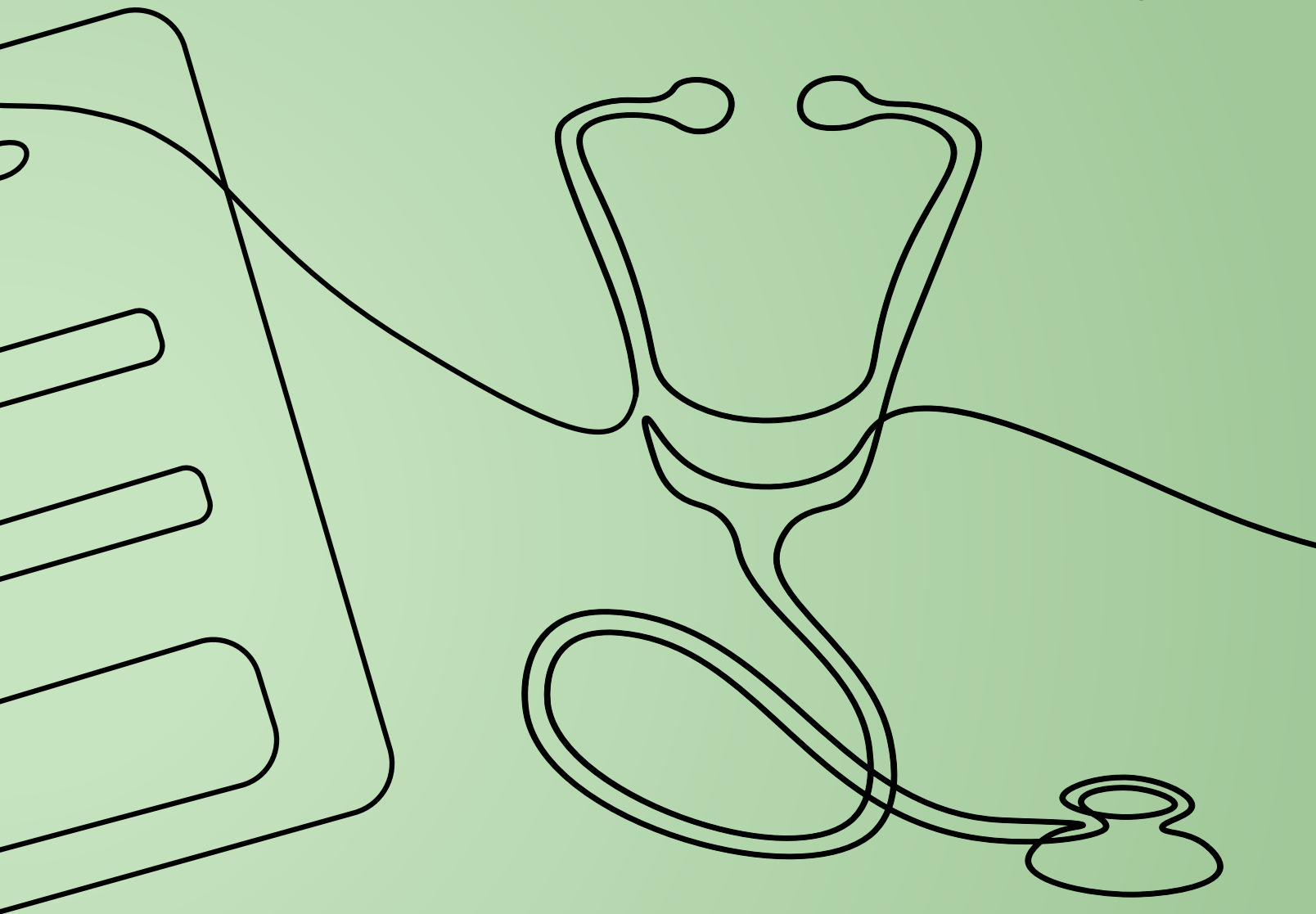
# Mental Health Parity Compliance:

*by* | **Marissa Rufo** and **Rebecca Wilen**

benefits MAGAZINE

# Tips for NQTL Testing



Testing a health care plan's nonquantitative treatment limitations (NQTLs) can be a confusing part of complying with mental health parity regulations. The authors describe the requirements and review common areas of noncompliance.

