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The Parity Act: Putting it to Use

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Colorado Center on Law and Policy

789 Sherman St., Suite 300, Denver, CO 80203

Growing commitment toward behavioral health

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- The World Health Organization

  An international study aims to evaluate the burden that mental health and substance use disorders place on the general population, as well as obstacles to accessing services.

- National: Mental Health Parity and Addiction Equity Act (2008), the Affordable Care Act (2010)

- Federal legislation prohibits certain discriminatory practices that limit mental health and substance use disorder treatment.

- Colorado SIM (State Innovation Model)

- Colorado was awarded $65 M in 2015 by the Centers for Medicare and Medicaid Innovation (CMMI) to integrate physical and mental health statewide over a four year period.

MHPAEA Regulations:

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Regulations applying to certain plans were finalized in 2013:

- non-Federal governmental plans with > 100 employees
- group health plans with > 50 employees
- plans in the individual health insurance market

And CMS has released *draft* regulations that will apply to CHIP plans, Medicaid benchmark benefit plans, and Medicaid managed care.

MHPAEA Regulations:

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Broadly speaking, the finalized regulations do the following:

- Bar separate deductibles and out-of-pocket limits
  - Plans cannot establish separate deductibles or out-of-pocket limits for mental health or substance use disorder benefits
- Within each class, require that plans provide parity between the medical/surgical and mental health/substance use disorder benefits:
  - Quantitative Treatment Limitations (QTLs) are analyzed with the use of a formula
  - Non-Quantitative Treatment Limitations (NQTLs) are analyzed without a formula

Final regulations can be found at: http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf

Classes

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Analysis must be done within a class:

- Inpatient, in network
- Inpatient, out of network
- Outpatient, in network
- Outpatient, out of network
- Emergency services
- Prescription drugs

Quantitative Treatment Limitations

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Definition:

- QTLs are limitations or aspects of plan design that are numerical, and include:
  - Copays
  - Coinsurance rates
  - Visit limits
  - Day limits

Quantitative Treatment Limitations

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- Comparison of QTLs uses a formula:
  - Based on the dollar amount of all plan payments in a class is there a quantitative treatment limitation applied to "substantially all" benefits, meaning at least 2/3?
  - And if so, is there a particular structure that predominates, meaning that it applies to at least half of benefits?

QTL Example

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- Example: based on the dollar amount of all plan payments for outpatient, out-of-network benefits, 80% of medical/surgical benefits are subject to coinsurance.
- That means that coinsurance applies to "substantially all" benefits.
- If over half of those benefits subject to coinsurance are subject to 15% coinsurance, that would mean that no more than 15% coinsurance could be required for MH/SUD benefits in this class.

The Problem

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- Providers and consumers will not have access to most of this information unless carriers are required to provide it to the public.
- However, the provider and consumer may suspect a parity violation if the cost-sharing for MH/SUD benefits appears to be higher than that for medical/surgical benefits, based on consumers' policy documents.

Non-Quantitative Treatment Limitations

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Definition:

- NQTLs are limits that are not expressed numerically, and include:
  - Medical management techniques, such as step therapy or "fail-first" therapy
  - Prior authorization requirements
  - Medical necessity definitions
  - Provider reimbursement or provider certification requirements
  - Formulary exclusions or limitations
  - Network tier design
  - Exclusions based on geography

Non-Quantitative Treatment Limitations

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- Comparison of NQTLs does not use a formula:

  A non-quantitative treatment limitation must be

  - comparable to
  - and applied no more stringently than

  a NQTL for a medical or surgical benefit.

Source: DORA ERISA Q&A (2012)

NQTL Example

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Both of the following would be violations:

- For inpatient medical benefits, approval of a prior authorization request is good for 7 days, while approval for a PAR for inpatient MH/SUD benefits is good for only 3 days.
- Medical drugs with black box warnings can be provided with prior authorization; MH/SUD drugs with black box warnings are not included in the plan formulary.

The Problem

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- Providers and consumers do not have access to some of this information.

- However, the regulations give providers and consumers the right to request medical necessity criteria, and policy documents may yield additional information.

