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For your information

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Further Guidance Issued on Nonquantitative Treatment Limitations under Mental Health Parity and Addiction Equity Act

DOL, Treasury, and HHS recently released FAQs that provide additional guidance on nonquantitative treatment limitations under the Mental Health Parity and Addiction Equity Act. The FAQs also address the question of what copayment can be applied to mental health/ substance use disorder benefits when a plan imposes higher copayments on specialist visits.

Background

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits group health plans (both self-funded and insured) from imposing any financial requirements or treatment limitations on mental health or substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations imposed on medical and surgical benefits. In February 2010, the Departments of Labor, Treasury, and Health and Human Services (collectively, the Departments) issued interim final regulations under MHPAEA that set out rules regarding the imposition of financial requirements (e.g., coinsurance or copayments), quantitative treatment limitations (e.g., limits on number of visits), and nonquantitative treatment limitations to mental health and substance use disorder benefits.

COMPLIANCE ALERT: Plan sponsors should review any nonquantitative treatment limitations, such as preauthorization requirements, imposed on mental health and substance use disorder benefits and confirm that they are comparable to, and not applied more strictly than, the nonquantitative treatment limits imposed on medical and surgical benefits. Any difference must be justified by reference to recognized clinically appropriate standards of care.

Nonquantitative treatment limitations are plan features that are not expressed numerically but may operate to limit the scope or duration of benefits for treatment, such as standards for determining medical necessity, preauthorization requirements, formulary design, determination of usual, customary and reasonable charges, and network standards for provider admission or reimbursement.

The regulations provide that a plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits unless "under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in applying the nonquantitative treatment limitation to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those applied to medical/surgical benefits" in the same classification. (For more information about MHPAEA classifications, see our March 2, 2010 For Your Information.)

MHPAEA FAQs

On November 17, 2011, the Departments issued "FAQs About Affordable Care Act Implementation (Part VII) and Mental Health Parity Implementation" (FAQs). The FAQ related to the Patient Protection and Affordable Care Act (PPACA) announced that group health plans and insurers would not have to provide the summary of benefits and coverage and uniform glossary until after final regulations are issued. (See our November 22, 2011 For Your Information.) The FAQs addressing mental health parity implementation consisted of five questions pertaining to nonquantitative treatment limitations and one pertaining to whether a plan can impose a specialist-level copayment on mental health and substance use disorder benefits.

The FAQs make it clear that the following practices violate MHPAEA:

- Requiring prior authorization from the plan's utilization reviewer for all mental health and substance use disorder benefits (or for all mental health/substance use disorder benefits in a particular classification) while not requiring prior authorization for all medical/surgical benefits (or all such benefits in a particular classification).
- Applying a nonquantative treatment limitation more strictly to mental health and substance use disorder benefits than to medical/surgical benefits. As an example of the improper application of a nonquantitative treatment limitation, the FAQ cites a situation in which preauthorization was required for all inpatient treatment, but inpatient medical/surgical benefits were routinely approved for seven days while inpatient treatment for mental health and substance use disorders were approved for only one day.

COMPLIANCE ALERT: Plan sponsors that have different utilization reviewers for medical/surgical benefits and mental health/substance use disorder benefits must make certain that the standards applied to mental health/substance use disorder benefits are not stricter than those applied to medical/surgical benefits.

The FAQs state that as long as any nonquantitative requirements imposed are based on recognized clinical standards of care and are applied consistently to both medical/surgical benefits and mental health and substance use disorder benefits, a plan complies with MHPAEA. In one example, the plan

considered the same wide range of factors (e.g., cost of treatment, variability in cost and quality, type or length of treatment) in developing its medical management techniques for both mental health/substance use disorder benefits and medical/surgical benefits; these techniques resulted in the requirement that prior authorization be obtained for some mental health and substance use disorder benefits and some medical/surgical benefits. Because comparable standards were used and were not applied more stringently to mental health/substance use disorder benefits, the plan complied with MHPAEA. In a second example, the plan applied a concurrent review to all inpatient care for which there were high levels of variation in length of stay. Although this resulted in twice as many mental health and substance use disorder conditions being subject to concurrent review as medical/surgical conditions, the Departments found no violation of MHPAEA because the standard was applied no more stringently to mental health/substance use disorder conditions than to other conditions.

Copayments for Mental Health/Substance Use Disorder Services

In the FAQs, the Departments also confirm that a plan can impose a higher specialist copayment on mental health/substance use disorders in a classification if the specialist copayment for medical/surgical benefits within that classification is the predominant copayment that applies to substantially all medical/surgical benefits within a classification. Note that that the "substantially all" test" can be applied separately to office visits. (See our July 6, 2010 For Your Information.)

COMPLIANCE ALERT: A plan sponsor that wants to impose a special copayment on mental health or substance use disorder benefits has to make certain that at least two-thirds of all medical/surgical benefits in the classification are subject to a copayment and that the specialist copayment applies to more than 50% of all medical/surgical benefits paid within that classification that are subject to a copayment.

Conclusion

The FAQs provide welcome additional clarification regarding nonquantitative treatment limitations and copayments for mental health and substance use disorder services. Buck's consultants are available to assist you in determining if your plan's nonquantitative treatment limitations comply with the interim final regulations and FAQs.

Buck Can Help

- Review plans to identify nonquantitative treatment limitations and determine whether they comply with MHPAEA
- Determine whether a plan can apply a specialist copayment to mental health and substance use disorder benefits