The Mental Health Parity Act of 1996 is still considered one of the most historic and pivotal laws in modern benefits compliance and was intended to greatly increase the public's access to mental and behavioral health services. The purpose of the act was "to provide for parity for mental health benefits under group health plans,"[1] which would be achieved through rules on lifetime and annual benefit limits. Since its passing in 1996, a string of laws and regulations have come into effect with the same purpose of improving access to mental health benefits, a category of benefits compliance now broadly referred to as mental health parity compliance.

Three other laws enacted since have further expanded mental health parity.

1. **The Mental Health Parity and Addiction Equity Act (MHPAEA)** was passed in 2008 and required that any financial and treatment-related limitations imposed on mental health or substance use disorder (MH/SUD) benefits could not be more restrictive than those applicable to medical and surgical (M/S) benefits. MHPAEA added a testing requirement for group health plans and included SUD benefits under the umbrella of benefits to be offered on substantially the same terms as M/S benefits in group health plans.
2. **The Affordable Care Act (ACA)** also amended the application of MHPAEA to apply to student health plans and non-federal governmental plans in addition to private group health plans. These groups were originally exempt from the mental health parity compliance regulations.
3. **The Consolidated Appropriations Act of 2021 (CAA21)** includes enforcement of quantitative treatment limitations (QTLs) and nonquantitative treatment limitations (NQTLs) testing within a bulky compliance bundle to further hammer home their goals. Congress included annual reporting requirements from the Departments of Labor (DOL), Health and Human Services and the Treasury as well as the Centers for Medicare and Medicaid Services (CMS) to monitor and evaluate the implementation of mental health parity regulation and enforcement.

Since the passing of CAA21, the Departments have consistently released guidance for the often-confusing testing requirements related to mental health parity compliance. This article will review the testing requirements, describe common NQTL mistakes and offer strategies for addressing them.

## takeaways

- Since the passage of the Mental Health Parity Act of 1996, a string of laws and regulations have come into effect with the same purpose of improving access to mental health benefits. These laws include the Mental Health Parity and Addiction Equity Act (MHPAEA), the Affordable Care Act (ACA) and the Consolidated Appropriations Act of 2021 (CAA21).
- Under CAA21, plans must test both their quantitative treatment limitations (QTLs) and their nonquantitative treatment limitations (NQTLs) to ensure that the plan is not subjecting mental health and substance use disorder (MH/SUD) benefits to greater restrictions than those implemented on medical and surgical (M/S) benefits.
- Insurance carriers often complete mental health parity testing for fully insured plans, but self-insured plans must complete their own testing. Challenges for self-insured plans include having multiple plan vendors to collect information and a need to get specific documentation for how their plans operate from their vendors.
- Common areas of NQTL noncompliance include provider network adequacy, out-of-network reimbursement rates and utilization management techniques.

## Testing Requirements for Compliance

The two testing requirements for mental health parity compliance have often left plan sponsors confused and unsure of how to move forward toward better plan compliance.

Plans are required to test both their QTLs and NQTLs to ensure that the plan is not subjecting MH/SUD benefits to greater restrictions than those implemented on M/S benefits.

Plans must compare the limitations on MH/SUD benefits against the limitations on M/S benefits for benefits in the following six categories.

1. Inpatient in-network care
2. Inpatient out-of-network care
3. Outpatient in-network care
4. Outpatient out-of-network care
5. Emergency care
6. Prescription drug benefits

If the limitations are substantially similar and no more restrictive, then the benefits could be considered "in parity."

### *Quantitative Treatment Limitation(s) Testing*

QTLs are financial and numerical limitations, including the following.

- Deductibles
- Out-of-pocket maximums
- Copays
- Coinsurance
- Day/visit limitations expressed numerically

Plans must analyze data using the "substantially all" test, which means looking at the QTLs applied to substantially all M/S benefits in one of the six categories and determining the acceptable predominant level of limitation that can be applied to MH/SUD benefits for the plan to be considered in parity.

***Nonquantitative Treatment Limitation(s) Testing***

NQTLs are non-numerical limitations, including the following.

