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Increasing Access to Mental Health and Addiction Treatment By Improving Parity Compliance

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Federal Parity Law

The Mental Health Parity and Addiction Equity Act (MHPAEA)

- Signed into law by President Bush in 2008 (sponsored by former Congressman Patrick Kennedy, founder of The Kennedy Forum)
- Insurance plans don't have to cover behavioral health treatment, but if they do, it must be *comparable* to other coverage of other medical treatment
- With ACA's essential health benefits, nearly all plans must offer mental health and addiction coverage, therefore they must comply with parity (primary exception is Medicare)

Main Categories in Parity Laws

Broadly plans **cannot**:

1. Charge higher co-payments or other out-of-pocket expenses for behavioral health than for physical health. (“Financial Requirements”)
2. Limit more stringently the number of visits or days for behavioral health services than they do for physical health. (”Quantitative Limitations”)
3. **Use more restrictive managed care practices for behavioral health than for physical health. (”Non-Quantitative Treatment Limitations” -- NQTLs)**

Parity must occur within each of six separate classifications of care: inpatient (in/out-of-network), outpatient (in/out-of-network), emergency, and prescription drugs. Both **as written** and **as applied**.

Potential Violations

Violations most likely for managed care practices (NQTLs), where applied more stringently to behavioral health coverage:

- More frequent and burdensome prior authorization requirements
- More frequent concurrent reviews to see if care is “medically necessary”
- More frequent fail-first protocols
- Stricter medical necessary criteria for behavioral health
- Stricter network admission criteria for behavioral health providers
- Formulary design that has behavioral health drugs on higher tiers
- Many others…

Highlights from 2019 Milliman Report

National Out-of-Network Disparities Growing Since Last Report

FIGURE 2: OUT-OF-NETWORK UTILIZATION RATES FOR PPO PLANS BY CARE SETTING AND YEAR

	INPATIENT FACILITY			OUTPATIENT FACILITY		
YEAR	MEDICAL/ SURGICAL	BEHAVIORAL	HIGHER PROPORTION OF BEHAVIORAL OUT-OF-NETWORK CARE	MEDICAL/ SURGICAL	BEHAVIORAL	HIGHER PROPORTION OF BEHAVIORAL OUT-OF-NETWORK CARE
2013	3.4%	9.6%	2.8x	5.3%	15.6%	3.0x
2014	3.9%	11.0%	2.8x	5.4%	21.8%	4.0x
2015*	**4.2%**	**16.1%**	**3.8x**	**5.8%**	**29.4%**	**5.1x**
2016	3.4%	16.3%	4.8x	4.6%	28.1%	6.1x
2017*	**3.3%**	**17.2%**	**5.2x**	**4.8%**	**27.6%**	**5.7x**

	OFFICE VISITS				
YEAR	PRIMARY CARE	SPECIALISTS	BEHAVIORAL	COMPARED TO PRIMARY CARE	COMPARED TO SPECIALISTS
2013	3.8%	5.1%	19.0%	5.0x	3.7x
2014	4.0%	5.1%	19.1%	4.8x	3.7x
2015*	**3.7%**	**5.2%**	**18.9%**	**5.1x**	**3.6x**
2016	3.1%	4.3%	17.9%	5.9x	4.2x
2017*	**3.2%**	**4.3%**	**17.2%**	**5.4x**	**4.0x**

- Texas disparities a bit worse than national average.

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http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf

