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BENEFITS BULLETIN

Mental Health Parity Non-Quantitative Treatment Limitations (NQTLs)

INSIDE THIS ISSUE:

PROPOSED FAQ AND GUIDANCE

The Departments of Labor, Treasury, and Health and Human Services, the federal departments responsible for regulating and enforcing the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), issued a proposed FAQ addressing non-quantitative treatment limits (NQTLs) on April 23, 2018. It was accompanied by an updated MHPAEA self-compliance tool, a document listing warning signs of non-compliance with MHPAEA's NQTL requirements, and a revised sample disclosure form for patients to use when seeking coverage information from their health plan.

Not only do these documents include some in-depth guidance for health plans, they also make it clear that the Departments interpret MHPAEA as governing every aspect of claims administration, including utilization review guidelines, application of medical necessity and experimental/investigative provisions, and drug formularies.

BACKGROUND

MHPAEA prohibits group health plans from imposing more stringent requirements on claims for mental health and substance use disorders (MH/SUDs) than claims for medical/surgical conditions (med/surg). The parity requirements apply to financial requirements—such as copays—and non-quantitative treatment limits (NQTLs)—such as pre-certification requirements. Previously issued guidance explained that the financial requirements and NQTLs for MH/SUDs should be compared to med/surg benefits by looking at benefits in the following six classifications:

MHPAEA Coverage Classifications	
• in-network inpatient	• out-of-network outpatient
• out-of-network inpatient	• emergency care
• in-network outpatient	• prescription drugs

MHPAEA does not require plans to cover mental health or substance use disorder treatments. It only requires such coverage to be no more restrictive than the plan's med/surg coverage.

MHPAEA does not apply to retiree-only plans.

GENERAL GUIDANCE ON NQTLS

The proposed FAQ and self-compliance tool provide guidance to help plans administer the parity requirements with respect to NQTLs. The final MHPAEA regulations described NQTLs as processes, strategies, evidentiary standards or other factors used in applying the nonquantitative treatment limitation in each of the six classifications listed above.

NQTLs are processes, strategies, evidentiary standards and other factors that result in plan limitations or exclusions.

Plans can use various factors to design medical management techniques (their NQTLs), such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. However, these factors must be applied to med/surg and MH/SUD treatments in a comparable fashion.

Written plan provisions stating that medical necessity and experimental/investigative exclusions apply equally to MH/SUD and med/surg conditions are insufficient.

Bringing SPDs and Plan Documents into compliance is insufficient.

In addition to amending plan language wherever needed to comply with the parity requirements, plans must ensure that their behind-the scenes practices are comparable.

It is important that a plan's guidelines and criteria used to determine whether a treatment is experimental/investigative or medically necessary must be comparable to the guidelines and criteria used for med/surg treatment. Most plans rely solely on third party medical reviewers to make these determinations.

Plans must ensure that their behind-the-scenes guidelines and criteria for MH/SUD claims are no less stringent than for med/surg claims.

The table on page 4 shows the NQTLs listed in the proposed FAQ and self-compliance tool, and indicates the plan-related entity that can best describe the processes and standards currently used to administer the plan.

SPECIFIC GUIDANCE IN FAQ

The questions and answers in the FAQ provide the following guidance and clarifications.

Experimental/Investigative Exclusions - A plan may exclude services that are experimental or investigational, provided that the plan, in practice, applies its definition of experimental/investigative to MH/SUD in the same way it does for med/surg conditions.

The specific example in the proposed FAQ was a plan that denies Applied Behavioral Analysis (ABA) therapy for autism as experimental/investigative. The FAQ indicated that if the plan covers med/surg treatments based on the existence of at least two randomized controlled trials supporting the treatment, it cannot deny ABA since there are two such trials.

Another Q&A references use of Hayes Medical Technology Directory ratings. If the evidentiary standard for defining a treatment as experimental is any Hayes rating below B for med/surg conditions, then a more restrictive standard cannot be used for MH/SUD.

Dosage Limits/Step Therapy - Dosage limits for drugs can be determined based on professionally-recognized guidelines or pharmacy and therapeutics (P&T) committees. If a plan follows the dosage recommendations of its chosen guideline for drugs to treat med/surg conditions, it must also apply the guidelines for drugs to treat MH/SUD disorders. The FAQ used the example of a plan with dosage limits on buprenorphine (Suboxone®) for opioid abuse.

Excluding Specific Conditions - Plans may still have general exclusions for a particular condition (diagnosis). For example, a plan can contain a general exclusion for items and services to treat bipolar disorder, including prescription drugs.

Fail-First Standards - Fail-first standards for substance abuse treatments will almost always be considered violations of MHPAEA. For example, requiring a participant to have two unsuccessful attempts at outpatient treatment in the past 12 months to be eligible for inpatient SUD benefits is not permissible because the same standard will not apply to substantially all inpatient med/surg treatments.