- Medical necessity reviews
- Prior authorizations (and other utilization management categories)
- Pharmacy limitations
- Provider network admission limitations

While this list is not exhaustive, it helps to illustrate the complexity of NQTL analyses. Instead of testing plan spending and numerical data, NQTLs must be analyzed using a two-prong test that looks at the NQTL as written as well as in operation.

The following discusses some common NQTL-related mistakes that lead to parity issues and provides strategies plans can implement to increase their chances of being considered in parity during NQTL testing.

## Provider Network Adequacy

Ensuring that group health plan networks have an adequate number of in-network MH/SUD service providers is one of the most important and often misunderstood NQTLs that plans analyze. The challenge in complying with this requirement—and the DOL and the other Departments have conceded this—is that changes to network adequacy and provider options are often outside the plan's control. When the plan completes NQTL testing, it may find that it has network adequacy issues, but its ability to improve that parity problem may be limited, for example, if there is a shortage of providers.

***Testing and Standards***

Outside of an NQTL analysis, the plan's network vendor(s) should assess network adequacy on a consistent

### Plan Funding and Testing

Whether a plan is fully insured or self-funded does not alter the legal responsibility to ensure mental health parity compliance. However, in practice, there is a vast difference in testing responsibility. Carriers will often complete mental health parity testing for fully insured plans. In this case, the plan sponsor should make sure that it receives a copy of any applicable documentation related to the testing to meet its compliance responsibilities.

Sponsors of self-insured plans, including level-funded plans, must complete their own testing. This is often a lengthier process since self-funded plans typically have multiple plan vendors to collect information from to complete testing. In addition, self-insured plans often deviate from their vendors' standard plan design and need documentation specific to how their plan is operating.

Plans must complete testing of QTLs and NQTLs regularly to be considered in complete compliance. While the statutory language does not impose an annual testing requirement, similar to other benefits compliance auditing measures, guidance from the Departments refers to having "fresh" reports. The Departments have held plans under audit accountable for performing MHPAEA testing with up-to-date data and relevant plan information, a requirement that lends to a regular cadence of plan testing. Whether plans perform this testing annually or bi-annually may be up to their ability to perform such testing in a timely manner. The requirement of NQTL testing has been the most misunderstood aspect of this testing since it became enforceable in 2021. In the years since the enactment of MHPAEA and the CAA21 requirement to test NQTLs for mental health parity, the Departments have focused on some commonly found impermissible NQTLs through their audits of group health plans.

A recent report from the Departments said that some of the treatment limitations commonly found for MH/SUD benefits include exclusions of specific treatments for covered mental health conditions and SUDs, disparate ways of determining reimbursement rates for MH/SUD providers compared with M/S providers, plan practices that may serve as barriers that prevent MH/SUD providers from joining a plan's network, and stricter prior authorization or medical necessity reviews for MH/SUD coverage.*

**MHPAEA Comparative Analysis Report to Congress*. July 2023. Page 16.

basis—at least once per year. This is often achieved through two numerical criteria established and relied upon by the National Committee for Quality Assurance (NCQA) and CMS, which have established standards for network adequacy. However, the carrier and plan networks may adjust these standards within reason.

NCQA and CMS network standards rely primarily on the following two parameters for network adequacy testing.

1. **Availability of practitioners:** This is generally represented by a provider-to-participant ratio and will vary based on provider specialty and geographic area (urban, suburban, rural).
2. **Accessibility of practitioners:** This is based on the physical time and distance from plan participants to practitioners, as well as potential wait times for appointments.

In addition to these commonly used standards, plan vendors often also rely upon plan participant feedback in the form of surveys and/or complaints to determine whether individuals enrolled in their plans have access to enough service providers across all categories of service.

If NQTL testing shows that the plan has network adequacy issues in relation to parity, plan sponsors can take some steps to establish evidence of compliance if they were to come under audit. Regulators and enforcement auditors will expect to see what, if any, additional steps the network and plan sponsor are taking to fill any gaps in coverage. Offering incentives, such as higher contracted in-network reimbursement rates, to practitioners within key service areas to join the network is one possible step. Offering an in-network telehealth option is another strategy for improved compliance, while not a direct fix for plan network adequacy issues. Telehealth may not provide all the missing in-network services the plan requires, but it demonstrates the plan's efforts to attain better access to in-network providers for plan participants.

