This may be an attempt to avoid fiduciary responsibility and liability. However, EBSA officials said actions determine whether a party is a fiduciary. Therefore, whether any party is successful at avoiding fiduciary status depends on the facts and circumstances of each case.[22]

Furthermore, EBSA may refer cases to SOL for litigation if attempts at voluntary compliance are unsuccessful. SOL has the discretion to accept or decline a referral for litigation. However, SOL attorneys often work alongside EBSA investigators to review comparative analyses and supporting documentation, participate in discussions about next steps, draft and review finding letters, and assist with voluntary correction. EBSA officials told us the combined effects of pushing for voluntary compliance and involving SOL attorneys early in the investigative process have helped in gaining voluntary compliance. Since the enactment of the CAA in 2021, EBSA told us no NQTL cases have been formally referred for litigation. Stakeholders were also aware that EBSA has not used this tool, which exists to aid EBSA in its enforcement of health plans' and issuers' parity compliance.

Even though EBSA has not referred any NQTL cases to SOL for litigation, the prospect of a lawsuit is a powerful deterrent and should continue to be considered, when warranted.

Cures Act Audit Requirements

The Cures Act requires EBSA to conduct audits of the following year's plan documents if at least five violations of the Act were cited for a plan or issuer.[23]

[21] A fiduciary is a person using discretion in administering and managing a plan or controlling the plan's assets and is a fiduciary to the extent of that discretion or control. Most employers who sponsor fully or partially self-funded group health plans exercise some discretionary authority and, therefore, are fiduciaries.
[22] The final rules require that, for plan years beginning on or after January 1, 2025, comparative analyses contain a certification by one or more named fiduciaries.
[23] 21st Century Cures Act, Section 13001(d)(1)

Our review of EBSA's health plan case data for the period of FY 2018 through FY 2023 found no case had reached this threshold to trigger this requirement. The most violations of the Act EBSA had cited in a closed case were three. Furthermore, EBSA officials explained that only measuring the number of violations does not take into account the gravity of the violations, which limits the required Cures Act audits' effectiveness.

For example, NQTL violations can include deficiencies in the written NQTL comparative analysis and those that impact access to care. For instance, a plan requiring preauthorization for all mental health services but not for any medical/surgical services could be considered a violation. If a plan has five NQTLs, each with an insufficient comparative analysis, that equates to five violations of the Act. EBSA officials explained that, while comparative analysis content is an important part of the Act, following up on this kind of violation is not as urgent, impactful, or significant as other violations. The mere existence of an incomplete comparative analysis does not necessarily mean there is an NQTL violation that impacts access to care. Auditing the same plan the following year may not be beneficial for plan participants.

By contrast, EBSA officials explained that a single violation related to network adequacy and network composition can impact access to mental health care. To correct this type of violation, the plan may take steps to monitor the adequacy of their network and identify network gaps using relevant data; address network gaps through recruiting and other targeted actions; and provide direct and immediate assistance to participants and beneficiaries who need help finding mental health care. This type of violation and its related corrections are aimed at expanding access to mental health care for plan participants. EBSA may want to return to this plan in future years to determine whether the processes to monitor network adequacy are being followed and to gauge the success of the plan's efforts to ensure parity in access to mental health care.

While the effectiveness of the required Cures Act audits may be diminished by the type of cited violations, it is still a tool EBSA can use. The prospect of EBSA coming back again to review the plan's documents may incentivize plans and issuers to comply with the Act's requirements.

EBSA's NQTL Comparative Analysis Reviews Take Years to Complete

We found that, while EBSA's NQTL comparative analysis reviews can take as little as 41 days to complete, some take years to complete. The CAA provided EBSA with an additional tool to perform NQTL comparative analysis reviews to ensure plans' and issuers' compliance with NQTL parity requirements.

The CAA also included statutory timeframes, specifically:

1. When EBSA issues an initial determination letter for an NQTL violation, the CAA requires plans or issuers to submit a corrective action plan and additional comparative analyses within 45 days.

2. After EBSA reviews the corrective action plan and additional comparative analyses and determines if the NQTL violation still stands, EBSA issues a final determination letter. The plan or issuer must notify all participants and beneficiaries that it was not in compliance with the Act within 7 days.

According to EBSA officials, when the CAA was enacted, EBSA established its own aggressive timeframes for the NQTL comparative analysis review process. For example, EBSA allowed plans or issuers 14 days to provide the requested comparative analysis and supporting documentation.[24] From February 10, 2021, through July 25, 2024, EBSA identified 1,177 NQTLs with potential violations of the Act. Our analysis of the NQTL data showed that, for 622 NQTL comparative analyses requested, plans and issuers took an average of 26 days to provide the comparative analysis and supporting documentation.

Accounting for both EBSA's (14 days) and the CAA statutory (as described above) timelines, we estimated EBSA generally allowed 7.9 months (238 days) to 11.3 months (338 days) to complete NQTL comparative analysis reviews (see Exhibit 1 for details). Our analysis of the same 1,177 NQTLs with potential violations showed:

- For 81 comparative analyses where EBSA made a decision to issue or not issue a final determination letter, EBSA took an average of 13 months (393 days) to arrive at the decision, almost twice as long as its overall established timeline.

- For 5 NQTL comparative analyses where EBSA issued a final determination letter, EBSA took between 8 months (251 days) and 36 months (1,065 days) to issue the final determination letter.