Enforcement in NY

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- Basic premise: if behavioral health services are denied far more frequently than medical services, there *must* be a parity violation.
  - New York's Attorney General's office has used its investigatory power to assess parity, but not all states have that power.
  - AG Eric Schneiderman has settled 5 cases since 2012, with the most recent announced March 2015 with carrier Excellus.

http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-excellus-health-plan-end-wrongful-denial-mental

Excellus violations

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- In 2012, Excellus issued denials for 48% of inpatient SUD treatment reviews, but only 20% of medical/surgical requests
- The denial rate for outpatient behavioral services was 29% versus 13% for medical/surgical services
- Fail-first requirements were applied only to SUD benefits, not to medical/surgical benefits
- Concurrent medical utilization review was required for inpatient behavioral services, but most medical cases were exempt
- Inadequate notice was provided, with generic denial letters that did not provide enough information to allow a meaningful appeal
- Higher cost-sharing (specialist rate) for routine outpatient behavioral health services, rather than the lower primary care copayment for routine medical health services

Other New York settlements

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- Settlements reached with Cigna, MVP Health Care, Emblem Health and ValueOptions.
- Focus on rates of denial, particularly with higher levels of care, as well as fail-first policies and higher cost-sharing

The role of state regulators

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With their superior resources and investigative powers, state regulators are able to review claims records and internal company policies in a way that consumers or private lawyers cannot.

In addition, agencies that regulate insurance may have the power to issue regulations that would require insurance carriers to provide evidence of compliance with the MHPAEA and related federal regulations.

State regulators, cont'd

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- Healthcare Exchanges and the ACA
  - In order for a health plan to be qualified for purchase on a state's healthcare exchange, the health plan must offer 10 essential health benefits (EHB)
  - *BUT* a plan can only be said to offer EHB if it also provides parity and is non-discriminatory.
  - State Divisions of Insurance can require plans to demonstrate parity before qualifying them for purchase on the state exchange.

Regulation in other states

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California has issued insurance regulations:

- Plans must publicly report on internal parity analyses
- Analysis must show compliance with financial requirements, QTLs, NQTLs
- To assist the regulatory agencies with analysis and enforcement of mental health parity laws, additional funds were provided in 2015

State regulation, cont'd

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- Massachusetts
  - Their Division of Insurance requires health plans to submit annual compliance reports

- Connecticut
  - Their Division of Insurance posts a consumer report card on carriers, with a portion devoted to behavioral benefits and services
  - Requires submission of documentation to support compliance with parity laws
  - Has a track record of intervention

What can be done in Colorado?

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Encourage the Division of Insurance

- To provide information about what parity is on the Division website, with examples of violations
- To provide information about how to appeal violations and how to make complaints regarding parity
- To explain what steps they take to ensure that plans offered on Connect for Health provide parity

Work with other stakeholders on legislation that would require that the Division of Insurance issue regulations regarding parity

And file complaints!

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Patients and families should pursue possible violations through the Division of Insurance.

A list of red flags follows.

If patients or families suspect a parity violation, they can call the DOI at **303-894-7490**, email their questions to **insurance@dora.state.co.us** or fill out the on-line Request Assistance form at Colorado.gov (search "division of insurance complaint")

What to look for: Red Flags

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- Separate deductibles
- Limits on visits or days of MH/SUD treatment
- High(er) cost-sharing for MH/SUD treatment
- Financial requirements for MH/SUD prescription drugs that seem more restrictive than those for medical drugs
- Exclusions that seem to apply only to MH/SUD services
- "Fail first" or step therapy requirements for MH/SUD treatment
- Limitations or exclusions of intermediate levels of care for MH/SUD benefits
- Limitations on location for accessing MH/SUD benefits

Source: Drug Policy & Public Health Strategies Clinic University of Maryland, Francis King Carey School of Law

And information is key

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- Always request the reason for a denial.
- And for the medical necessity criteria, because patients are generally entitled to this information.
- Failure to provide the reason and criteria are violations in themselves.

Colorado Health Institute, 2013 Colorado Health Access Survey, 20 High Level Findings, p. 13; http://www.coloradohealthinstitute.org/uploads/downloads/CHAS_2013_Chartpack.pdf

Sources

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A Consumer's Guide to the MHPAEA

http://www.nationaldisabilitynavigator.org/wp-content/uploads/resources-links/SAMHSA-Parity-guide.pdf

The Regulations

http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf

Contact information

COLORADO CENTER on LAW & POLICY

Bethany Pray

Colorado Center on Law and Policy

(303) 573-5669 x 310

bpray@cclponline.org

www.cclponline.org