# Nonquantitative treatment limitations in the spotlight

Steve Melek, FSA, MAAA
Daniel Perlman, FSA, MAAA
Stoddard Davenport
Katie Matthews, ASA, MAAA

Milliman

When the interim final rules (IFR) of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) were implemented, there was much ambiguity surrounding the topic of nonquantitative treatment limitations (NQTLs). The final rules attempted to clarify some of this ambiguity; however, NQTLs continue to be a source of difficulty in attaining compliance for many plans. Now that a few years have passed since the implementation of the final rules, we can see examples of MHPAEA enforcement related to NQTLs and the types of NQTLs being investigated and settled.

The final rules state that any NQTL applied to behavioral disorders (mental health and substance use disorders) must be "comparable to, and applied no more stringently than" the comparable NQTL applied to medical/surgical benefits in the same benefit classification. Differences were allowed in the IFR in the event that "recognized clinically appropriate standards of care may permit a difference." However, that exception is not included in the final rules; it was determined to be confusing, unnecessary, and subject to potential abuse.

Eight specific examples of different types of NQTLs are provided in the rules, though this list is not comprehensive of all NQTLs imposed on mental health and substance use disorder benefits by plans and issuers:

1. Medical management standards
2. Prescription drug formulary design
3. Design of network provider tiers
4. Standards for provider admission to a network
5. Determination of usual, customary, and reasonable payment amounts
6. Step therapy protocols
7. Requirements to complete a course of treatment in order for benefits to be provided
8. Restrictions based on geographic location, facility type, provider specialty, or similar criteria

For NQTLs, the phrases "comparable to" and "applied no more stringently than" are not given exact definitions in the final rules. As we will see in cases presented here, determining NQTL compliance can be tricky; however, it is important to do so, as the penalty for noncompliant NQTLs is the same as that for quantitative treatment limitations: up to $100 per member per day. This can be a significant penalty for most health insurance issuers or employer plan sponsors.

## Parity task force report

On October 27, 2016, the White House Mental Health and Substance Use Disorder Parity Task Force (Task Force) released a report detailing the requirements of MHPAEA and the Patient Protection and Affordable Care Act (ACA), describing recent developments in parity and their impacts, and giving an overview of enforcement activities since implementation. The Task Force examined plans offered in fiscal years (FYs) 2010 to 2015.

The Task Force's report shows that a majority of parity violations have been related to NQTLs. Specifically, of the 171 violations identified for plans subject to MHPAEA, 59% of them were related to NQTLs.[1] The three most frequently violated NQTLs were:

- Broad preauthorization requirements on all mental health and substance use disorder treatments that were not required for medical/surgical treatments
- Written treatment plan requirements that only applied to behavioral health services
- Mental health or substance use disorder treatment conditional upon the likelihood of the patient succeeding without applying a similar requirement to medical/surgical treatment

1 White House Mental Health and Substance Use Disorder Parity Task Force (October 2016). Final Report. Retrieved April 26, 2017, from **https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.pdf**.

The Task Force also reported plan and issuer feedback requesting more guidance regarding compliance and NQTLs, specifically surrounding the following NQTLs:

- Preauthorization requirements
- Utilization review (especially concurrent and retrospective)
- "Fail first" or step therapies
- Provider reimbursement

Given the heavy penalty for being found noncompliant, it is important that plan sponsors and issuers gain a solid understanding of all NQTLs and how they are implemented for mental health and substance use disorder services in plan offerings. This year, as a result of the Task Force's efforts, the U.S. Office of Personnel Management will undertake another detailed review of NQTLs applicable to substance use disorder benefits, in particular.

## Department of labor enforcement actions in 2016

On January 11, 2017, the U.S. Department of Labor released a fact sheet summarizing its MHPAEA enforcement actions for FY 2016. The Employee Benefits Security Administration (EBSA) employs 460 investigators to review plans for compliance with ERISA and MHPAEA, and another 110 benefit advisers that provide education and compliance assistance regarding MHPAEA. During FY 2016, EBSA investigated 191 plans that were subject to MHPAEA, and cited 44 violations for noncompliance. Among them, 55% of violations were related to NQTLs.[2]

The fact sheet describes some of the important functions that EBSA benefit advisers have, including pursuing voluntary compliance on behalf of plan participants and beneficiaries. In some examples, investigations were sparked by inquiries from members of the public that had concerns about their health plans' implementations of parity. Benefit advisers were able to contact the health plans and provide education about how MHPAEA requirements applied to each plan. In some cases, the benefit advisers were able to obtain voluntary compliance and no further fines or enforcement actions were taken.

Some examples of the types of violations they responded to include the following:

- Requiring participants to complete a different course of treatment before residential treatment would be covered, even though this requirement did not apply in parity to medical benefits.
- Overly stringent prior authorization requirements or benefit exclusions, especially when in practice such requirements only exclude coverage for substance use disorder benefits.
- Requirements for written treatment plans for mental health and substance use disorder benefits, when no comparable requirements are applied to medical and surgical benefits.