When the CAA was enacted, it only included minimal timeframe requirements for plans and issuers to: (1) submit the corrective action plan within 45 days of the initial determination letter and (2) notify participants and beneficiaries within 7 days of the final determination letter of noncompliance. There were no

[24] EBSA may grant plans and service providers an extension of 1 week to a maximum of 2 weeks only for legitimate reasons, such as illness, absence, or to gather or perfect a comparative analysis that already exists.

requirements for when plans and issuers must provide the requested comparative analyses and/or supporting documentation or respond to an insufficiency letter. For the same 1,177 NQTLs with potential violations, we found EBSA issued insufficiency letters related to 418 of them. However, EBSA did not receive responses for 267 of these NQTLs. For the remaining 151 NQTLs, it took on average, 102 days for plans and issuers to provide responses.

According to EBSA officials, plans and issuers were unprepared for the NQTL comparative analysis requests and/or provided partial responses that caused significant delays. EBSA found it was necessary to expend significant investigative resources to identify and obtain needed information to determine NQTL compliance. These efforts included multiple rounds of interviews, depositions, document requests, data requests, and subpoenas to gather basic information from multiple sources. Additionally, EBSA officials also expressed that plans and issuers, at times, seemed to strategically respond slowly or provide partial responses to requests, possibly because they knew they would have multiple chances to correct deficiencies, both before and after, an initial determination of noncompliance letter.

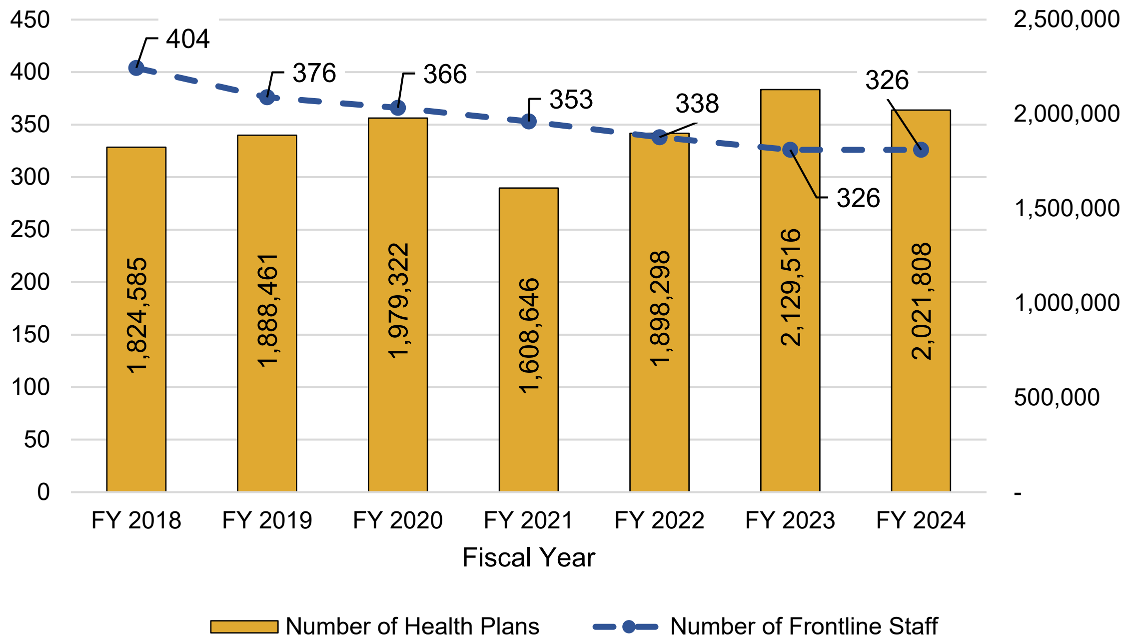
With the release of the final rules on September 23, 2024, the implementing regulations under the Act were amended to include new timeframe requirements. Specifically, plans and issuers must submit to the Secretary of the appropriate Department the requested NQTL comparative analysis within 10 business days from the date the request was received. Plans and issuers must also provide additional information within 10 business days after receiving an insufficiency letter.[25] In its 2023 Report to Congress, EBSA acknowledged that, because the comparative analysis process was new, it intentionally chose to engage with plans and issuers in repeated exchanges without making final determinations of noncompliance. However, as plans and issuers, along with EBSA, have continued to gain experience in this space, EBSA explained it will move directly to issuing insufficiency letters followed by initial and final determination letters should plans and issuers not provide the requested information within the newly required timeframes.

As previously mentioned, in April 2021, the Departments collectively published Frequently Asked Questions for Part 45. However, many stakeholders continued to raise concerns about the availability and quality of guidance issued by the Departments. Stakeholders indicated additional guidance, including clear, concise, and detailed NQTL comparative analysis examples and lists of NQTLs, would assist them in more timely submitting documentation that meets legal and regulatory requirements. The Departments stated in the 2024 final rules that they

[25] For both of the new timeframe requirements, the final rules state that the Departments are allowed to grant additional time as specified by the Secretary of the respective Department.

intend to provide additional guidance and compliance assistance materials. In addition to the challenges above, EBSA's frontline staff,[26] which is responsible for detecting and correcting all ERISA violations, including violations of the Act, continues to decline, while the number of plans subject to the Act continues to grow. From FY 2018 through FY 2024, EBSA saw a decline of 19 percent in its frontline staff, from 404 to 326, while the number of ERISA-covered group health plans subject to the Act grew by 11 percent, from approximately 1.8 million to 2.0 million (see Figure 1).[27]

Figure 1: EBSA Frontline Staff Compared to Health Plans Subject to the Act



Source: OIG analysis of EBSA provided data

Of the remaining 326 frontline staff, 117 are supported by supplemental funding provided by the CAA, which is set to expire at the end of September 2025. Taking into consideration the 801,000 private retirement plans and 514,000 other welfare benefit plans with the 2.6 million health plans EBSA has jurisdiction over, this equates to 1 investigator for roughly every 16,472 plans. Furthermore, EBSA officials stated the potential reduction in staffing is equivalent to losing 3 of its 10 regional offices.

