Mental Health Parity: The Basics

Simple concept: insurance coverage for mental health and substance use disorder (MH/SUD) treatment should be **no more restrictive** than coverage for other medical care

1

What's The Goal Today?

- The goal today is for you to grasp the outlines of what might be the most complex federal law that exists
- If this is your first time trying to understand this, you **WILL NOT** fully grasp the law after the presentation: **that is impossible**
- If you are serious in your attempts to secure compliance with this law, you will need to dedicate significant time to understanding and unpacking the intricacies
- State and federal regulators are dedicating more time and effort to enforcing the law

2

Why is There a Federal Law?

- Historically, insurance coverage for MH/SUD treatment was more restrictive than coverage for other conditions
- Hard limits on inpatient care
  - Annual day limits (i.e., 30 days per year)
- Hard limits on outpatient care
  - Annual visit limits (i.e. 20 visits)
- Higher copays and coinsurance than for other care
- Separate deductibles for MH/SUD

3

State “Parity” Laws Prior to Federal Law

- Most state laws that governed MH/SUD insurance explicitly codified restrictive coverage
- State laws specified that coverage limitations for MH/SUD could and SHOULD be less generous
- Only certain MH conditions included (schizophrenia, bipolar disorder, panic disorder, etc.)
- SUD treatment was often explicitly excluded

4

The Federal Parity Law: 2008

- The Mental Health Parity and Addiction Equity Act, enacted in October, 2008
- Bipartisan law sponsored by Rep. Patrick J. Kennedy (D-RI) and signed into law by President George W. Bush
- The Federal Parity Law applies to most health plans in America, except for Medicare

5

Enforcement: State and Federal Balance

- States insurance departments enforce for individual plans and group insurance policies sold to employers
- U.S. Department of Labor (DOL) has sole enforcement for self-insured group plans;
- CMS and state Medicaid agencies have dual responsibility for Medicaid coverage
- Center for Consumer Information and Insurance Oversight (CCIIO) has enforcement authority over self-insured non-federal governmental plans

6

Are There Issues Still?

- Issuers and health plans have struggled with some of the more complex components of the law
- State and federal regulators have been slow to implement and provide guidance
- While the concept of parity is simple, the Federal Parity Law is INCREDIBLY COMPLICATED

7

Avert your eyes!

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.

8

The Federal Parity Law's Foundation

- What is an MH/SUD disorder?
- What is an MH/SUD benefit?
- Classification of benefits
- Quantitative treatment limitations and financial requirements
- Non-quantitative treatment limitations
- Disclosure

9

WHAT IS AN MH/SUD DISORDER?

- Plan definition must be consistent with generally recognized standards of current medical practice.
  - Diagnostic and Statistical Manual of Mental Disorders (DSM)
  - International Classification of Diseases (ICD)
  - State law or guidelines that define; e.g. autism
  - Diagnosis exclusion is permissible unless state law precludes- not a treatment limitation
  - Creates the framework for defining benefits

10

WHAT IS A MH/SUD BENEFIT ?

- Benefits provided in conjunction with treatment for MH/SUD conditions
- What about Items or services provided for both MH/SUD and Medical/Surgical, such as occupational therapy, habilitative, home health?
- Why are coverage exclusions important?

11

BENEFITS CLASSIFICATIONS FOR MH/SUD and Medical/Surgical CONDITIONS

- 6 classifications
- Plan can choose the standard for classification assignment but it must be the same for MH/SUD and Medical/Surgical
- MH/SUD benefits must be provided in every classification where medical/surgical benefits are provided
- All plan benefits must be classified into one of the 6 classifications
- There are permissible sub-classifications

12

The 6 Benefits Classifications

- Inpatient in-network
- Inpatient out-of-network
- Outpatient in-network (may divide into office visits and all other outpatient services)
- Outpatient out-of-network (may divide into office visits and all other outpatient services)
- Prescription drugs
- Emergency services

13

The Subclassification Rule

- The reason for the rule
- Outpatient visits and outpatient-other
- Separate subclassifications for generalists and specialists is not permitted
- Other permissible “subclasses”; e.g., drug tiering, network tiering (subject to NQTL testing)
- Required parity testing for FRs, QTLs and NQTLs must occur independently within each classification or subclassification as a whole

14

Financial Requirements and Quantitative Treatment Limitations

- Financial requirements (FRs): copays, coinsurance, deductibles, out-of-pocket maximums
- Quantitative treatment limitations (QTLs): outpatient visit/inpatient day limits per year, maximum visits per episode
- Financial Requirements and Quantitative Treatment Limitations have a two-part test:
  - The substantially all test
  - The predominant test

15

The Predominant / Substantially All Test

- Substantially all: **cannot apply** an FR or QTL to MH/SUD benefits within a classification unless it applies to 2/3 of medical/surgical benefits within the same classification

If you pass the substantially all test, then you go to the predominant test

- Predominant: cannot apply an FR or QTL to MH/SUD benefits in the classification that is more restrictive than the FR or QTL that applies to more than 50% of medical/surgical benefits in the classification
- The rule applies to each distinct type of FR or QTL and not FRs or QTLs as a class

16

Substantially All and Predominant Defined

- How do you figure out what is 2/3 or more than 50%?
- Substantially all: does the FR or QTL apply to at least 2/3 of expected medical/surgical plan payments for that classification? Yes, then move on to predominant test
- Predominant: What is the level of the FR or QTL that applies to at least 50% of expected medical/surgical plan payments in that classification subject to the FR or QTL? That is the most restrictive level that can then be imposed on MH/SUD benefits in the classification

17

Illustration of the Substantially All Test

- A plan has a copayment requirement in the outpatient- office visits sub-classification. Expected medical/surgical plan payments for the outpatient visit sub-classification are $1,000,000 and copays apply to $800,000 of expected plan payments. **$800,000/$1,000,000 = 80%**, therefore the plan can apply a copayment requirement to MH/SUD benefits in the sub-classification.
- The testing would be more complicated if more than one type of FR applies (e.g., copayment and coinsurance) but the testing remains the same. For example, there is a copay which applies to $400,000 of expected plan payments and coinsurance applies to $600,000 of expected plan payments. In this case **neither FR type meets the 2/3 threshold so the plan could not apply either a copay or coinsurance requirement to MH/SUD benefits**.

