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

[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.