[26] EBSA's frontline staff includes auditors, investigators, and senior investigators.
[27] EBSA provided the approximate number of ERISA-covered group health plans subject to the Act as derived from the Medical Expenditure Panel Survey.

According to EBSA officials, the loss of supplemental funding and subsequent reduction in staffing will have a significant impact on EBSA's ability to aggressively enforce the Act's NQTL provisions. With the continued decline in resources, EBSA's ability to implement and enforce the 2024 final rules will also be diminished.

CONCLUSION

EBSA faced significant challenges that limited its efforts to enforce compliance with mental health parity NQTL laws and requirements. EBSA was limited by statutorily available enforcement tools that did not include the authority to issue civil monetary penalties or hold health plan issuers and other responsible parties directly accountable for NQTL violations. Regardless of these limitations, EBSA also did not use many of its available enforcement tools, like the excise tax, when it may have been appropriate to do so. EBSA should ensure it has processes in place to use its available tools in the appropriate circumstances, which may encourage plans and issuers to come into compliance with NQTL requirements. Additionally, we found some of EBSA's NQTL comparative analysis reviews took up to 3 years to complete because there were only minimal timeframe requirements. EBSA, together with HHS and Treasury, released final rules in September 2024 with additional timeframe requirements that should assist in shortening the NQTL comparative analysis review process.

In conjunction with these limitations, EBSA experienced a 19 percent decrease in its frontline staff who detect and correct ERISA violations, including violations of the Act, while the number of plans subject to the Act grew. Supplemental funding that supported over 33 percent of its remaining frontline staff is set to expire at the end of September 2025.

Due to these challenges, EBSA's efforts to enforce compliance with the Act's parity requirements are diminished. As a result, health plans that offer mental health benefits have reduced incentives to comply with NQTL parity requirements, placing participants and beneficiaries at increased risk of being financially responsible for treatments that should be covered by their plan or not receiving treatments altogether.

OIG'S RECOMMENDATIONS

We recommend the Assistant Secretary for Employee Benefits Security:

1. Pursue legislative changes regarding the authority to impose civil monetary penalties for Mental Health Parity Addiction and Equity Act violations to increase compliance with Part 7 of ERISA, which includes the mental health parity provisions.

2. Pursue legislative changes regarding the authority to enforce the group health plan requirements of Part 7 of ERISA against service providers, including insurance issuers and third-party administrators for violations such as designing and applying impermissible non-quantitative treatment limitations.

3. Pursue legislative changes regarding provisions that specify remedies available for violations of Part 7 of ERISA, including the ability to force the re-adjudication of wrongfully denied claims or other remedies to restore losses resulting from Mental Health Parity and Addiction Equity Act violations.

4. Develop processes to utilize enforcement tools available to the agency, including referring health plans to the U.S. Department of the Treasury to levy the excise tax for Mental Health Parity and Addiction Equity Act violations, as appropriate.

5. Develop and issue additional guidance to support the implementation of the 2021 Consolidated Appropriations Act non-quantitative treatment limitation comparative analysis requirements and the September 2024 Mental Health Parity and Addiction Equity Act final rule, such as an updated Mental Health Parity and Addiction Equity Act Self-Compliance Tool or Frequently Asked Questions document(s).

Analysis of Agency's Comments

In response to a draft of this report, EBSA largely agreed with and provided corrective actions in response to our five recommendations. EBSA intends to pursue crucial legislative changes to increase its authority, develop a referral process to help levy the excise tax, and provide NQTL guidance.

Synopses of EBSA's comments and our corresponding responses are detailed as follows:

- EBSA agreed with Recommendations 1–3, which mirror recommendations EBSA made in its 2022, 2023, and 2024 Reports to Congress. EBSA stated it will continue to recommend these changes in future reports.
  - The OIG agrees with the proposed actions to pursue legislative changes.

- EBSA agreed to take action to address Recommendation 4 by: (1) revising its existing referral procedures with Treasury to include referrals for NQTL violations; (2) making formal referrals to SOL based on the facts and circumstances of each case and where voluntary compliance efforts are not successful; and (3) continuing to keep investigations open until full correction of cited violations is achieved and review case closure activity and Mental Health Parity Addiction and Equity Act violation counts to comply with the Cures Act requirement.
  - The OIG agrees with the proposed changes to EBSA's referral and investigation processes.

- EBSA agreed to address Recommendation 5 by having the Departments issue additional guidance to provide more information on the Act's requirements. For example, the Departments intend to issue future guidance that includes the type, form, and manner of collection and evaluation for the data required; examples of data that are relevant across the majority of NQTLS; and examples of additional relevant data for NQTLs related to network composition. EBSA also intends to update DOL's Mental Health Parity and Addiction Equity Act Self-Compliance Tool to provide a framework and roadmap for plans and issuers to comply with the 2024 rules.
  - The OIG agrees with the proposed guidance from the Departments and EBSA's updates to the Mental Health Parity and Addiction Equity Act Self-Compliance Tool.

