June 27, 2016

Quick Facts:

- The DOL has provided guidance and FAQs on health plan provisions that could trigger a violation of the MHPAEA.
- Non-quantitative treatment limitations (NQTLs) generally may not be more stringent for MH/SUD benefits than they are for comparable medical/surgical benefits.
- The guidance includes examples of impermissible NQTL plan provisions that violate the MHPAEA.
- Recent DOL FAQs clarify additional disclosure requirements by which plan sponsors must abide.

The U.S. Department of Labor (DOL) recently issued guidance regarding certain group health plan terms that could violate the parity rules of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The DOL’s guidance sheds light for plan administrators to spot terms and conditions that may violate the MHPAEA. Violations of the MHPAEA can result in penalties of up to $100 per day per covered individual.

Background

The MHPAEA generally requires group health plans sponsored by employers with 50 or more employees (including all employees in a controlled group) on business days in the prior calendar year to ensure that financial (e.g., co-pays) and treatment (e.g., number of office visits) limits on MH/SUD benefits are no more restrictive than on medical or surgical benefits. But the law also imposes restrictions on non-quantitative treatment limits (NQTLs), which the DOL specifically targets in the recent guidance. In addition, it is helpful to note that DOL investigations routinely review plans for compliance with the MHPAEA, including NQTLs that may be imposed under the plan.

The MHPAEA forbids a plan from imposing an NQTL on MH/SUD benefits unless, under the plan’s written terms and day-to-day operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL are comparable to, and apply no more strictly than, those used in applying the limit to medical and surgical benefits.
What is a NQTL?

The MHPAEA has requirements for determining parity with respect to financial aspects (such as copays) and for treatment limitations (such as hospital stays), 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). The rules for financial requirements and QTLs are different from the rules for NQTLs.

The MHPAEA forbids a plan from imposing an NQTL on MH/SUD benefits unless, under the plan’s written terms and day-to-day operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL are comparable to, and apply no more strictly than, those used in applying the limit to medical and surgical benefits.

List of NQTLs

The final regulations provide the following list of NQTLs that must be in parity between a plan’s MH/SUD and medical or surgical benefits:

- 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.

Checklist of potentially non-compliant terms

Plan sponsors and practitioners had asked the DOL for further guidance regarding what specific plan terms could signify an unpermitted NQTL, so the DOL provided a helpful checklist. The checklist is not exhaustive, nor does the presence of one of the listed NQTLs automatically trigger liability. Rather, the DOL states that plan sponsors who identify one of the listed NQTLs should further review any processes, strategies, evidentiary standards, or other factors used in applying the NQTL so a plan sponsor will be able to provide evidence to the DOL to substantiate MHPAEA compliance.

The checklist includes the following categories and examples that can serve as a red flag that a plan may be imposing an impermissible NQTL.
Preauthorization & pre-service notification requirements

- Plan requires preauthorization for all mental health and substance use disorder services.
- Plan 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 inpatient mental health services require precertification.
- Plan requires pre-notification (or notification as soon as possible) for unscheduled MH/SUD admissions, and reduces benefits 50% for failing to provide pre-notification.
- 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 medical and surgical services.
- Plan’s medical management program (precertification and concurrent review) delegates its review authority to attending physicians for medical and surgical services but conducts its own reviews for MH/SUD services.
- Plan requires preauthorization every three months for pain medications prescribed in connection with MH/SUD conditions.
- Plan 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.

Fail-first protocols

- For coverage of intensive outpatient treatment for MH/SUD, the plan requires that a patient has not achieved progress with non-intensive outpatient treatment of a lesser frequency.
- For inpatient SUD rehabilitation treatment plan 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 requires that an individual first complete partial hospitalization treatment program.

Probability of improvement

- For residential treatment of MH/SUD, the plan requires the likelihood that inpatient treatment will result in improvement.
- Plan covers only services that result in measurable and substantial improvement in mental health status within 90 days.

Written treatment plan required

- For MH/SUD benefits, plan requires a written treatment plan prescribed and supervised by a behavioral health provider.
Plan 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 biopsychosocial evaluation. Plan needs to be reviewed at least once a week for progress.

Plan requires that an individual-specific treatment plan will be updated and submitted, in general, every six months.

**Other**

Plan 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.

Plan excludes residential level of treatment for chemical dependency.

Plan imposes a geographical limitation related to treatment for MH/SUD conditions but does not impose any geographical limits on medical and surgical benefits.

Plan requires that MH/SUD facilities be licensed by a state but does not impose the same requirement on medical and surgical facilities.

**Disclosure requirements**

The DOL recently released FAQs that include MHPAEA guidance and new disclosure requirements with which plan sponsors must comply. Any current or potential participant or enrollee (or a provider acting as such an individual’s representative) in a group health plan has the right to request from the plan sponsor a copy of the medical necessity criteria the plan employs.

The FAQs provide the above individuals have the right to receive from the plan, within 30 days of a request, the following documents:

- a Summary Plan Description (SPD) from an ERISA plan, or similar summary information that may be provided by non-ERISA plans;
- the specific plan language regarding the imposition of the NQTL (such as a preauthorization requirement);
- the specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that the NQTL will apply to this particular MH/SUD benefit;
- information regarding the application of the NQTL to any medical or surgical benefits within the benefit classification at issue;
- the specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which the NQTL will apply to any medical/surgical benefits within the benefit classification at issue; and
- any analyses performed by the plan as to how the NQTL complies with the MHPAEA.
Key takeaways

Plan sponsors of insured plans rely on carriers to ensure operational compliance with the MHPAEA and other federal mandates. Plan sponsors of self-funded plans often rely on their third party administrators (TPAs) to do the same. However, the DOL requires the plan sponsor – not the insurer or the TPA – to exercise its fiduciary duty and monitor third parties to ensure compliance with applicable laws. Therefore, unless a plan’s providers and TPAs have assumed fiduciary responsibility and contractually obligated themselves to adhere to the MHPAEA’s operational and disclosure requirements, the plan sponsor may be liable for any defects in plan design and administration.

In summary, sponsors of plans that cover MH/SUD benefits should closely examine and monitor their plans using the DOL’s recently released materials as a guide. Plan sponsors should also confirm in writing that carriers and TPAs are administering their plans and providing the required disclosures in compliance with the MHPAEA. In addition, benefit materials such as Evidences of Coverage (EOCs), which are typically provided to plan participants, should be reviewed to ensure that MH/SUD benefits, including any NQTLs, are described in accordance with the MHPAEA.

EPIC Employee Benefits Compliance Services
For further information on this or any other topics, please contact your EPIC benefits consulting team.

EPIC offers this material for general information only. EPIC does not intend this material to be, nor may any person receiving this information construe or rely on this material as, tax or legal advice. The matters addressed in this document and any related discussions or correspondence should be reviewed and discussed with legal counsel prior to acting or relying on these materials.