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

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Agenda

• Basics of the Federal Parity Act
• Who enforces parity
• Examples of potential violations
• Continued disparities
• What needs to be done
Basics of Parity
What is Parity?

Insurance coverage for mental health and addiction services should be the same as insurance coverage for other medical conditions:

• Same terms and conditions
• NO MORE RESTRICTIVE

Parity is fundamentally an anti-discrimination law for behavioral health in insurance coverage.
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.
Health Insurance is Fragmented

- **49% of Americans are covered by employers**
  - Includes those covered by employer-sponsored coverage through their own job or as a dependent in the same household

- **7% are in Non-Group**
  - Includes individuals and families that purchased or are covered as a dependent by non-group insurance

- **29% are in Medicaid**
  - Includes those covered by Medicaid, CHIP, and those who have both Medicaid and another type of coverage, such as dual eligible who are also covered by Medicare

- **14% are in Medicare**
  - Includes those covered by Medicare, Medicare Advantage, and those who have Medicare and another type of non-Medicaid coverage where Medicare is the primary payer. Excludes those with Medicare Part A coverage.

- **2% are in Other Public**
  - Includes those covered under the military or Veterans Administration

Source: Kaiser Family Foundation
States

- Fully-insured individual/group plans
- Medicaid MCOs
  - All Medicaid expansion population (not relevant for GA)

Federal

- Self-funded ERISA (employer) plans

Not Covered By Federal Parity Act

- Medicare
- Medicaid fee-for-service (except Medicaid expansion population)
Examples of 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…
Evidence of Non-Compliance
### Highlights from 2019 Milliman Report

#### Out-of-Network Disparities Growing Since Last Report

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

<table>
<thead>
<tr>
<th>YEAR</th>
<th>INPATIENT FACILITY</th>
<th>OUTPATIENT FACILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MEDICAL/SURGICAL</td>
<td>BEHAVIORAL</td>
</tr>
<tr>
<td></td>
<td>2013</td>
<td>3.4%</td>
</tr>
<tr>
<td></td>
<td>2014</td>
<td>3.9%</td>
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<tr>
<td></td>
<td>2015*</td>
<td>4.2%</td>
</tr>
<tr>
<td></td>
<td>2016</td>
<td>3.4%</td>
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<tr>
<td></td>
<td>2017*</td>
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<tr>
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<td>5.3%</td>
<td>15.6%</td>
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<tr>
<td></td>
<td>5.4%</td>
<td>21.8%</td>
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<tr>
<td></td>
<td>5.8%</td>
<td>29.4%</td>
</tr>
<tr>
<td></td>
<td>4.6%</td>
<td>28.1%</td>
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<tr>
<td></td>
<td>4.8%</td>
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<tr>
<td></td>
<td>4.8%</td>
<td>27.6%</td>
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</table>

#### OFFICE VISITS

<table>
<thead>
<tr>
<th>YEAR</th>
<th>PRIMARY CARE</th>
<th>SPECIALISTS</th>
<th>BEHAVIORAL</th>
<th>COMPARED TO PRIMARY CARE</th>
<th>COMPARED TO SPECIALISTS</th>
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<tbody>
<tr>
<td></td>
<td>2013</td>
<td>3.8%</td>
<td>5.1%</td>
<td>19.0%</td>
<td>5.0x</td>
</tr>
<tr>
<td></td>
<td>2014</td>
<td>4.0%</td>
<td>5.1%</td>
<td>19.1%</td>
<td>4.8x</td>
</tr>
<tr>
<td></td>
<td>2015*</td>
<td>3.7%</td>
<td>5.2%</td>
<td>18.9%</td>
<td>5.1x</td>
</tr>
<tr>
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<td>2016</td>
<td>3.1%</td>
<td>4.3%</td>
<td>17.9%</td>
<td>5.9x</td>
</tr>
<tr>
<td></td>
<td>2017*</td>
<td>3.2%</td>
<td>4.3%</td>
<td>17.2%</td>
<td>5.4x</td>
</tr>
<tr>
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<td>4.2x</td>
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<td></td>
<td></td>
<td></td>
<td>4.0x</td>
</tr>
</tbody>
</table>

[http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf](http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf)
Reimbursement Disparities Growing Too