We look forward to working with EBSA personnel to ensure the intent of the recommendations is addressed. The agency's response to the draft report is included in its entirety in Appendix B. We appreciate the cooperation and courtesies EBSA extended to us during this audit.

Laura B. Nicolosi
Assistant Inspector General for Audit

EXHIBIT 1: ESTIMATED NQTL COMPARATIVE ANALYSIS REVIEW TIMEFRAMES

Table 1: NQTL Comparative Analysis Review Timeline – No Extensions[28]

Step	Description	Allotted Time	Allotted Time Established By
1	EBSA requests a comparative analysis, supporting documentation, and a list of NQTLs for which comparative analyses were prepared.	14 Days	EBSA
2	EBSA reviews the comparative analysis and documentation to determine the sufficiency of the materials.	14 Days	EBSA
3	EBSA drafts an insufficiency letter and any requests for additional documentation and information.	7 Days	EBSA
4	EBSA conducts internal review and approval of the draft insufficiency letter. EBSA issues the insufficiency letter and requests additional documentation and information.	14 Days	EBSA
5	Plan/issuer responds to the insufficiency letter request.	14 Days	OIG Estimate
6	EBSA reviews materials provided in response to the insufficiency letter.	7 Days	EBSA
7	EBSA drafts the initial determination letter.	14 Days	EBSA
8	EBSA conducts internal review and approval of draft initial determination letter. This includes review and approval by EBSA leadership and consultation with, and clearance from, Treasury and HHS.	30 Days	EBSA

[28] These timeframes were developed prior to the 2024 final rules' issuance. EBSA did not establish a timeframe for Step 5 and Step 10. Based on our review of EBSA's internal timelines, we allotted 14 days to align with similar steps with timeframes specified by EBSA.

Step	Description	Allotted Time	Allotted Time Established By
9	EBSA issues the initial determination letter, which triggers a 45-day corrective action period. The plan/issuer is required to provide a corrective action plan and additional analyses showing its NQTL compliance within the 45 days.	45 Days	CAA
10	EBSA reviews the corrective action plan.	14 Days	OIG Estimate
11	EBSA engages plan/issuer with any concerns regarding the corrective action plan.	30 Days	EBSA
12	If the corrective action plan does not address the violation and the plan/issuer is unwilling to amend it or does not follow through on implementation, EBSA drafts a final determination letter.	7 Days	EBSA
13	EBSA conducts internal review and approval or drafts final determination letter. This includes review and approval by EBSA leadership and consultation with, and clearance from, Treasury and HHS.	21 Days	EBSA
14	EBSA issues a final determination letter. The plan/issuer has 7 days to notify participants and beneficiaries that the plan has violated the Act's NQTL provisions.	7 Days	CAA
Total Allotted Days (Months)		**238 Days (7.9 months)**	-

Source: OIG analysis of the CAA and EBSA internal policies and written responses

Table 2: NQTL Comparative Analysis Review Timeline – With Extensions and Second Insufficiency Letter[29]

Step	Description	Allotted Time	Allotted Time Established By
1	EBSA requests a comparative analysis, supporting documentation, and a list of NQTLs for which comparative analyses were prepared.	14 Days	EBSA
2	EBSA grants a maximum 2-week extension.	14 Days	EBSA
3	EBSA reviews the comparative analysis and documentation to determine the sufficiency of the materials.	14 Days	EBSA
4	EBSA drafts an insufficiency letter and any requests for additional documentation and information.	7 Days	EBSA
5	EBSA conducts internal review and approval of the draft insufficiency letter. EBSA issues the insufficiency letter and requests additional documentation and information.	14 Days	EBSA
6	EBSA grants a maximum 1-week extension to plans/issuers to respond to the insufficiency letter.	7 days	EBSA
7	Plan/issuer responds to the insufficiency letter request.	14 Days	OIG Estimate
8	EBSA grants additional time, if needed, to respond to requests for claims data.	30 Days	EBSA
9	EBSA reviews materials provided in response to the insufficiency letter.	7 Days	EBSA
10	EBSA drafts a second insufficiency letter and any requests for additional documentation and information.	7 Days	EBSA

[29] These timeframes were developed prior to the 2024 final rules issuance. EBSA did not establish a timeframe for Step 7, Step 13, and Step 18. Based on our review of EBSA's internal timelines, we allotted 14 days to align with similar steps with timeframes specified by EBSA.

Step	Description	Allotted Time	Allotted Time Established By
11	EBSA conducts internal review and approval of the second draft insufficiency letter. EBSA issues the second insufficiency letter and requests additional documentation and information.	14 Days	EBSA
12	EBSA grants a maximum 1-week extension to plans/issuers to respond to the second insufficiency letter.	7 Days	EBSA
13	Plan/issuer responds to the second insufficiency letter request.	14 Days	OIG Estimate
14	EBSA reviews materials provided in response to the second insufficiency letter.	7 Days	EBSA
15	EBSA drafts an initial determination letter.	14 Days	EBSA
16	EBSA conducts internal review and approval of initial determination letter. This includes review and approval by EBSA leadership and consultation with, and clearance from, Treasury and HHS.	30 Days	EBSA
17	EBSA issues the initial determination letter, which triggers a 45-day corrective action period. The plan/issuer is required to provide a corrective action plan and additional analyses showing its NQTL compliance within the 45 days.	45 Days	CAA
18	EBSA reviews the corrective action plan.	14 Days	OIG Estimate
19	EBSA engages the plan/issuer with any concerns regarding the corrective action plan.	30 Days	EBSA
20	If the corrective action plan does not address the violation and the plan/issuer is unwilling to amend it or does not follow through on implementation, EBSA drafts a final determination letter.	7 Days	EBSA
21	EBSA conducts internal review and approval of the draft final determination letter. This includes review and approval by EBSA leadership and consultation with, and clearance from, Treasury and HHS.	21 Days	EBSA

Step	Description	Allotted Time	Allotted Time Established By
22	EBSA issues a final determination letter. The plan/issuer has 7 days to notify participants and beneficiaries that the plan has violated the Act's NQTL provisions.	7 Days	CAA
Total Allotted Days (Months)		**338 Days (11.3 months)**	-

Source: OIG analysis of the CAA and EBSA internal policies and written responses

EXHIBIT 2: ACCESSIBLE DATA TABLE

This exhibit contains accessible data for Figure 1.