Highlights from 2019 Milliman Report

MH and SUD Spending Very Low

FIGURE 9: DISTRIBUTION OF COSTS BETWEEN BEHAVIORAL HEALTH AND MEDICAL/SURGICAL CARE FOR PPO PLANS

PERCENTAGE OF TOTAL HEALTHCARE COSTS

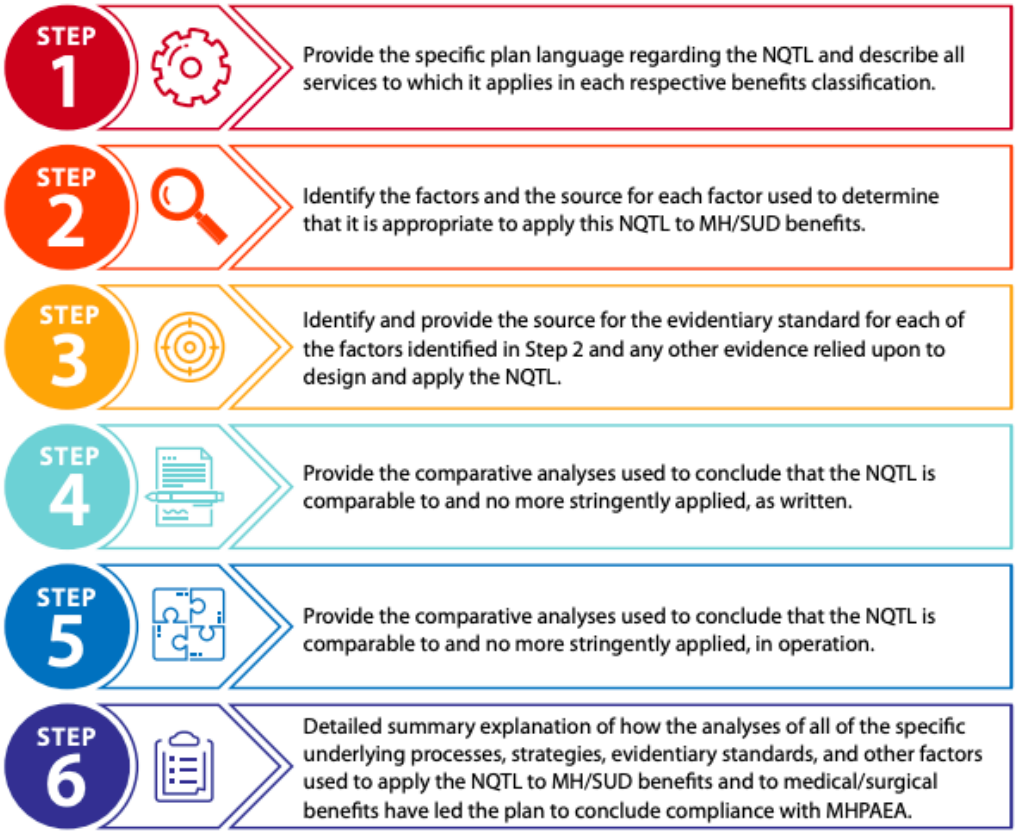
YEAR	MENTAL HEALTH (ONLY)	SUBSTANCE USE DISORDERS (ONLY)	TOTAL BEHAVIORAL HEALTH	MEDICAL/SURGICAL	TOTAL (BEHAVIORAL & MEDICAL/SURGICAL)
TOTAL HEALTHCARE COSTS					
2013	4.4%	0.7%	5.1%	94.9%	100%
2014	4.4%	0.9%	5.3%	94.7%	100%
2015*	**4.5%**	**1.1%**	**5.6%**	**94.4%**	**100%**
2016	4.3%	0.9%	5.3%	94.7%	100%
2017*	**4.3%**	**1.0%**	**5.2%**	**94.8%**	**100%**

Key NQTL Paragraph in Regulations

A group health plan (or health insurance coverage) may not impose a **non-quantitative 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 non-quantitative 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**. [emphasis added]

Reporting Needs to be Stepwise Approach

Measures Compliance with Each Component of NQTL Rule



- Similar to steps in U.S. Dept. of Labor's MHPAEA Self-Compliance Tool
- 12 states now have enacted these requirements into statute (AZ, CO, CT, DC, DE, IL, IN, MD, NJ, OK, TN, WV)
- Other state regulators are doing without legislation (e.g. Louisiana)
- Failure to test each component of rule can lead to illusion of compliance

TDI Proposed Draft Rule Is Excellent

If Adopted, Rule Would Follow National Best Practices

- **"Quantitative Parity" Spreadsheet** – Excellent. Should be adopted.
  - Federal Parity Act's requirements on Quantitative Treatment Limitations and Financial Requirements are very explicit and requires *calculations*
  - Spreadsheet captures all essential information necessary to determine compliance. Avoids duplicative and time-consuming work of evaluating and validating variety of tools developed internally by insurers.
- **"Nonquantitative Parity" Spreadsheet** – Excellent. Should be adopted.
  - Is the best practice being adopted by wide range of states. It has the necessary specificity to test all aspects of the federal NQTL parity rule
- Parity violations are not inconveniences – they can result in bankruptcy, deterioration of health, disability, unemployment, homelessness, and even death
- Identifying violations after-the-fact in market conducts exams is not enough. Must work to proactively ensure MH/SUD care is properly covered

Other Suggestions

- **Require Parity Compliance Programs**
  - Essentially impossible for plans to be in compliance without formal parity compliance program
  - New York State now requiring formal parity compliance programs
- **Ensure Disclosures Are Made**
  - Federal law requires plans to provide parity compliance analysis, medical necessity criteria (for both MH/SUD and med/surg) upon request
  - Plans frequently do not provide requested information as provided by law
- **Follow Generally Accepted Standards of Care**
  - Insurers should be explicitly required to follow Generally Accepted Standards of Behavioral Health Care when making medical necessity determinations
  - Described in detail by Federal Court in Wit v. United Behavioral Health

8 Generally Accepted Standards of Care

1. Effective treatment of underlying conditions, rather than mere amelioration of current symptoms, such as suicidality or psychosis.
2. Treatment of co-occurring behavioral health disorders or medical conditions in a coordinated manner.
3. Treatment at the least intensive and restrictive level of care that is safe and effective; a lower level or less intensive care is appropriate only if it safe and *just as effective* as treatment at a higher level or service intensity.
4. Erring on the side of caution, by placing patients in higher levels of care when there is ambiguity as to the appropriate level of care, or when the recommended level of care is not available.
5. Treatment to maintain functioning or prevent deterioration.
6. Treatment of mental health and substance use disorders for an appropriate duration based on individual patient needs rather than on specific time limits.
7. Accounting for the unique needs of children and adolescents when making level of care decisions.
8. Applying multidimensional assessments of patient needs when making determinations regarding the appropriate level of care.