### *Analyzing Out-of-Network Utilization*

How often plan participants utilize out-of-network providers for MH/SUD services versus M/S services is an indication of not only a parity issue, but it may also indicate network adequacy concerns. Plans can confirm this by analyzing out-of-network utilization rates, data and policies. When analyzing plan data for NQTL compliance, the plan should compare the number of out-of-network claims with the number of in-network claims for the same category of services.

For example: Consider a plan that has a total of 1,000 in- and out-of-network inpatient M/S claims, and 20 are out-of-network claims. The same plan has a total of 100 in- and out-of-network inpatient MH/SUD claims, and ten of those claims are out of network. In this scenario, the data shows that a higher percentage of out-of-network claims for MH/SUD benefits than M/S benefits (10% and 2%, respectively). This is likely an indication of a lack of accessible providers within the network. A deeper dive into those claims and where they are originating from may indicate that providers are available to add within the network service area. It may also identify facilities and/or named providers that the plan may want to initiate direct contracting with if those facilities and/or providers are unable or unwilling to join the plan's selected network vendor.

### *Rate Exceptions*

The final indication that the plan may have network adequacy issues would be data showing that the plan and/or network vendors are offering in-network rate exceptions consistently for specific facilities or providers. Carriers and network providers often allow in-network rate exceptions when specific benefit providers are not available to plan participants within a designated geographic service area (generally around 50 miles). Reviewing any of the trends in rate exceptions and claims data will indicate where the plan likely has adequacy concerns by facility or provider type within the network itself.

## Out-of-Network Reimbursement Rates

Out-of-network reimbursement rates are another common NQTL that directly correlate with out-of-network usage between MH/SUD and M/S benefits. Having out-of-network reimbursement rates that are not in parity is an indication of not only a parity concern but possibly an even larger provider type reimbursement rate issue.

The first step in understanding an out-of-network reimbursement rate NQTL is who is responsible for setting and processing out-of-network reim-

## learn more

**Online Resource**
**Workplace Mental Health Toolkit**
Visit *www.ifebp.org/toolkits* for more information.

bios

**Marissa Rufo** is a compliance advisor, regulatory affairs, and subject matter expert at MZQ Consulting, LLC, a benefits compliance and Affordable Care Act reporting firm in Pikesville, Maryland. Her legal background focused on litigation including broad civil litigation, personal injury, employment/union contracts as well as civil and criminal tax controversy. Rufo can be reached at marissa@mzqconsulting.com.

**Rebecca Wilen** is an account manager at MZQ Consulting, LLC. She can be reached at rebecca@mzqconsulting.com.

bursement rates for the plan. This may be handled by the network, a third-party administrator or even a third-party contractor of a plan vendor. After determining which entity is responsible for setting these rates, the plan should review its summary plan description (SPD) to see how it outlines out-of-network reimbursement. This may be under its own section or documented under titles such as:

- Usual and customary rates (UCRs)
- Allowable amount
- Maximum allowable charge
- Percentage of Medicare

It's important to ensure that the SPD accurately reflects how out-of-network reimbursement rates are being paid operationally. If the process works differently in writing than in operation, the plan is likely to be out of parity.

For example, sometimes the plan has a hierarchy of options instead of just one method for determining the reimbursement rate. The vendor might first try negotiating based on in-network rates. If the out-of-network provider does not accept these rates, the vendor may move on to negotiating a percentage of Medicare reimbursement rates. For parity purposes, the plan needs to demonstrate that MH/SUD providers are being reimbursed using the same methodology as M/S providers. This is easy to achieve when all providers are reimbursed a flat percentage of Medicare reimbursement rates and harder to demonstrate when there is a hierarchy of reimbursement methods starting with negotiations between the claims payer and the provider. In that instance, the claims payer would need to outline the factors used as the base to start its negotiations and demonstrate that a similar methodology is being used to determine the base and end thresholds for the negotiations for both MH/SUD benefits and M/S benefits. Unlike some details that can be found in the SPD for the plan, this information is likely to be kept in internal vendor documentation that will need to be provided to the plan.