Table 3: EBSA Frontline Staff Compared to Health Plans Subject to the Act

Fiscal Year	Number of Frontline Staff	Number of Health Plans
FY 2018	404	1,824,585
FY 2019	376	1,888,461
FY 2020	366	1,979,322
FY 2021	353	1,608,646
FY 2022	338	1,898,298
FY 2023	326	2,129,516
FY 2024	326	2,021,808

Source: EBSA

APPENDIX A: SCOPE AND METHODOLOGY

Scope

EBSA reported in 2022 and 2023 that plans and issuers were unprepared for or provided insufficient comparative analyses when EBSA requested NQTL comparative analyses for review. Given these concerns, we reviewed EBSA's enforcement of the Act's NQTL parity requirements from February 2021 through July 2024. Within this audit scope, we specifically reviewed:

- available enforcement authorities granted to EBSA through regulations and

- NQTL comparative analysis review data from February 10, 2021, through July 25, 2024.

Methodology

We conducted this performance audit 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

To accomplish our audit objective, we obtained an understanding of applicable EBSA policies, laws, guidance, requirements, and regulations relating to EBSA's enforcement of health plans' compliance with mental health parity NQTL laws and requirements. We interviewed EBSA staff and officials. We also met with and surveyed a selection of stakeholders nationwide, which consisted of unions, consumers, employers, and state partners, regarding EBSA's enforcement of mental health parity NQTL laws and requirements. Furthermore, we interviewed HHS and Treasury officials to obtain an understanding of their roles in enforcing compliance with mental health parity laws and regulations. Finally, we obtained an understanding of the available corrective action tools that are granted to EBSA through regulations. We reviewed the corrective action tools and determined whether EBSA used them and identified related limitations.

To determine the timeliness of EBSA's comparative analysis review process, we analyzed EBSA's NQTL comparative analysis review data from February 10, 2021, to July 25, 2024. We met with EBSA multiple times to obtain

an understanding of both its NQTL comparative analysis review data and its ERISA Management System, which holds all of EBSA's investigations data, including NQTL review data. Our timeliness analysis consisted of calculating: (1) the length of time it took EBSA to perform NQTL comparative analysis reviews from the date of the initial request for the NQTL comparative analysis to the date EBSA made a decision to issue or not issue an initial or final determination letter for each NQTL and (2) the overall average time taken.

We also surveyed 198 stakeholders nationwide for their input on EBSA's enforcement of the Act and NQTL parity. We selected stakeholders representing consumers, providers, employers, issuers, unions, and state partners. We identified the stakeholders through internet research and information provided by EBSA. We received 56 survey responses.

Data Reliability

In conducting this audit, we relied on NQTL comparative analysis review data from EBSA's ERISA Management System. To assess the reliability of EBSA's NQTL comparative analysis review data, we conducted reliability testing and worked with OIG data scientists to test for obvious errors in accuracy and completeness of the data. When we found discrepancies (such as missing dates), we brought them to EBSA's attention and worked with EBSA officials to correct the discrepancies before conducting our analysis. We determined the data were sufficiently reliable for the purpose of describing the timeliness of EBSA's NQTL comparative analysis reviews.

During the audit, EBSA transitioned its NQTL comparative analysis review data to a new NQTL dedicated tab in ERISA Management System. The updated tab contains "fatal" error messages that will not allow users to save entries or proceed with entering additional data until corrected, such as missing fields required based on entries in another field or a final determination letter issuance date preceding the date of the initial determination letter. The updated tab also contains error warning messages for "non-fatal" errors, such as missing attachments. EBSA completed this transition in September 2024, after our audit work had concluded.

Internal Controls

In planning and performing our audit, we considered EBSA's internal controls relevant to our audit objective by obtaining an understanding of those controls and assessing control risks relevant to our objective. We considered the internal control elements of control environment, risk assessment, control activities, information and communication, and monitoring during our planning and substantive phases, and we evaluated relevant controls. The objective of our

audit was not to provide assurance of the internal controls; therefore, we did not express an opinion on EBSA's internal controls. Because of the inherent limitations on internal controls, or misstatements, noncompliance may occur and not be detected.

Criteria

- Employee Retirement Income Security Act of 1974, as amended in December 2022
- Mental Health Parity Act of 1996, as enacted in September 1996
- Mental Health Parity and Addiction Equity Act of 2008, as enacted in October 2008
- 21st Century Cures Act, as enacted in December 2016
- 2021 Consolidated Appropriations Act, as enacted in December 2020
- Requirements Related to the Mental Health Parity and Addiction Equity Act, published on September 23, 2024
- U.S Government Accountability Office Standards for Internal Control in the Federal Government, GAO-14-704G, September 2014
- EBSA Memorandum, "Implementation of ERISA section 712(a)(8)," issued August 11, 2021

Prior Relevant Coverage

During the last 5 years, the OIG has not issued reports of significant relevance to the subject of this report.