18

Determining the Predominant Level

- The plan has passed the substantially all test by applying copays to 80% of expected plan payments ($800,000/$1,000,000).
- A plan has three copayment requirements ($20, $30 and $45). To determine predominant, the plan must figure out the percentage that each level applies out of $800,0000:
  - $20 level applies to $200,000: $200,000/$800,000 = 25%
  - **$30 level applies to $480,000: $480,000/$800,000 = 60% PREDOMINANT LEVEL**
  - $45 level applies to $120,000: $120,000/$800,000 = 15%
- Plan cannot apply copay higher than $30 to MH/SUD benefits in this classification

19

What if No Level Applies to 50%?

- The plan has the following levels:
  - $20 level applies to $200,000: $200,000/$800,000 = 25%
  - $30 level applies to $320,000: $320,000/$800,000 = 40%
  - $45 level applies to $280,000: $280,000/$800,000 = 35%
- The plan must combine the different copayment levels until a 50% threshold is met or just pick the least restrictive ($20).
- If the plan combines the $45 copayment (35%) with the $30 copayment (40%) to satisfy the greater than 50% requirement, the **$30 copayment** is the most restrictive level the plan may use for MH/SUD benefits. If the plan combines the $30 copayment with the $20 copayment, the **$20 copayment** is the most restrictive level the plan may use for MH/SUD benefits. Either combination of levels would be permissible MH/SUD benefits.

20

Nonquantitative Treatment Limitations

- A health plan feature which is not expressed numerically but otherwise affects the scope or duration of the benefit

21

NON-QUANTITATIVE TREATEMENT LIMITATIONS

- Medical Management
  - Medical Necessity Criteria
  - Utilization Management; prior authorization, concurrent review, retrospective review
  - Step therapy
- Benefit Coverage/Exclusions
  - Categorical exclusion of a particular service for covered condition (i,e, no residential treatment for eating disorders)
  - Experimental/Investigational
  - CPT coding edits

22

NON QUANTITATIVE TREATMENT LIMITATIONS

- Formulary Design
- Plan Network Adequacy
- Provider Admission Standards; i.e., credentialing and contracting
- Setting Provider Reimbursement Rates
- Anything else that limits the scope or duration of treatment

23

THE PARITY TEST FOR NQTLs

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.**

24

UNBUNDLING THE NQTL TEST

- As written and in operation
- Comparable to and applied no more stringently
- Processes, strategies, evidentiary standards and factors
- Compared to medical surgical

25

Examples of Factors

Utilization Review Factors

- Claims associated with a high percentage of fraud
- Excessive utilization
- High levels of variation in length of stay
- High variability in cost per episode of care

Network and Reimbursement Factors

- Geographic access standards
- Provider scarcity
- Practitioner supply and provider-to-enrollee ratios

26

Examples of Evidentiary Standards That Could Define Factors

- Fraud and abuse: Greater than 5% of claims associated with fraud over previous three plan years
- Excessive utilization: Two standard deviations above average utilization per episode of care (or something more simple)
- High variation in length of stay: Claims data showed 25% of patients stayed longer than the median length of stay
- Specialty provider to enrollee ratio falls below 1.67 per 1,000 triggers reimbursement rate adjustment
- Provider scarcity: Average wait time for appointment exceeds 30 days triggers network admission standard adjustment

27

Other Evidentiary Standards

- Recognized medical literature
- Professional standards and protocols (including comparative effectiveness studies and clinical trials)
- Published research studies
- Treatment guidelines created by professional medical associations or other third-party entities
- Outcome metrics from consulting or other organizations

28

As Written Processes and Strategies

- Utilization management manuals
- Utilization review criteria
- Specific criteria hierarchy
- Initial screening scripts and algorithms, case management referral criteria
- Stipulations about submitting written treatment plans
- Utilization management committee notes
- Description of processes for identifying and evaluating clinical issues and utilizing performance goals

29

In Operation Processes and Strategies

- Peer clinical review
- Telephonic consultations with attending providers
- Consultations with expert reviewers
- Clinical rationale used in approving or denying benefits
- Selection of information deemed reasonably necessary to make a medical necessity determination
- Adherence to utilization review criteria and criteria hierarchy
- Professional judgment used in lieu of utilization review criteria
- Actions taken when incomplete information is received from attending providers
- Requests for patient medical records

30

Disclosure and Vendor Coordination

- MHPAEA and its regulations have a number of stipulations about disclosure of medical necessity criteria, the exact reason for a denial of benefits and plan documents concerning the basis for a plan's application of an NQTL
- MHPAEA testing invariably involves comparative analysis between MH/SUD and M/S services. Specialty vendors and plans must assure that proper information is exchanged. Plan policies for assurance of coordination to assure compliance with vendors; e.g., PBMs are important.

31

What's on the Horizon in 2019?

- State legislatures are increasingly interested in passing bills that require parity transparency from issuers
- State insurance departments are increasing efforts to probe for parity compliance both in the form-filing process and through market conduct exams
- Federal agencies will be more restrained than state regulators

32