Residential Treatment Facilities - If a plan covers out-of-network inpatient treatment for med/surg conditions, it must do so

on the same basis for MH/SUD. The example given was residential treatment for eating disorders. A plan cannot exclude coverage for eating disorders treatment in an out-of-network residential treatment facility if the plan covers out-of-network inpatient treatments for med/surg conditions.

Plans can still require physician authorization and apply standard-of-care guidelines, provided the guidelines are no more stringent than the guidelines for inpatient out-of-network med/surg treatment.

Provider Reimbursement Rates - While a plan is not required to pay identical provider reimbursement rates for med/surg and MH/SUD providers, the plan's standards for admitting a provider to the network (including the plan's reimbursement rates for providers) is an NQTL.

Provider Network Composition - The proposed FAQ would require plans that do not meet the safe harbor requirements for electronic disclosure (29 CFR 2520.104b-1(c)) to mail printed provider directories to their participants. Only plans that do meet the save harbor requirements would be able to simply provide a URL link to their network listing.

As a rule, multiemployer plans do NOT meet the safe harbor requirements since the plan administrator cannot guarantee that all participants have computer access during regular working hours at their work sites. They would therefore be required to distribute printed provider directories.

If issued as proposed, the FAQ will require plans that do not satisfy the DOL's safe harbor for the distribution of electronic plan documents to mail printed lists of in-network providers to all participants. Most multiemployer plans do not meet the safe harbor requirements.

Revised Model Disclosure Form - The MHPAEA regulations require plans to disclose their criteria for making determinations with respect to MH/SUD benefits, including the criteria for medical necessity determinations. This information must be provided to any "current or potential participant, beneficiary, or contracting provider" upon request.

The Departments are soliciting comments on a revised draft model form that participants could use to request information from their plan regarding the NQTLs that could affect their MH/SUD benefits, or to obtain documentation to support an appeal. (The initial draft was issued in June 2017.)

WARNING SIGNS

The Departments have published a document entitled "Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance." This 3-page document helpfully lists some examples of the types of NQTL requirements the Departments are concerned with. We have incorporated many of these warning signs into the table on page 4.

ENFORCEMENT EFFORTS

MHPAEA enforcement is a priority with the DOL. 187 ERISA plans were reviewed for MHPAEA compliance in 2017, and 92 violations were discovered.

Plans should review their written and behind-the-curtain provisions affecting claims for mental health or substance abuse to ensure compliance. See page 4 for a sample list of non-quantitative limits identified by the regulations to date.

ACTION NEEDED

Plan sponsors should direct the appropriate plan professional(s) to review their plans, and the provisions of their service providers (PPOs, UR organizations, PBMs, etc.) to make sure their plans do not include provisions that violate MHPAEA rules, particularly the plan provisions on non-quantitative treatment limitations (NQTLs).

WHERE TO READ THE GUIDANCE

The proposed FAQ, the Warning Signs document, the self-compliance tool and the disclosure form are all available on the EBSA website: https://www.dol.gov/agencies/ebsa.

SUMMARY OF NON-QUANTITATIVE TREATMENT LIMITS IDENTIFIED BY REGULATORY GUIDANCE

(List Should Not Be Considered Exhaustive – Other Standards Could Apply)

Non-Quantitative Treatment Limit (NQTL) Standard	Who/What Imposes the Standard
1. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols) ❗ *It is a warning sign to the DOL if a plan requires previous failed substance abuse treatment attempts before coverage is granted for more intensive treatment.*	Utilization review organization and prescription benefit manager
2. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative ❗ *Warning signs:* • *Policies excluding services that do not result in measurable and substantial improvement in mental health status within 90 days* • *Requiring individualized written treatment plans for MH/SUD services, and/or updated individualized plans on a periodic basis*	Utilization review organization
3. Prior authorization or ongoing authorization requirements ❗ *Warning sign: Unequal medical/Rx pre-certification or prior authorization requirements*	Utilization review organization and plan documents
4. Exclusions based on failure to complete a course of treatment ❗ *Warning sign: Excluding substance abuse treatment when patient leaves against medical advice*	Plan documents
5. Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits ❗ *Warning signs:* • *Imposing a geographical limitation for MH/SUD but not to medical/surgical treatment* • *Requiring MH/SUD facilities to be state-licensed, and not having the same requirement on medical/surgical facilities*	Plan documents
6. Exclusions of specific treatments for certain conditions ❗ *Warning sign: Excluding all residential treatment for substance use disorders*	Plan documents
7. Concurrent review standards	Utilization review organization
8. Standards for providing access to out-of-network providers	Plan documents
9. Plan methods for determining usual, customary, and reasonable charges	Claims administrator and plan documents
10. Restrictions on applicable provider billing codes	Provider network administrator and claims administrator
11. For plans with multiple network tiers (such as preferred providers and participating providers), network tier design	Provider network administrator
12. Standards for provider admission to participate in a network, including reimbursement rates	Provider network administrator
13. Formulary design for prescription drugs	Prescription benefit manager