The Government Accountability Office's relevant report titled, "Mental Health and Substance Use - State and Federal Oversight of Compliance with Parity Requirements Varies," GAO-20-150 (December 13, 2019), is available at https://www.gao.gov/assets/gao-20-150.pdf.

APPENDIX B: AGENCY'S RESPONSE TO THE REPORT

The agency's response to our draft report follows.

DATE: January 17, 2025

MEMORANDUM FOR: LAURA B. NICOLOSI
Assistant Inspector General for Audit

FROM: LISA M. GOMEZ LISA GOMEZ Digitally signed by LISA GOMEZ Date: 2025.01.17 15:29:45 -05'00'
Assistant Secretary of Labor for Employee Benefits Security

SUBJECT: EBSA Response to OIG Performance Audit
Draft Audit Report No. 09-25-00X-12-001

Thank you for the opportunity to comment on the recommendations in your above referenced Audit Report on the Employee Benefits Security Administration's (EBSA) efforts to enforce compliance with non-quantitative treatment limitation (NQTL) laws and requirements under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Below, EBSA responds to the report's findings and describes its plans to implement the report's recommendations.

To fully answer the research question ("To what extent did EBSA enforce compliance with mental health parity NQTL laws and requirements?") EBSA notes the scope of its efforts and achievements to date in MHPAEA enforcement.

Since 2021, EBSA has undertaken significant efforts to enforce compliance with MHPAEA NQTL laws and requirements. In recent years, EBSA devoted nearly 25% of its enforcement resources to MHPAEA NQTL enforcement.[1] From 2021 through 2024, EBSA has:

- Conducted over 150 investigations of plans and service providers focused on MHPAEA compliance concerns;
- Requested comparative analyses for well over 500 NQTLs;
- Issued hundreds of findings letters noting deficiencies in NQTL compliance analyses provided by plans and issuers, engaging them in dialogue and exchanges about compliance concerns;
- Issued over 70 determination letters citing violations tied to over 100 NQTLs; and
- Conducted over 100 NQTL-focused trainings for investigators, supervisors, attorneys, and managers.

Despite the challenges that OIG outlines in its report, EBSA's work led to corrections that expanded access to mental health and substance use disorder benefits for **over 22 million American workers and their families across more than 74,000 group health plans** between February 2021 and July 2024. Corrections included removal of impermissible barriers to mental

[1] 2023 MHPAEA Comparative Analysis Report to Congress at page 23, available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis; 2024 MHPAEA Report to Congress at page 14, available at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2024.pdf.

health and substance use disorder care, expansion of access to care, and payment of wrongfully denied claims. The following are some examples:

- ABA therapy exclusion removed: As a result of an investigation by EBSA's Los Angeles Regional Office, one of the largest service providers in the country removed an impermissible exclusion on applied behavioral analysis (ABA) therapy, a key treatment for autism. The service provider removed the ABA exclusion from across its entire book of business, affecting nearly 1,000 self-funded plans covering well over 500,000 participants, who now have access to ABA therapy. The service provider is in the process of reviewing and paying tens of thousands of wrongly denied claims.

- Drug testing exclusion removed: Due to an investigation by EBSA's Kansas City Regional Office, a service provider to many self-funded plans stopped its practice of denying drug testing claims when tied to treatment for a substance use disorder (SUD). The service provider would pay claims for the same services if tied to a medical/surgical condition but deny them when related to SUD treatment. The service provider reprocessed over 3,000 wrongly denied drug testing claims, resulting in reducing the amounts charged to participants by $925,755 and ultimately paying $1,006,857 to participants and providers.

- Changes to monitor the adequacy of a network and fill gaps: A large self-funded plan covering over 17,000 participants using a network from a national network administrator had gaps in its provider network for mental health (MH)/SUD care. The plan did not pay the same kind of attention to problems with access to MH/SUD care as it did to medical/surgical care or measure network adequacy using comparable metrics, resulting in many participants going out of network for MH/SUD care. After EBSA's Kansas City Regional Office cited the MHPAEA violation, the plan made significant changes to how it monitored the adequacy of its network and how it identified and addressed network gaps. The Plan also set up extra supports to help participants access MH/SUD care.

For additional examples of important corrections resulting from EBSA's enforcement efforts, see Attachment A.

EBSA recognizes that it faces many challenges in MHPAEA NQTL enforcement and that much work remains. One immediate challenge is the loss of supplemental funding for NQTL enforcement. In the first quarter of 2025, the Congress extended the period of availability of any remaining supplemental funding through the end of FY 2025. However, the remaining funding is insufficient to maintain the supplemental funding levels that EBSA has depended upon. The supplemental funding has supported 117 full-time equivalent employees. This is the equivalent of 3 out of EBSA's 10 regional field offices. After the loss of supplemental funding, EBSA will have less than one investigator for every 16,472 plans. At that level, all aspects of the agency's enforcement and compliance assistance program will suffer, but especially MHPAEA efforts. Given the resource-intensive nature of EBSA's NQTL investigations, the loss of supplemental funding for NQTL work will drastically slow the progress of all NQTL work. EBSA will face

difficult choices when evaluating new leads for investigation and selecting priorities among existing NQTL cases.