## Utilization Management Techniques

Utilization management (UM) processes include but are not limited to medical necessity determinations, prior authorization, concurrent review, retrospective review and treatment plan limitations. There are a few common causes for parity concerns within the UM NQTL category, described as follows.

### *Multiple and Separate Vendors for M/S and MH/SUD Benefits*

UM vendors may use different standards for making determinations when reviewing claims for the plan. If the methodologies for determining the NQTLs are different between M/S and MH/SUD benefits, that is an inherent parity concern. For example, if the MH/SUD vendor notes a factor such as cost of the treatment or improvement in the patient's condition, and the M/S vendor does not, then the plan is not considered to be in parity for that NQTL.

Having numerous UM vendors also makes it harder for the plan to identify whether comparable services are subject to substantially the same limitations. For example, rehabilitative therapy, which includes speech therapy, is generally specific to M/S diagnoses, while habilitative therapy, which also includes speech therapy, is generally specific to MH/SUD diagnoses. If the MH/SUD UM vendor requires prior authorization for habilitative therapies, but the M/S UM vendor does not require prior authorization on rehabilitative therapies, the plan is not considered to be in parity. If plans can't reduce the number of vendors to provide covered services, it will be essential to conduct annual testing to determine which benefits are being offered on different terms and under different UM conditions between the vendors under contract. It is important to note that simply testing the plan does not put the plan in compliance, and utilizing various vendors to perform the same function for MH/SUD ben-

efits and M/S benefits will always increase the possibility of NQTLs being not in parity upon testing.

***Prior Authorizations and Concurrent Reviews***

All UM processes and benefits subject to those processes should be fully outlined in the SPD. For a category of UM, such as prior authorization reviews, this does not mean every surgery subject to these reviews must be listed. They can be grouped into "like" categories such as all nonemergency inpatient admissions, all nonemergency outpatient surgeries, etc.

Concurrent reviews (reviews of patient care while they are receiving the care) are often conducted for the same list of services/providers that are subject to prior authorization reviews under the plan. If that is the case, the plan can simply state that the lists are the same for those types of UM reviews. A common issue when reviewing UM techniques in plans is the focus on subjecting only inpatient admissions to concurrent reviews in plan SPDs, even though other categories of services/facilities are also subject to the NQTL category. Plans should ensure that their plan documents are thorough and accurate for how these types of reviews are conducted and fix any parity issues found in writing.

***Timing of UM Reviews***

The plan documents should reflect how often and for how long UM reviews are conducted for all applicable benefits. Is it only when an extension is requested or every two weeks for a benefit that exists over a much longer period? Plans should ensure that any policy they utilize is applied similarly to both MH/SUD benefits and M/S benefits in that category and is documented sufficiently to ensure better chances of passing NQTL testing.

The most common mistake when evaluating a plan's UM procedures for NQTL testing is that the policies and rules around retrospective reviews (those that occur after the patient receives the care and is billed) are missing from SPDs and plan documentation altogether. Alternatively, details around UM policies in relation to retrospective reviews may be missing while the plan documents detail only how monetary claims and payment are treated in relation to retrospective reviews. If the UM vendor is conducting retrospective reviews of claims, the SPD and other plan documents should make clear the timing of these reviews and identify any additional information plan participants will need to know in relation to all benefits categories.

Will retrospective views be conducted on all claims or only claims that required prior authorization and were unable to obtain it prior to the service being rendered? These are not only pertinent details for testing, but also for plan participants to understand how benefits claims are treated under the plan.

## Conclusion

Mental health parity compliance and the testing required by the rules related to it can be confusing for plan sponsors and can result in potentially costly changes to plan design.

It is important for plan sponsors to understand their obligations under these rules as well as the steps they can take to mitigate the risk of noncompliance by conducting regular testing of their plans. It is vital to update and review plan documentation not only when conducting mental health parity testing but also annually to avoid potential missteps.

While plans are not expected to be perfect, the DOL and auditors do expect to see plans taking action regularly to improve mental health parity compliance and document those actions.

## Endnote

1. Mental Health Parity Act of 1996.

pdf/125