Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the Affordable Care Act, generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage[1] ensure that the financial requirements and treatment limitations on Mental Health or Substance Use Disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical (med/surg) benefits. This is commonly referred to as providing MH/SUD benefits in parity with med/surg benefits.

There are requirements for determining parity with respect to financial requirements (such as copays) and for treatment limitations, which limit the scope or duration of benefits for treatment. Treatment limitations may be quantitative treatment limitations (QTLs) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment (such as preauthorization requirements).[2] The rules for financial requirements and QTLs are different from the rules for NQTLs. This publication focuses on NQTLs and how to identify provisions that will require inquiry beyond the plan/policy terms in order to determine compliance with mental health parity requirements.

Under MHPAEA regulations, a plan or issuer may not impose an NQTL on MH/SUD benefits unless, under the terms of the plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification[3] are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to med/surg benefits in the same classification. Federal MHPAEA regulations contain an illustrative, non-exhaustive list of NQTLs,[4] which include:

- medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for concurrent review);
- formulary design for prescription drugs;
- network tier design;
- standards for provider admission to participate in a network, including reimbursement rates;
- plan methods for determining usual, customary, and reasonable charges;
- fail-first policies or step therapy protocols;
- exclusions based on failure to complete a course of treatment; and
- restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

Stakeholders have asked for examples of plan provisions they might see on the MH/SUD side which should trigger careful analysis of the coverage on the med/surg side in order to ensure MHPAEA NQTL compliance.

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1 MHPAEA contains an exemption for small employers (generally those with 50 or fewer employees), as well as plans that meet an increased cost exemption. The Affordable Care Act extended MHPAEA to individual coverage and HHS's essential health benefits regulations require non-grandfathered individual and small group coverage to ensure parity as an EHB requirement. Retiree health plans continue to be exempt.

2 See 29 CFR 2590.712(c)(2)-(3) for the test for financial requirements and QTLs and 29 CFR 2590.712(c)(4) for the requirements for NQTLs. 26 CFR 54.9812-1(c)(2)-(4); 29 CFR 2590.712(c)(2)-(4); 45 CFR 146.136(c)(2)-(4); and 147.160.

3 The classifications are inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network; prescription drugs and emergency care. Sub-classifications for outpatient office visits and network tiering are permissible. 26 CFR 54.9812-1(c)(2)(ii), (3)(iii); 29 CFR 2590.712(c)(2)(ii), (3)(iii); 45 CFR 146.136(c)(2)(ii), (3)(iii); and 147.160.

4 26 CFR 54.9812-1(c)(4)(ii); 29 CFR 2590.712(c)(4)(ii); 45 CFR 146.136(c)(4)(ii); and 147.160.

Language contained in the following provisions (absent similar restrictions on med/surg benefits) can serve as a red flag that a plan or issuer may be imposing an impermissible NQTL. Further review of the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to both MH/SUD and med/surg benefits will be required to determine parity compliance. Note that these plan/policy terms do not automatically violate the law, but the plan or issuer will need to provide evidence to substantiate compliance. The categories and examples below are not exhaustive and are not a substitute for any regulations or other interpretive guidance issued by the Departments.

EXAMPLE PROVISIONS: If you see these types of plan or policy provisions, investigate if these types of limits are also applied to med/surg benefits and if so, if they are being applied to MH/SUD and med/surg benefits in a manner that complies with MHPAEA.

I. Preauthorization & Pre-service Notification Requirements

- ***Blanket Preauthorization Requirement:*** Plan/insurer requires preauthorization for all mental health and substance use disorder services.

- ***Treatment Facility Admission Preauthorization:*** Plan/policy states that if the insured is admitted to a mental health or substance abuse facility for non-emergency treatment without prior authorization, insured will be responsible for the cost of services received.

  Plan states that for inpatient mental health precertification is required.

  Plan requires pre-notification or notification ASAP for non-scheduled MH/SUD admissions and reduces benefits 50% if pre-notification is not received.

  Plan requires preauthorization for all inpatient and outpatient treatment of chemical dependency and all inpatient and outpatient treatment of serious mental illness and mental health conditions.

  Plan requires preauthorization or concurrent care review every 10 days for MH/SUD services but not for med/surg services.

- ***Medical Necessity Review Authority:*** Plan's/insurer's medical management program (precertification and concurrent review) delegates its review authority to attending physicians for med/surg services but conducts its own reviews for MH/SUD services.

- ***Prescription Drug Preauthorization:*** Plan/insurer requires preauthorization every three months for pain medications prescribed in connection with MH/SUD conditions.

- ***Extensive Pre-notification Requirements:*** Plan/insurer requires pre-notification for all mental health and substance use disorder inpatient services, intensive outpatient program treatment, and extended outpatient treatment visits beyond 45-50 minutes.

II. Fail-first Protocols

- ***Progress Requirements:*** For coverage of intensive outpatient treatment for MH/SUD, the plan/insurer requires that a patient has not achieved progress with non-intensive outpatient treatment of a lesser frequency.

- ***Treatment Attempt Requirements:*** For inpatient SUD rehabilitation treatment plan/insurer requires a member to first attempt two forms of outpatient treatment, including the intensive outpatient, partial hospital, outpatient detoxification, ambulatory detoxification or inpatient detoxification levels of care.

  For any inpatient MH/SUD services, the plan/insurer requires that an individual first complete a partial hospitalization treatment program.

III. Probability of Improvement

- ***Likelihood of Improvement:*** For residential treatment of MH/SUD, the plan/insurer requires the likelihood that inpatient treatment will result in improvement.

  Plan/policy only covers services that result in measurable and substantial improvement in mental health status within 90 days.

IV. Written Treatment Plan Required

- ***Written Treatment Plan:*** For MH/SUD benefits, plan/insurer requires a written treatment plan prescribed and supervised by a behavioral health provider.

- ***Treatment Plan Required within a Certain Time Period:*** Plan/insurer requires that within seven days, an individualized problem-focused treatment plan be completed, including nutritional, psychological, social, medical and substance abuse needs to be developed based on a complex bio-psychosocial evaluation. Plan needs to be reviewed at least once a week for progress.

- ***Treatment Plan Submission on a Regular Basis:*** Plan/insurer requires that an individual-specific treatment plan will be updated and submitted, in general, every 6 months.

V. Other

- ***Patient Non-compliance:*** Plan/policy excludes services for chemical dependency in the event the covered person fails to comply with the plan of treatment, including excluding benefits for MH/SUD services if a covered individual ends treatment for chemical dependency against the medical advice of the provider.

- ***Residential Treatment Limits:*** Plan/policy excludes residential level of treatment for chemical dependency.

- ***Geographical Limitations:*** Plan/policy imposes a geographical limitation related to treatment for MH/SUD conditions but does not impose any geographical limits on med/surg benefits.

- ***Licensure Requirements:*** Plan/policy requires that MH/SUD facilities be licensed by a State but does not impose the same requirement on med/surg facilities.