Even with the loss of supplemental funding and other significant challenges, EBSA remains steadfastly committed to MHPAEA's purpose and will continue to vigorously enforce MHPAEA to the limit of its resources. EBSA will work on implementing OIG's recommendations.

OIG'S RECOMMENDATIONS 1-3: Pursue legislative changes regarding -

- **The authority to impose civil monetary penalties for MHPAEA violations to increase compliance.**
- **The authority to enforce group health plan requirements of Part 7 of ERISA against service providers, including insurance issuers and third-party administrators for violations such as designing and applying impermissible NQTLs.**
- **Provisions that specify remedies available for violations of Part 7 of ERISA, including the ability to enforce re-adjudication of wrongfully denied claims or other remedies to restore losses resulting from MHPAEA violations.**

EBSA agrees with these recommendations, which mirror recommendations the agency made in the 2022, 2023, and 2024 MHPAEA Reports to Congress.[2] EBSA will continue to recommend these changes in future reports.

OIG'S RECOMMENDATION 4: Develop processes to utilize enforcement tools available to the agency, including referring health plans to the U.S. Department of the Treasury to levy the excise tax for MHPAEA violations, as appropriate.

OIG's report identified three underutilized enforcement tools. EBSA agrees that these three tools can assist in NQTL enforcement, but notes the following for each tool:

Tool 1: Referrals to Treasury to Levy an Excise Tax

While no referrals have been yet made to the Treasury Department for MHPAEA NQTL violations, this is not due to a lack of process. EBSA has a process for general referrals to Treasury, but EBSA has to date made a strategic choice to focus on voluntary compliance leading to making participants and beneficiaries whole for NQTL violations, rather than levying excise taxes. As noted in OIG's report, EBSA recognizes that levying substantial monetary taxes on single employer plans could negatively affect participants and beneficiaries if the plan were to

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[2] 2022 MHPAEA Report to Congress at pages 51-53, available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mental-health-parity-report-to-congress.pdf; 2023 MHPAEA Comparative Analysis Report to Congress at pages 32, 46, and 91, available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis; 2024 MHPAEA Report to Congress at pages 19, 24, and 114, available at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2024.pdf.

no longer be able to offer health benefits or no longer offer mental health or substance use disorder benefits. Additionally, excise taxes would have the greatest positive impact on enforcement efforts and compliance if the IRS were able to levy excise taxes on the service providers themselves who are often functionally responsible for the violations. However, under current law, excise taxes would be levied on covered plans, not service providers.

In light of these limitations, thus far, EBSA has opted to worked directly with the plans and service providers to obtain correction without referring to Treasury for an excise tax. The agency recognizes, however, that the excise tax may have an additional deterrent impact that could encourage plans to comply with MHPAEA. As a result of discussions with OIG, EBSA is in the process of revising its existing referral procedures with Treasury to expressly include referrals for NQTL violations. Implementation efforts include refreshing an inter-agency memorandum of understanding, finalization of formal referral procedures separate from existing referral procedures, and confirmation of Treasury's preferred channels of receipt of such referrals.

Tool 2: Referrals to SOL to Pursue Litigation

The report points to the relatively small number of formal case referrals to the Solicitor's Office (SOL). However, this is more a reflection of the way these investigations are jointly worked by SOL and EBSA from their inception than an indicator of any shortcomings in the use of the Solicitor's Office. EBSA and SOL work hand-in-hand investigating NQTLs, even without a formal referral. SOL involvement early in the investigative process is routine in NQTL investigations, and SOL's presence helps EBSA to have greater success at achieving voluntary compliance from plans and issuers. A formal referral to SOL is an internal step only and does not have an impact on external actors. As evidenced by the results of EBSA enforcement efforts affecting 22 million American workers across more than 74,000 health plans, voluntary compliance efforts aided by SOL involvement absent litigation referrals have been successful in many NQTL cases. EBSA will make formal referrals to SOL based on the facts and circumstances of each case. EBSA is eager to litigate NQTL issues where voluntary compliance efforts are not successful.

Tool 3: Cures Act Audit Requirements

The Cures Act requires the Tri-Agency Departments (Labor, Treasury, and Health and Human Services) to open an investigation in the following plan year if at least five violations of the Act were cited for a plan or issuer. EBSA's policy implementing this requirement is triggered when an investigation closes. As a matter of practice, EBSA usually keeps investigations open until full correction of cited violations is achieved. During the audit period under review by OIG, EBSA did not have any closed investigations with five or more MHPAEA violations cited. Therefore, the Cures Act requirement was not triggered. EBSA has a least one investigation with five or more cited MHPAEA violations, but the investigation is still open pending full correction. EBSA will continue to review case closure activity and MHPAEA violation counts to comply with the Cures Act requirement.

OIG'S RECOMMENDATION 5: Develop and issue additional guidance to support the implementation of the 2021 Consolidated Appropriations Act NQTL comparative analysis

requirements and the September 2024 MHPAEA final rule, such as an updated MHPAEA Self-Compliance Tool or Frequently Asked Questions document(s).

The Departments (Labor, Treasury, and Health and Human Services) have stated that they intend to issue additional guidance in the future to provide more information on MHPAEA's requirements. For example, the Departments intend to issue future guidance on the type, form and manner of collection and evaluation for the data required and the lists of examples of data that are relevant across the majority of NQTLs, as well as additional relevant data for NQTLs related to network composition. DOL also intends to update the MHPAEA Self-Compliance Tool to provide a robust framework and roadmap for plans and issuers to determine which data to collect and evaluate, and to assist plans and issuers as they work to comply with the 2024 Rules. The Departments have also provided additional guidance in the 2024 Report to Congress, including an important settlement that provides a detailed framework for improving network adequacy.

