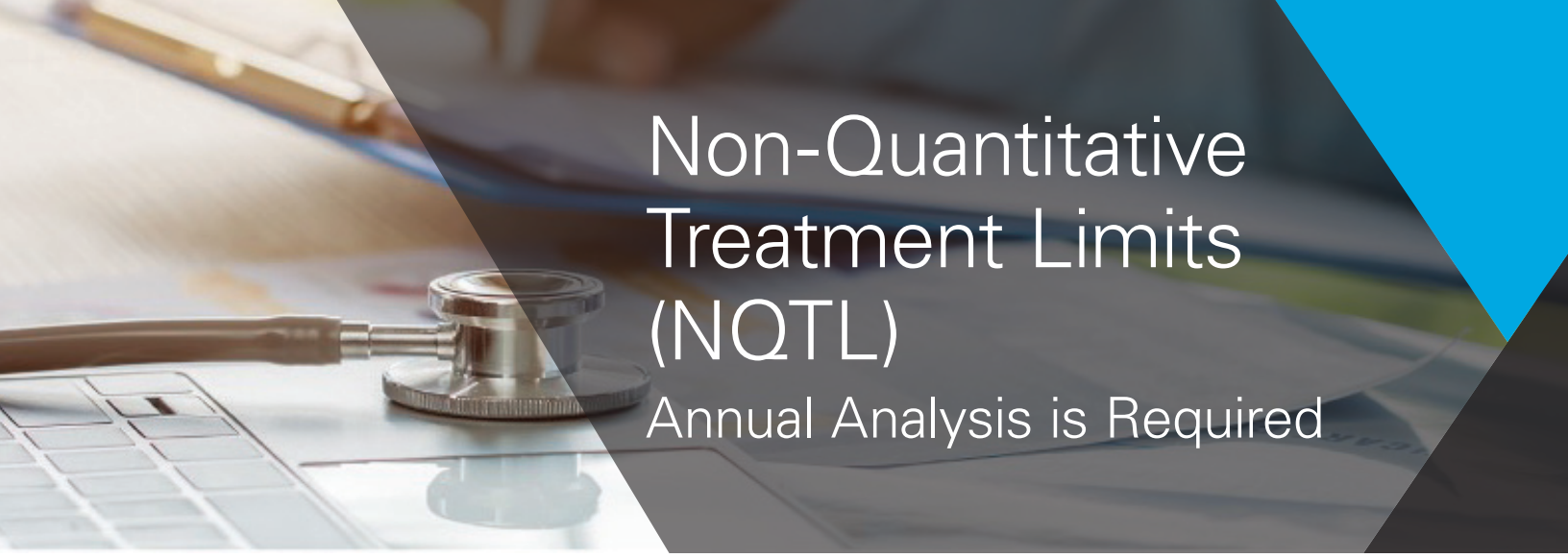

Non-Quantitative Treatment Limits (NQTL)

Annual Analysis is Required

June 10, 2022

All group health plan sponsors of both fully-insured and self-funded plans must consider the requirements of the Mental Health Parity and Addiction Equity Act and the Patient Protection and Affordable Care Act (ACA). The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents large group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. The ACA then impacts smaller employers by requiring coverage of mental health and substance use disorder services as one of the ten Essential Health Benefit (EHB) categories.

These rules were modified and enhanced by the Consolidated Appropriations Act (CAA) of 2021, which will require group health plans and health insurance carriers to perform comparative analyses to demonstrate compliance with mental health parity requirements. The results of the testing will be provided to the Department of Labor (DOL), Health and Human Services (HHS) and state agencies upon request. These rules went into effect on February 10, 2021. Agencies will be required to audit plans annually. Guidance is required to be issued by these agencies within 18 months of the Consolidated Appropriations Act (CAA) being enacted. Plan participants, beneficiaries and enrollees will be permitted to request copies of the comparative analysis and plan sponsors will be required to provide the information under ERISA.

Action Plan: Employers should now be actively working on the annual analysis of their group health plans. Fully insured plan sponsors should reach out to their carriers to determine how the carrier will be handling the requirements. Self-funded plan sponsors should put an action plan in place to complete the testing. A small number of third-party administrators are offering this service to their self-funded clients. Additionally, reputable vendors are now offering these services. Alera Group strongly recommends that employers sponsoring self-funded health plans complete this analysis in 2022 and annually thereafter in the event they are audited by the Department of Labor or a plan participant requests a copy of the analysis.

The DOL had previously issued warning signs for plan sponsors to review in determining compliance with the parity rules. In April of 2021, they released an FAQ on these new requirements. The DOL has also updated its self-compliance tool for plan sponsors. The DOL has been increasing the number of audits in this space and all employers at risk of receiving a request, particularly those who are already being investigated by the Department of Labor on unrelated benefits or wage and hour issues.

Within each of the MHPAEA's six classifications, the financial requirements and treatment limitations that apply to mental health or substance abuse disorder benefits must be compared to the financial requirements and treatment limitations that apply to medical/surgical benefits in that same classification. If a financial requirement or treatment limitation does

not apply to "substantially all" of the medical/surgical benefits in that classification, it cannot be applied to mental health or substance abuse disorder benefits in that classification. "Financial requirements" include deductibles, copayments, coinsurance and out-of-pocket expenses, but exclude an aggregate lifetime limit and an annual limit. Additional NQTLs are held to the same parity.

