RECOMMENDATIONS ON GUIDANCE TO INSURERS/PLANS FOR NQTL DISCLOSURE

This document is intended to outline in detail the specific information required to be disclosed for a determination to be made whether an employer's group plan's nonquantitative treatment limitations ("NQTLs"), as written and applied, are in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA" or the "statute"). The statute and Interim Final Rules ("IFR") set forth the general areas of required disclosure and the Department of Labor ("DOL") released sub-regulatory guidance with respect to this issue. However, plans are reportedly confused about exactly what NQTL criteria the statute and IFR require them to provide. As a result, most plans are refusing to disclose sufficient information that would allow a consumer or provider to determine whether an NQTL is non-comparable or being applied in a more stringent manner with respect to the mental health or substance use disorder ("MH/SUD") benefit as compared to the medical/surgical benefit.

Further, both insurers and the Departments have requested recommendations for what specific documents and information (e.g., criteria, policies, strategies) are needed to be disclosed in order to determine whether and when a parity violation has occurred.

This document focuses on three areas:

1. A brief review of and rationale for what information is needed in order to determine NQTL compliance;

2. An example with a check list of needed documents;

3. Proposed sample FAQs.

1. **Review of rationale for specific disclosure for determination of NQTL compliance.**

The following is an excerpt from the NQTL section of the IFR, with emphasis supplied:

> "*Nonquantitative treatment limitations--(i) General rule*. A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification **are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification**, except to the extent that recognized clinically appropriate standards of care may permit a difference.
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> (ii) *Illustrative list of nonquantitative treatment limitations*. Nonquantitative treatment limitations include--

(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(B) Formulary design for prescription drugs;

(C) Standards for provider admission to participate in a network, including reimbursement rates;

(D) Plan methods for determining usual, customary, and reasonable charges;

(E) 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); and

(F) Exclusions based on failure to complete a course of treatment.

(iii) *Examples*. The rules of this paragraph (c)(4) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits." (75 Fed. Reg. 5436).

The guidelines for what MH/SUD and medical/surgical information is needed to determine whether a plan is in compliance with the NQTL provisions are governed by the above emphasized quote from the IFR. Ultimately, a medical insurer must perform an internal analysis of each NQTL (either type or subtype, e.g., medical management standards is a type, pre-authorization and concurrent reviews are subtypes) that is applied to the MH/SUD benefit and determine whether the NQTL meets the above stated standard: i.e., is the NQTL comparable to and applied no more stringently than the same NQTL that is applied to a medical condition and/or a category of medical/surgical services, and/or to a classification of medical/surgical benefits. Given the current lack of clarity in the IFR with respect to a requirement for a specific quantitative floor for NQTLs, these guidelines assume that the tests for compliance are comparability and stringency.

While the IFR did not set a specific quantitative floor for NQTLs, a plan will necessarily have to consider quantitative factors and/or magnitude and/or proportionality in determining whether an NQTL is comparable and applied no more stringently. This deduction is based on multiple factors:

A. The clear statutory definition of a "treatment limitation" (the IFR clearly defines an NQTL as a treatment limitation) as requiring the substantially all and predominant test floors.

B. Common definitions of both "comparability" and "stringency" encompass aspects of similarity in type or nature, **and also in proportion, magnitude, and/or quantity as to how that limit is applied**. Is it possible to determine whether a limit is applied in a comparable and no more stringent manner without considering any aspect of quantity, proportion or magnitude? Clearly not.

For example, if a treatment limitation, (whether quantitative or nonquantitative), is applied to a classification of medical benefits 20% of the time and applied to that same classification of behavioral benefits 100% of the time, is there any way to conclude that the limit is comparable? No. Thus, disclosure of how an NQTL is applied to the medical/surgical benefit necessitates consideration of the proportion of the medical/surgical benefit that is subject to the particular

NQTL, even though there is no fixed floor as to what quantity is sufficient to make a case for comparability.

C. The IFR itself does establish that quantitative levels are an essential factor with respect to how NQTLs are applied. In all of the examples in the IFR, percentages and/or quantities are identified when illustrating how to compare MH/SUD and medical/surgical applications of NQTLs. Most of the examples assumed a 100% or 0% application of an NQTL, but this demonstrates that quantity is an essential factor in determining the parity compliance of an NQTL.

In addition, *Example 2* of the IFR does provide an example in which an NQTL is applied in varying (not 100% vs. 0%) quantitative levels:

> "(i) *Facts*. . . For mental health and substance use disorder treatments that do not have prior approval, no benefits will be paid; for medical/surgical treatments that do not have prior approval, there will only be a 25 percent reduction in benefits the plan would otherwise pay.
> (ii) *Conclusion.* **. . [T]he penalty for failure to obtain prior approval for mental health and substance use disorder benefits is *not comparable* to the penalty for failure to obtain prior approval for medical/surgical benefits.**"(Emphasis supplied) (75 Fed. Reg. 5436).

The Departments use this example to demonstrate how comparability must be applied when different quantities of an NQTL are to be deemed compliant or non-compliant. While this example refers to a quantitative financial penalty (100% financial penalty vs. a 25% penalty), this quantitative difference is used in the IFR to determine whether the NQTL is comparable.

2. **Recommendations for specific information to be disclosed with examples:**

The following are guidelines for and examples of specific medical/surgical criteria, policies, strategies, etc. needed to be disclosed in order to determine compliance with the NQTL rule. The check list following the below example is meant to illustrate what types of assessments would be needed for an internal analysis by a health plan, as well as what types of information may be needed for disclosure. .