**FIGURE 7: OFFICE VISITS – IN-NETWORK PROVIDER PAYMENT LEVELS RELATIVE TO MEDICARE-ALLOWED IN PPO PLANS**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>PRIMARY CARE</th>
<th>SPECIALISTS</th>
<th>BEHAVIORAL</th>
<th>PRIMARY CARE</th>
<th>SPECIALISTS</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>ALLOWED CHARGES RELATIVE TO MEDICARE</td>
<td>HIGHER PAYMENTS COMPARED TO BEHAVIORAL</td>
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<td></td>
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<tr>
<td></td>
<td>ALL OFFICE VISITS</td>
<td></td>
<td></td>
<td>PRIMARY CARE</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>112.1%</td>
<td>110.1%</td>
<td>92.8%</td>
<td>20.7%</td>
<td>18.5%</td>
</tr>
<tr>
<td>2014</td>
<td>113.0%</td>
<td>112.0%</td>
<td>94.3%</td>
<td>19.8%</td>
<td>18.8%</td>
</tr>
<tr>
<td><strong>2015</strong></td>
<td><strong>114.7%</strong></td>
<td><strong>111.1%</strong></td>
<td><strong>95.0%</strong></td>
<td><strong>20.8%</strong></td>
<td><strong>17.0%</strong></td>
</tr>
<tr>
<td>2016</td>
<td>117.6%</td>
<td>112.3%</td>
<td>95.9%</td>
<td>22.6%</td>
<td>17.2%</td>
</tr>
<tr>
<td><strong>2017</strong></td>
<td><strong>120.4%</strong></td>
<td><strong>115.6%</strong></td>
<td><strong>97.2%</strong></td>
<td><strong>23.8%</strong></td>
<td><strong>18.9%</strong></td>
</tr>
</tbody>
</table>

*The Kennedy Forum*
# 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](image)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MENTAL HEALTH (ONLY)</th>
<th>SUBSTANCE USE DISORDERS (ONLY)</th>
<th>TOTAL BEHAVIORAL HEALTH</th>
<th>MEDICAL/SURGICAL</th>
<th>TOTAL (BEHAVIORAL &amp; MEDICAL/SURGICAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>4.4%</td>
<td>0.7%</td>
<td>5.1%</td>
<td>94.9%</td>
<td>100%</td>
</tr>
<tr>
<td>2014</td>
<td>4.4%</td>
<td>0.9%</td>
<td>5.3%</td>
<td>94.7%</td>
<td>100%</td>
</tr>
<tr>
<td>*<em>2015</em></td>
<td><strong>4.5%</strong></td>
<td><strong>1.1%</strong></td>
<td><strong>5.6%</strong></td>
<td><strong>94.4%</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td>2016</td>
<td>4.3%</td>
<td>0.9%</td>
<td>5.3%</td>
<td>94.7%</td>
<td>100%</td>
</tr>
<tr>
<td>*<em>2017</em></td>
<td><strong>4.3%</strong></td>
<td><strong>1.0%</strong></td>
<td><strong>5.2%</strong></td>
<td><strong>94.8%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
Large Disparities in Georgia

Outpatient facility behavioral health treatment occurs out-of-network **9.7 times** more often than outpatient facility medical care – up from 4X in 2013.

Primary care doctors reimbursed **38% more than** behavioral health doctors for low and moderate complexity office visits.

Sampling of Recent State Actions

Massachusetts Attorney General
- Five settlements with major insurers for $1 million
- Violations in reimbursement rates and prior authorization
- Inaccurate provider directories

Illinois Dept. of Insurance
- Fines against 5 insurers, totaling over $2 million
- Violations in prior authorization, step therapy, and medical necessity criteria

Pennsylvania Dept. of Insurance
- Over $1 million in fines against large insurers
- Violations in cost-sharing and SUD coverage
What Can Be Done?
Improving Parity Compliance

Require Plans to Demonstrate Compliance (Don’t Put Burden on Patients)

- Require plans submit parity compliance analysis for every non-quantitative treatment limitation that demonstrates compliance with federal NQTL rule
- Plans are already supposed to be conducting these analyses under federal law
- Allows regulators to more easily spot issues and moves away from a reactionary, complaint-based approach
- Prevents illegal limitations on coverage and increases access to care
- Finding violations after-the-fact does little to help patients
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

**STEP 1** Provide the specific plan language regarding the NQTL and describe all services to which it applies in each respective benefits classification.

**STEP 2** Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.

**STEP 3** Identify and provide the source for the evidentiary standard for each of the factors identified in Step 2 and any other evidence relied upon to design and apply the NQTL.

**STEP 4** Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written.

**STEP 5** Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation.

**STEP 6** Detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.
Quick Word on Telehealth
Telehealth and Parity

Access to Telehealth Vital During COVID

• Variety of state and federal rules in place.

• Federal government has relaxed many rules during crisis. Strong interest in Congress and Administration to continuing many of these “flexibilities”.

• MHPAEA applies to MH/SUD benefits provided via telehealth.

• “Telehealth Parity” compares telehealth services to in-person services (not MH/SUD vs. med/surg). Usually refers to parity in reimbursement.

• Telehealth is a critical access issue for MH/SUD care – both in rural and other underserved communities.