DOL, along with the Departments of Health and Human Services and the Treasury, will continue to engage with the regulated community and other interested parties, and will consider the issuance of additional guidance related to the implementation of MHPAEA, including the comparative analysis requirements, as appropriate in the future.

We appreciate the opportunity to provide our comments on your report and hope that they will be helpful to you in developing a final document.

ATTACHMENT A

1. Additional Examples of Important Results of EBSA's NQTL Investigations

Example 1 (ABA therapy exclusion - plan): As a result of an investigation by EBSA's Chicago Regional Office, a self-funded plan covering over 2,500 participants removed an impermissible exclusion of applied behavioral analysis (ABA), a key treatment for autism. The plan began covering ABA going forward and readjudicated over 1,100 previously denied ABA therapy claims for just 7 participants, resulting in $256,365 claims payments and $291,333 in network discounts for those participants. The plan also returned $5,760 in premiums to a parent who purchased additional insurance so their child could continue ABA therapy despite the plan's original claim denial.

Example 2 (residential treatment exclusion): After EBSA's Philadelphia Regional Office cited a MHPAEA violation, an issuer removed an impermissible exclusion of residential treatment for mental health conditions. Residential treatment is an important component of the continuum of care for some mental health conditions, like eating disorders. The service provider covered similar services for medical/surgical conditions, but not mental health conditions. The service provider made the correction across its entire book of business, affecting 382 plans covering over 1.4 million participants.

Example 3 (preauthorization): A self-funded plan covering over 3,000 participants required preauthorization in order to access many outpatient mental health and substance use disorder services from network providers. EBSA cited the plan for a violation because its comparative analysis did not reflect analysis required by statute. EBSA's New York Regional Office worked with the plan to remove prior authorization from several outpatient mental health services. The plan's service provider made the change across its book of business, affecting 144 plans covering over 790,000 participants.

Example 4 (medication-assisted treatment, methadone, and naltrexone exclusion): After EBSA's Boston Regional Office's citation of an NQTL violation, a self-funded plan covering over 9,000 participants removed an impermissible exclusion of methadone and naltrexone, key medications for opioid addiction. EBSA's New York Regional Office similarly cited a large self-funded plan for a violation stemming from an exclusion of methadone maintenance treatment. The plan's 22,000 participants now have access to this proven therapy for opioid addiction.

Example 5 (nutritional counseling exclusion): Two unrelated large service providers both covered nutritional counseling for medical/surgical conditions like diabetes but excluded the same services if offered for a mental health condition, such as an eating disorder. As a result of investigations by EBSA's Boston Regional Office and San Francisco Regional Office, both service providers removed the impermissible exclusion and now cover nutritional counseling for mental health conditions. The service providers effected the change across their entire books of business, affecting 23,731 plans and over 332,900 participants, and 521 plans and over 289,900 participants, respectively.

2. Examples of impact of EBSA helping specific individuals who sought EBSA assistance

Example 6 (mom took out second mortgage to pay for child's mental health care): A mother sought help for her child, who needed inpatient residential treatment for a MH condition. EBSA received the complaint through Oregon state regulators after the mom's self-funded ERISA plan denied claims for the daughter's treatment, which included weeks of stay at a local emergency room while waiting for a bed to open at an in-network residential treatment program that could treat her acute MH condition. The plan refused to offer an exception to allow the daughter to go out-of-network (OON) for care, so the mother took out a **second mortgage on her house to pay $204,000** out of pocket for the care her daughter needed at an OON residential facility. The Plan withheld payment and did not respond to the participant's claims until EBSA's San Francisco Regional Office intervened. After 9 months of follow-up by EBSA's benefits advisor, the plan finally processed the claims and sent the participant 65 separate checks totaling **$203,750** for her daughter's treatment. The participant used the money to pay back the second mortgage she was forced to take to fund her daughter's treatment while the plan delayed the processing of her claim and refused to authorize OON care.

Example 7 (insurer reneges on agreement to pay for mental health treatment): A participant contacted EBSA seeking help because her plan had denied a claim for her teenage daughter's mental health treatment at an out-of-network (OON) residential treatment program. The plan did not have a network facility to provide the necessary care, so the plan had agreed to pay for the OON care using in-network rates under a special "network deficiency" agreement. After the patient received the services, the administrator did not honor the network deficiency agreement. They denied the **$92,202** claim and tried to reverse all payments to the facility due to it being an OON provider. As a result of intervention by EBSA's Philadelphia Regional Office investigator, the administrator reversed the claim denial and paid it in full. After applying a $29,939 network discount, the **participant received $62,263**, including interest.

Example 8 (substance abuse treatment denial, residential treatment exclusion): A participant in a self-funded plan received care for detox and participated in an addiction-focused residential treatment program for his substance use disorder. After 10 days of treatment, the plan denied his **$56,945** claim, citing an exclusion of residential treatment for mental health and substance use disorders. The plan covered similar inpatient care for medical/surgical conditions, but not for mental health and substance use disorders. A patient advocacy group reached out to EBSA about the denial. EBSA's Atlanta Regional Office investigated the matter and cited the plan for an impermissible exclusion of residential treatment for mental health and substance use disorders. As a result, the plan paid the claim in question and removed the illegal exclusion so all 827 plan participants could access residential treatment for mental health and substance use disorder if needed. The plan paid **$27,463** for the complaining participant's denied claim, and the participant was not billed for the difference.

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