The general rule is: Any policy, procedures, criteria, standards and strategies that would allow a third party (e.g. consumer, provider, regulator or auditor) to determine whether any specific NQTL (type or subtype) that **is applied** to a MH or SUD benefit in a classification is comparable to and no more stringent than the manner in which that NQTL is applied to medical/surgical benefits in that classification.

Example

Facts. A group health plan limits benefits to 100% of inpatient treatment for both medical/surgical conditions and mental health/substance use disorders that is medically necessary. The plan requires precertification and concurrent review for all (100%) inpatient, in-network mental health and substance use disorder benefits, but only requires precertification and

concurrent review for elective admissions for inpatient, in-network medical/surgical benefits. This represents 30% of the inpatient, in-network spending under the medical/surgical benefit.

Disclosure Requirements

The group health plan would need to assess and examine the following "**processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification."** (75 Fed. Reg. 5436). The following illustrates what types of assessments would be needed for an internal analysis by a health plan as well as what types of information may be needed for disclosure. This information would need to be disclosed when requested by a person or entity with appropriate standing.

1 Criteria and strategies used to perform precertification and concurrent review for inpatient, in-network medical/surgical admissions.

2. Definitions of what is considered an elective vs. an emergency admission for a medical/surgical condition in this classification of benefits.

3. What percentage of total admissions in this classification of benefits are defined as elective vs. emergency for both medical/surgical and for MH/SUD.

4. An analysis of any differences (between medical/surgical and MH/SUD), if present, of clinical or provider variables that trigger a review. Are best practice guidelines used to support more stringent reviews?

5. An analysis of differences between how medical/surgical vs. MH/SUD reviews are conducted, e.g. differences in patient information, who is required to conduct the review on the facility side and the frequency of reviews.

3. **Proposed FAQs**

Q1: I was denied benefits for mental health treatment by my plan because the plan determined that the treatment was not medically necessary for inpatient care. I requested and received a copy of the criteria for medical necessity determinations for mental health and substance use disorder treatment as well as a description of how those criteria are applied to behavioral health, and the reason for denial. I think my plan is applying medical necessity standards more stringently and in a non-comparable manner to benefits for mental health and substance use disorder treatment than for medical/surgical benefits. How and what information on the medical necessity criteria used for medical/surgical benefits, as well as how these criteria and policies are applied differently to mental health and substance use benefits, is a plan required to disclose to me?

A1: Under both ERISA and MHPAEA, documents with information on the medical necessity criteria for both medical/surgical benefits and mental health/substance use disorder benefits are plan documents, and copies of plan documents must be furnished within 30 days of your request. See ERISA regulations at 29 CFR 2520.104b-1. Additionally, if a provider or other individual is acting as a patient's authorized representative in accordance with the Department of Labor's

claims procedure regulations at 29 CFR 2560.503-1, the provider or other authorized representative may request these documents. If your plan is not subject to ERISA or MHPAEA (for example, a plan maintained by a State or local government), you should check with your plan administrator.

The plan must disclose all policies, criteria, strategies and documents that are used to apply medical necessity determinations to the inpatient classification of benefits for medical and surgical conditions. This should include what types of medical reviews are being conducted, e.g. concurrent vs. precertification, what proportion of medical admissions are subject to each review type, the factors that determine how and when a medical review is implemented and how they are different from the reviews that are conducted for the inpatient classification of benefits for mental health conditions and substance use disorders, and the rationale for the difference.

Q2: I am a health insurance plan administrator and offer both medical/surgical benefits as well as mental health and substance use disorder benefits for most mental health and substance use disorder diagnoses. Our plan includes a number of medical management and cost containment protocols, which are nonquantitative treatment limitations, for both the medical/surgical and the mental health/substance use disorder benefits. We believe that we are in compliance with MHPAEA even though some of our nonquantitative treatment limitations for behavioral health are different than those for medical/surgical benefits. What type of internal analysis is required in order to support our conclusions that we are in compliance? Based on this analysis what type of information are we required to disclose to a consumer or provider?

A2: A plan should conduct a thorough review of any non quantitative treatment limitation (for example, application of utilization review criteria and protocols, use of scientific criteria to determine experimental vs. non-experimental status, establishment of fee schedules, provider admission standards) that is applied differently to mental health or substance use disorder treatment services as compared to medical/surgical treatment services in the same classification of benefits.

The internal review should measure whether these non quantitative treatment limitations are applied in a more stringent or non-comparable manner and should include an assessment of what proportion of the medical/surgical benefit the non quantitative treatment limitation is applied to as compared to what proportion of the mental health/substance use disorder benefit the non quantitative treatment limitation is applied to within the same classification of benefits (e.g. outpatient, in-network medical to outpatient, in-network behavioral). While the IFR does not set forth a quantitative minimum for the percentage of the benefits in a classification that a non quantitative treatment limitation must be applied to under the medical/surgical benefit before it can be applied to the mental health or substance use disorder benefit, the plan will need to explain the rationale for any differences in the proportion of benefits in a classification the non quantitative treatment limitation is applied to. For example, if pre-certification is required for 100% of all mental health or substance abuse inpatient admissions, but is only required for 30 % of medical admissions, this difference will need to be justified and the rationale and support for this difference disclosed.