The MHPAEA notably does not require equitable lifetime limits or annual limits, which raises the question as to whether an annual lifetime or dollar limit on particular therapies would be permissible. The code does require that plans without an annual limit on medical/surgical benefits cannot impose an annual limit on mental health benefits. By virtue of the ACA, few plans today have annual or lifetime limits. Mental health benefits do not have to be covered by plans that are not subject to EHB requirements, however, once a plan covers an EHB, it is subject to the full EHB rules. One important EHB rule to remember is that the ACA prohibits annual or lifetime dollar limits on EHBs. Any plan (including large, grandfathered or self-funded plans) that chooses to offer a benefit that falls into an EHB category is then subject to the same prohibition on annual or lifetime dollar limits.

The substantially all/predominant test outlined in the statute must be applied separately to six classifications of benefits: inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network; emergency; and prescription drug. Sub-classifications are permitted for office visits separate from all other outpatient services, as well as for plans that use multiple tiers of in-network providers.
The regulation requires that all cumulative financial requirements, including limits, deductibles and out-of-pocket limits, in a classification must combine both medical/surgical and MH/SUD benefits in the classification.
The regulation distinguishes between quantitative treatment limitations and NQTLs. • Quantitative treatment limitations are numerical, such as visit limits and day limits. • NQTLs (NQTLs) include but are not limited to medical management, step therapy and pre-authorization.
A group health plan or coverage cannot impose a NQTL with respect to MH/SUD benefits in any classification 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 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.
The regulation provides that all plan standards that limit the scope or duration of benefits for services are subject to the NQTL parity requirements. This includes restrictions such as geographic limits, facility-type limits and network adequacy.

Under the requirements set forth by the CAA, plans and issuers should ensure that NQTL comparative analyses are sufficiently specific, detailed and reasoned to demonstrate whether the processes, strategies, evidentiary standards or other factors used in developing and applying an NQTL are comparable and applied no more stringently to MH/SUD benefits than to medical/surgical benefits. Regulators have been very clear that a general statement of compliance, coupled with a conclusory reference to broadly stated processes, strategies, evidentiary standards or other factors will be insufficient to meet this statutory requirement.

The CAA testing will require plans to be able to show:

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical or surgical benefits to which each such term applies in each respective benefits classification;
2. The factors used to determine that the NQTLs will apply to MH/SUD benefits and medical or surgical benefits;

3. The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and medical or surgical benefits;
4. The comparative analyses demonstrate that the processes, strategies, evidentiary standards and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than, the processes, strategies, evidentiary standards and other factors used to apply the NQTLs to medical/surgical benefits in the benefits classification; and
5. The specific findings and conclusions reached by the plan or issuer, including any results of the analyses indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.

Analysis under the CAA must include discussion on the following:

1. A clear description of the specific NQTL, plan terms and policies at issue.
2. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.
3. Identification of any factors, evidentiary standards or sources or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
4. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.
5. The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
6. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions and the qualifications of the decision maker(s).
7. If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.
8. A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.
9. The date of the analyses and the name, title and position of the person or persons who performed or participated in the comparative analyses.

Plans should have the following to support their NQTL testing:

Records documenting NQTL processes and detailing how the NQTLs are being applied to both medical/surgical and MH/SUD benefits to ensure the plan or issuer can demonstrate compliance with the law, including any materials that may have been prepared for compliance with any applicable reporting requirements under state law.	Any documentation, including any guidelines, claims processing policies and procedures or other standards that the plan or issuer has relied upon to determine that the NQTLs apply no more stringently to MH/SUD benefits than to medical/surgical benefits. Plans and issuers should include any available details as to how the standards were applied, and any internal testing, review or analysis done by the plan or issuer to support its rationale.
Samples of covered and denied MH/SUD and medical/ surgical benefit claims.	Documents related to MHPAEA compliance with respect to service providers (if a plan delegates management of some or all MH/SUD benefits to another entity).

There are four areas of critical focus regarding NQTL enforcement at this time:

Prior authorization requirements for in-network and out-of-network inpatient services	Concurrent review for in-network and out-of-network inpatient and outpatient services
Standards for provider admission to participate in network, including reimbursement rates	Out-of-network reimbursement rates (plan methods for determining usual/customary/reasonable charges)

Consequences of non-compliance: if federal regulators do not receive sufficient NQTL testing information, they will direct the plan to submit a more responsive request. If the plan is not in compliance with the MHPAEA, they must detail how they will bring the plan into compliance and submit additional analysis showing compliance within 45 days of failing. If the plan is unable to bring the plan into compliance at that point, they will have seven days to notify plan participants that coverage is non-compliant and federal regulators will report the plan to the state where the employer is located or licensed to do business. Failure to provide the required analysis is likely to trigger the $100 a day penalty per plan participant.

Dickerson Insurance Services
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