FEDERAL AGENCIES ISSUE FAQS REGARDING NONQUANTITATIVE TREATMENT LIMITATIONS UNDER THE MHPAEA AND CURES ACT

Hodgson Russ Employee Benefits Newsletter
May 31, 2018

Practices & Industries

Employee Benefits

The Mental Health Parity and Addiction Equity Act of 2008 and the 21st Century Cures Act provide that financial requirements (i.e., coinsurance and copays), quantitative treatment limits (i.e., number of visits), and nonquantitative treatment limits (i.e., facility limits) cannot be more restrictive or applied more stringently to mental health or substance use disorders (MH/SUD), than to medical/surgical conditions. The Departments of Labor and Health and Human Services have issued proposed FAQs [Part 39] demonstrating how the requirements of the MHPAEA and Cures Act apply to nonquantitative treatment limitations.

Nonquantitative treatment limitations ("NQTL") are operations, processes, strategies, evidentiary standards and other factors used to determine benefits and coverages under a group health plan. NQTLs must be applied to MH/SUDs in a manner comparable to medical/surgical conditions. In addition, an NQTL may not be applied more stringently with respect to MH/SUDs than to medical/surgical benefits.

Examples of NQTLs include:

- Medical management standards based on medical necessity or appropriateness, including benefits exclusions based upon the experimental or investigative nature of treatment;
- Limits on prescription drug formulary design, such as the use of "step therapy" or "fail-first" policies;
- Network admission standards (i.e., credentialing) and provider reimbursement rates;
- Network adequacy standards (i.e., distance standards, waiting times); and
- Facility limitations (i.e., in patient, residential, emergency room).

The FAQs remind plan administrators that a plan may exclude all benefits for a particular condition or disorder, as such exclusions are not treatment limitations for purposes of the parity requirements of the MHPAEA and Cures Act. However, state laws applicable to insured group health plans may or may not permit such exclusions from coverage.

The FAQs discuss participant disclosures for MH/SUD benefits, including the requirement that the criteria for medical necessity determinations be made available within 30 days of a participant's request. In addition, summary plan descriptions must provide up-to-date, accurate and complete descriptions of the plan's provider network. Plan administrators may provide electronic access (URL address, or hyperlink) to provider networks, but must comply with the DOL's electronic disclosure safe harbor requirements. *[Proposed] FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part XX*.