

Nonquantitative treatment limitation analyses to assess MHPAEA compliance: A uniform approach emerges

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The Final Rules of the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) contain detailed requirements for health insurance plans and issuers in terms of how their designs and applications of “nonquantitative treatment limitations” (NQTLs) for mental health and substance use disorder (MH/SUD) benefits must compare to those for medical and surgical (M/S) benefits. NQTLs are plan features or protocols that, while not expressed numerically like “financial requirements” and “quantitative treatment limits” set forth in the Final Rules, nonetheless limit the scope or duration of benefit coverage in significant ways.

Milliman has completed a considerable amount of MHPAEA compliance testing for our clients, focusing mostly on financial requirements and quantitative treatment limits (QTLs). That testing requires understanding the plan’s or issuer’s definition of MH/SUD benefits, mapping the M/S benefits into the six allowed benefit classifications under the Final Rules,¹ and building actuarial cost models for performing the “Substantially All” and “Predominant” tests for each benefit classification for each of the plan’s or issuer’s health products. While there has been much less progress on NQTL compliance testing to date, this is changing rapidly as more state departments of insurance and other regulators and agencies turn their MHPAEA compliance focus onto NQTL testing. Over the past year, Milliman has been retained by a number of state agencies to advise them on appropriate methods by which to conduct parity compliance analyses and audits for NQTLs.

KEY TERMS FOUND WITHIN THE NQTL TEST

There are several groups of key terms found within the NQTL test defined at 45 CFR 146.136(c)(4)(i):

A group health plan (or health insurance coverage) 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 (or health insurance coverage) **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.

¹ The six classifications of benefits are (1) Inpatient, in-network, (2) Inpatient, out-of-network, (3) Outpatient, in-network, (4) Outpatient, out-of-network, (5) Emergency care, and (6) Prescription drugs. See <https://www.govinfo.gov/content/pkg/FR-2013-11-13/pdf/2013-27086.pdf>.

The first group of key terms includes “processes, strategies, evidentiary standards, and other factors” used in applying an NQTL to MH/SUD and M/S benefits. The second group of key terms requires that these factors be “comparable to and are applied no more stringently” for MH/SUD benefits than they are for M/S benefits. The third group of key terms is “as written and in operation” and the requirement that *both of these components* for any NQTL must be tested. Many state regulators are moving toward the requirement that plans or issuers perform a quantitative “outcomes data” analysis of NQTLs, showing MH/SUD *as compared to* M/S, rather than simply providing a narrative or statement that such limitations, both as written and in operation, are comparable and applied no more stringently.

The phrase “applied no more stringently” was included to ensure that any processes, strategies, evidentiary standards, or other factors that are comparable on their face as written are actually applied in the same manner to M/S benefits and to MH/SUD benefits. For example, claim administrators typically have discretion to approve certain types of benefits for treatment based on medical necessity. If that discretion is routinely used to approve M/S benefits, but frequently used to deny MH/SUD benefits, the review process and the medical necessity standards may be considered to be applied more stringently, in operation, to MH/SUD benefits than to M/S benefits. *The use of discretion in this manner would likely violate the parity requirements for NQTLs.* In addition, because many processes and strategies for applying NQTLs evidence themselves in terms of quantitative measures, outcomes data becomes very important in conducting comparative analyses, particularly for “in operation” comparisons.

Guidance from federal regulators provides that, in order to determine whether an NQTL is applied more stringently in operation, it is important to analyze quantitative “outcomes data,” such as rates of denials, for MH/SUD *as compared to* M/S benefits. The [federal MHPAEA self-compliance tool](#) issued by the federal regulators, as more fully described below, includes the following guidance in this regard: “[S]tandards for provider admission to participate in a network are NQTLs because such standards are treatment limitations that typically are not expressed numerically [citations omitted]. Nevertheless, these standards sometimes rely on numerical standards, for example, **numerical reimbursement rates.**” (Self-compliance tool at p.13). The Compliance Tips provided in the self-compliance tool include: “Determine how much discretion is allowed in applying the NQTL and whether such discretion is afforded comparably for processing MH/SUD benefit claims and medical/surgical benefits claims”; and “[d]etermine **average denial rates and appeal overturn rates** for concurrent review and assess the parity between these rates for MH/SUD benefits and medical/surgical benefits.” The federal regulators note that: “[R]ates of denials may be reviewed as a warning sign, or *indicator* of a potential operational parity noncompliance.” Thus, NQTLs that result in disparate outcomes “should be carefully examined to ensure that the [NQTL]...is not being applied more stringently to MH/SUD benefits than to medical/surgical benefits in operation.” (Self-compliance tool at p. 17).²

² Federal regulatory guidance in the form of FAQs issued prior to the MHPAEA self-compliance tool are consistent with the need for quantitative data and analyses. See, FAQs About ACA Implementation (Part VII) and Mental Health Parity Implementation issued Nov. 17, 2011, **Q3**; FAQs About ACA Implementation Part 34 and Mental Health and Substance Use Disorder Parity Implementation issued Dec. 27, 2016, **Q5, Q6, Q7, Q8**; FAQs About ACA Implementation Part 31, Mental Health Parity Implementation, and Women’s Health and Cancer Rights Act Implementation issued on April 20, 2016, **Q9**.