Despite some plans being able to satisfy MHPAEA investigations with voluntary compliance, not all plans have been able to escape more significant enforcement actions.

## Other enforcement and settlements

As stated previously, the penalty for being found noncompliant with MHPAEA, whether for quantitative or nonquantitative treatment limitations, can be quite substantial. For any given health plan, the penalty alone may cost up to $100 per member per day. This does not include the cost of additional claims to be paid out to correct the parity noncompliance. As a result, the cost of being noncompliant can be a significant financial burden on health plans.

Since implementation of the final rules, there have been a number of legal settlements regarding NQTLs and MHPAEA. There have also been enforcement actions under similar state parity laws. One issuer was assessed $900,000 in penalties in addition to $250,000 of retroactive payments for previously denied behavioral health claims.[3] In a related case, another issuer was assessed $1.2 million in penalties in addition to over $31 million in reimbursement to members.[4] Another state issued fines against four insurers for a variety of violations of state parity law, including some related to preauthorization and claim denials.[5]

## What can plans do to ensure compliance?

To determine compliance of NQTLs with MHPAEA, a deep understanding of a health plan's operations and policies is necessary. Many of the NQTL rules deal with operations of the plan that might not be clearly communicated to members in the summary plan description, such as provider reimbursement rates. These types of NQTLs are particularly complicated for plans where the behavioral health benefits are administered by a different company from the one that administers medical/surgical benefits.

2 EBSA. Fact Sheet: FY 2016 MHPAEA Enforcement. Retrieved April 26, 2017, from https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2016.pdf.

3 New York State Office of the Attorney General (March 5, 2015). A.G. Schneiderman announces settlement with ValueOptions to end wrongful denial of mental health and substance abuse treatment services. Press release. Retrieved April 26, 2017, from https://ag.ny.gov/press-release/ag-schneiderman-announces-settlement-valueoptions-end-wrongful-denial-mental-health.

4 New York State Office of the Attorney General (July 9, 2014). A.G. Schneiderman announces settlement with Emblem Health for wrongfully denying mental health and substance abuse treatment for thousands of New York members. Press release. Retrieved April 26, 2017, from https://ag.ny.gov/press-release/ag-schneiderman-announces-settlement-emblem-health-wrongly-denying-mental-health-and.

5 Oregon.gov (March 2, 2017). State to fine 4 insurers involving mental health coverage. Department of Consumer and Business Services. Retrieved April 26, 2017, from http://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=1896.

Regarding medical management standards, it would be beneficial for plans to have written policies outlining exactly how medical management is performed, for both medical/surgical and behavioral health services. Equally important, plans must understand and monitor how the policy is applied in practice. Does the same policy result in claim denial rates of 5% for medical/surgical services but 50% for behavioral services? This could be indicative of a difference in how stringently the standards are applied and subject the plan to noncompliance risk.

Similarly, plans should have a consistent policy (and apply it consistently) for building provider networks and setting reimbursement rates. Do behavioral specialists receive reimbursement at Medicare rates while medical specialists receive reimbursement well above that level? Do patients face significantly more difficulty finding an in-network psychiatrist than finding cardiologists and oncologists in their geographic areas? If so, this could indicate more violations of an MHPAEA by an NQTL.

It is also important to carefully review requirements for behavioral health treatments as compared with medical/surgical treatments. Is the prescription drug formulary consistent for drugs used to treat behavioral conditions, as well as medical/surgical? Is there a specific course of treatment required for behavioral health benefits that doesn't exist for medical/surgical benefits? A common example of an NQTL violation we see regarding this is for smoking cessation therapies, which may be covered only for members actively participating in a smoking cessation class while a similar requirement is not required for medical/surgical conditions such as diabetes.

A thorough analysis of NQTL compliance requires an in-depth understanding of a plan's policies and the implementation of those policies. For plans with carved-out behavioral health benefits, it is crucial for the medical and behavioral organizations to communicate to understand each other's policies and standards and to ensure that they are applied in a comparable manner.

## Caveats

This briefing paper presents a summary of nonquantitative treatment limits (NQTLs) in relation to MHPAEA, based on the authors' review of available resources. This does not represent conclusive recommendations regarding NQTLs, this legislation, or legal advice. Milliman does not intend to benefit or create a legal duty to any recipient of this work.

**FOR MORE ON MILLIMAN'S PERSPECTIVE ON HEALTHCARE:**

Visit milliman.com/insight/healthcare
Visit our blog at healthcaretownhall.com
Or follow us at twitter.com/millimanhealth

Milliman

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

**CONTACT**

Steve Melek
steve.melek@milliman.com

Daniel Perlman
daniel.perlman@milliman.com

Stoddard Davenport
stoddard.davenport@milliman.com

Katie Matthews
katie.matthews@milliman.com