A SIX-STEP APPROACH TO DOCUMENTING NQTL COMPLIANCE

How can a health plan systematically evaluate its NQTLs for parity compliance? The [federal MHPAEA self-compliance tool](#), as discussed above, was issued by the U.S. Departments of Labor, Health and Human Services (HHS), and Treasury in April 2018,³ and includes what can be translated to a series of steps for determination of NQTL compliance. See also the [Six-Step Parity Compliance Guide for NQTLs](#), which was published by leading industry advocacy organizations prior to issuance of the federal MHPAEA self-compliance tool. This six-step guide covers 19 different NQTLs and provides extensive illustrations. A description of the six steps follows:

Step 1: Identify the specific plan or insurer language regarding the NQTL and describe all services to which it applies in each respective benefits classification.

Step 2: Identify all the factors that were used to determine that it is appropriate to apply the NQTL to MH/SUD benefits, and the source for each factor. Many factors rely on “measures” that can be expressed quantitatively, and thereby require a quantitative evidentiary standard. Examples of such factors include:

Utilization review factors: Claims associated with excessive utilization; high levels of variation of length of treatment; a high percentage of fraud; high variability in cost per episode of care.

Network access and reimbursement factors: Geographic access standards; provider supply and demand; out-of-network utilization rates.

Step 3: Identify the evidentiary standard used to define each factor identified in Step 2 and any other evidence relied upon to design and apply the NQTL. Some examples of evidentiary standards to define factors are:

Excessive utilization: Two standard deviations above average utilization per episode of care.

High variation in length of treatment: Claim data showed 25% of patients stayed longer than two standard deviations from the median length of stay.

Fraud and abuse: Greater than 5% of claims associated with fraud over previous three plan years.

High variability in cost per episode of care: Two standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period.

Provider scarcity: Average wait times for appointments exceeding 30 days triggers network admission standard adjustment.

Step 4: Provide the comparative analyses used to conclude that design and application of the NQTL, *as written*, is comparable to and applied no more stringently to MH/SUD benefits than to M/S benefits. “As written” processes and standards may include utilization management manuals, utilization review criteria, specific criteria hierarchy, initial screening scripts and algorithms, stipulations about submitting written treatment plans, utilization management committee notes, descriptions of processes for identifying and evaluating clinical issues and utilizing performance goals, reimbursement rates for the same Current Procedural Terminology (CPT) codes and/or for similar services, etc.

³ Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA). Retrieved September 24, 2019, from <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf>.

Step 5: Provide the comparative analyses used to conclude that the processes and strategies used to apply the NQTL, *in operation*, are comparable to and applied no more stringently to MH/SUD benefits than to M/S benefits. “In operation” processes and strategies may include peer clinical review, telephonic consultations with attending providers, consultations with expert reviewers, clinical rationale used in approving or denying benefits, interpretation of benefit plan language in applying exclusions from coverage, selection of information deemed reasonably necessary to make a medical necessity determination, adherence to utilization review criteria and criteria hierarchy, professional judgment and discretion used in tandem with or in lieu of utilization review criteria, actions taken when incomplete information is received from attending providers, and requests for patient medical records. Such processes and strategies may also include adjustments to baseline reimbursement rates, handling or screening of provider requests for admission to the network, etc. In order to properly assess these “in operation” processes, quantitative “outcomes data” analyses are essential.

Step 6: Detailed summary explanation of how the analyses of all the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to M/S benefits have led the plan or insurance issuer to conclude compliance with MHPAEA.

This six-step approach provides a logical and structured set of criteria for comparative analyses for the testing of NQTL compliance. Several state insurance departments are incorporating these steps into their parity compliance and review processes. In addition to the federal adoption of this methodology in the MHPAEA self-compliance tool, state legislatures in Delaware, the District of Columbia (D.C.), Colorado, Illinois, New Jersey and Tennessee have codified this approach to compliance in legislation passed in 2018 and 2019. Furthermore, a December 2018 amendment to the New York State parity law requires detailed reporting of NQTL “outcomes data” for MH/SUD as compared to M/S, with such data for each plan, insurer and/or managed behavioral care organization to be made available to the public. Finally, as noted above, Milliman has worked with a number of state insurance departments to help them understand the various forms of QTL and NQTL compliance testing, both during premarket policy form and rate reviews *and* post-market field audits.

The six-step methodology places the burden of demonstrating NQTL compliance *on health plans, as well as on health insurance issuers, who are often also third-party administrators (TPAs)*, and not on federal or state regulators. This health plan and insurance issuer NQTL compliance responsibility is what the MHPAEA Interim and Final Rules have always intended. It not only ensures uniformity of response to a wide range of plan and issuer policies and practices, but also greatly eases the administrative burden for state regulators to initiate review and compliance evaluation.

Given the trends we have observed in the enforcement of MHPAEA, we recommend that state departments of insurance, federal agencies, and any private entities developing and providing compliance testing and auditing require the analyses and documentation described above for each NQTL that is identified for a plan or issuer of health insurance under review.

THE DISPARATE RESULTS “DOCTRINE”

In late 2017, Milliman completed a national analysis of two large claim databases commissioned by the Mental Health Treatment and Research Institute LLC, a not-for-profit subsidiary of the Bowman Family Foundation (MHTARI). (See the [2017 Disparities Research Report](#).) We analyzed two different NQTLs by evaluating detailed

outcomes claim data: out-of-network use rates (a network adequacy measure) and provider reimbursement rates. Member access to network providers for the behavioral health treatment they need is a key tenet of the parity law. The quantitative, claim data-driven comparative analysis between M/S and MH/SUD benefits we conducted found large disparities in virtually all states, with MH/SUD out-of-network use averaging *three to five times* higher than M/S out-of-network use. In some states, the disparity was *10 times* higher or more. With respect to the quantitative comparative analysis of actual provider payment levels for professional services, we found that M/S providers were paid on average about 20% more than MH/SUD providers for outpatient professional services, even for the same evaluation and management (E&M) billing codes. In some states, the reimbursement disparity was 50% or more. These are examples of essential types of comparative analyses of NQTLs for the *in operation* component of the NQTL rule.

For these two types of NQTLs, as with all NQTLs, different types of illnesses or injuries may require different review, as well as different care. The acute versus chronic nature of a condition, its complexity and/or the treatment involved, and other factors may affect the review of NQTL comparability as written. However, the processes, strategies, evidentiary standards, and other factors used in applying these limitations must generally be applied in comparable and no more stringent manners. In addition to analyses of these factors, in accordance with the six-step approach, the existence of disparate results (e.g., differences in out-of-network use rates, provider reimbursement levels, and claim denial rates) would warrant further, more careful examination of the NQTL for potentially more stringent application, in operation. While disparate outcomes alone do not dictate that a parity violation has occurred, notably disparate outcomes are an indicator of operational parity noncompliance per the federal MHPAEA self-compliance tool. Of course, the greater the disparity of outcomes between M/S as *compared to* MH/SUD, the more likely that a comprehensive operational audit will show parity noncompliance.

THE MODEL DATA REQUEST FORM AND BEST PRACTICE EXAMPLES

Employers generally must rely on their health insurance plans or TPAs to provide MHPAEA compliance documentation of fully insured and self-insured plans. As a public service, MHTARI has funded the development of a series of tools for measuring and addressing network access disparities, including a [Model Data Request Form](#) (MDRF, see Appendix A hereto) and [best practice examples](#) (see Appendix B hereto). The MDRF was designed for and has been used by both individual employers and employer coalitions, although the definitions and analytic approach could be used by multiple entities, including regulators. The best practice examples were designed to assist insurers, TPAs, regulators and private entities in how to conduct compliant NQTL analyses, testing, and documentation.

The MDRF is a targeted, quantitative, “fill in the blanks” tool, developed with input from Milliman and several other organizations that are very familiar with concerns related to inadequate access to in-network care and parity compliance. The MDRF contains instructions and questions that employers can send to their TPAs (or consultants) to obtain meaningful data reporting from them with respect to four key NQTLs: network adequacy (out-of-network use), provider reimbursement rates, claim denial rates, and network provider directory accuracy. Using the MDRF allows employers to examine these four key NQTLs and better understand the experience of their employees when seeking to access MH/SUD benefits as compared to M/S benefits, assess the adequacy of their TPAs’ MH/SUD provider networks, request improvements if deemed necessary, and obtain detailed data

sets that allow for consistent reporting on key network access issues. These data sets are in line with those used by Milliman and the National Alliance of Healthcare Purchaser Coalitions' eValue8 "score cards" regarding MH/SUD insurance coverage.

Tools such as the MDRF and the best practice examples can be helpful additions to the work needed for determination of MHPAEA compliance by all interested stakeholders. The MDRF helps to standardize the data request and review process, which is an important element of performing effective comparative reviews and analyses of NQTLs.

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