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Ensuring the Promise of Mental Health Parity in California

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Project Background

- **Purpose of study:** To assess California's progress in enforcing the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) in California
- **Funding:** California Health Care Foundation (CHCF)
- **Approach:** Review of legal authority, regulatory requirements, and enforcement actions; interviews with 22 stakeholders, including state officials, insurers, health plans, and representatives of provider and consumer organizations
- This presentation is a high-level summary of a draft report; the final published report, forthcoming August 2020 from CHCF, will include a fuller discussion of regulatory processes and stakeholder views.
 - Neither this presentation nor the report includes activities authorized under the recently adopted 2020-21 California state budget.



What Is the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)?

- Requires insurers and health plans *that cover mental health and substance use disorders (MH/SUD)* to do so in parity with medical/surgical care.
 - Financial requirements, quantitative treatment limits, and non-quantitative treatment limits that apply to mental health / substance use disorder benefits can be no more restrictive than those that apply to medical/surgical benefits.
- Affordable Care Act of 2010 (ACA) mandated coverage of MH/SUD consistent with MHPAEA as part of the essential health benefits (EHB) requirement that applies to most individual and small group market plans beginning in 2014.
- MHPAEA does not, on its own, ensure broad access to care for MH/SUD. Rather, it seeks to rectify longstanding disparate treatment of MH/SUD.



Glossary

- **Mental Health Parity and Addiction Equity Act (MHPAEA):** Federal law enacted in 2008 that requires insurers and health plans providing coverage of mental health and substance use disorders to do so on par with coverage for medical/surgical benefits.
- **Financial Requirements (FR):** Copays, co-insurance, deductibles, out-of-pocket limits.
- **Quantitative Treatment Limits (QTL):** Visit limit, days of coverage (e.g., hospital stays).
- **Non-quantitative Treatment Limits (NQTL):** Prior authorization, step therapy (i.e., must try lower-cost drug before more-costly drug will be approved), medical management standards.
- **Utilization management:** Health plan and insurer techniques to review requests for health care services or claims for services already received for the appropriateness of the care or care setting, the medical necessity of the care, and whether the care meets quality standards. Examples include prior authorization and retrospective review.



Glossary, *continued*

- **Substantially all/predominant test:** Test in federal regulations that allows for comparison of FRs and QTLs between medical/surgical benefits and MH/SUD benefits.
- **Essential Health Benefits (EHB):** Affordable Care Act requirement that non-grandfathered individual and small group market plans cover 10 essential health benefits, including mental health and substance use disorder.
- **Department of Managed Health Care (DMHC):** State agency that regulates health maintenance organizations (HMOs) and some preferred provider organizations (PPOs), covering 15 million Californians.
- **California Department of Insurance (CDI):** State agency that regulates all other types of health insurance policies, including indemnity plans and most PPOs, covering about 1 million Californians.



Parity in California Law

- California law took a relatively narrow approach and created a patchwork of protections over time:
 - California Mental Health Parity Act, enacted in 1999, ties protections under DMHC- and CDI-regulated plans and policies, both group and individual, to diagnosis (nine specified “severe mental illnesses” and “serious emotional disturbances of a child”).
 - CDI- and DMHC-regulated plans must cover behavioral health treatment for pervasive developmental disorder or autism (2012).
 - CDI-regulated plans that cover disorders of the brain must cover treatment of specified biologically based severe mental disorders “in the same manner” (1989, amended 1992).



MHPAEA in California Law

- 2014: All DMHC-regulated plans are required to comply with federal MHPAEA and all its implementing regulations.
- 2015: Post-ACA, California enacts a law incorporating the ACA's essential health benefits requirements into state law, applicable to most individual and small group plans.
 - Codifies the state's chosen benchmark plan
 - Adds the pre-existing state benefit mandates to the definition of EHB
 - Reiterates the requirement that plans and policies comply with MHPAEA
- 2017: All CDI-regulated insurers are required to comply with federal MHPAEA and all its implementing regulations.



Interaction of Federal and State Law Parity Laws

- All state-regulated health plans and insurance must comply with MHPAEA, which requires parity for any MH/SUD benefits.
- All state-regulated non-grandfathered individual and small group market health plans and insurance must comply with EHB, including MH/SUD.
 - EHB in California law requires benefits and diagnostic conditions to be covered to be “substantially equal” to the state’s benchmark plan.
 - State’s EHB benchmark plan defines mental health conditions using the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV)*.
- State-regulated large group health plans are subject to more-limited benefit requirements than EHB (i.e., nine severe mental illnesses, serious emotional disturbances of a child, care at a psychiatric facility, certain biologically based severe mental disorders).



Parity Enforcement in California



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DMHC's Enforcement Approach

- Following issuance of federal MHPAEA rules that took effect in 2014, DMHC conducted an initial compliance review of all 25 commercial plans between 2014 and 2015:
 - Conducted webinars and teleconferences to educate plans on new federal rules
 - Developed worksheets to capture data from plans (before federal enforcement tools became available in 2018)
 - Reviewed up to 15 plan products for each of the 25 commercial plans, drawn from individual and small group market products in each metal level and representing different cost-sharing designs (e.g., co-insurance or copays), and from the large group market, with plans representing different network designs (e.g., PPO or HMO)
 - Examined, following the initial desk review, the same 25 commercial plans for compliance in focused MHPAEA surveys (audits)



DMHC's Two-Phased Approach

- Phase 1: Conducted “desk survey” – a paper review of information from plan and all delegates:
 - Plans completed DMHC-developed worksheets that:
 - Documented classification of benefits
 - Reported quantitative treatment limits and financial requirements, and demonstrated compliance with “substantially all / predominant” test
 - Reported NQTLs, including plan definition of “medical necessity”
 - DMHC worked with clinical consultants, particularly on NQTLs, to review documents and conducted lengthy back-and-forth with plans to identify and resolve issues, then produced a “closing letter” that details plan revisions required to comply with MHPAEA.
- Phase 2: Conducted on-site survey focused on NQTLs:
 - Reviewed utilization management (UM) files for both medical/surgical and MH/SUD for plan and any delegates
 - Confirmed changes made as required under Phase 1



Results of DMHC's Initial Comprehensive Review and Focused Surveys

- DMHC published reports between 2017 and 2018 with [findings from initial comprehensive reviews](#).
 - Of the 25 plans reviewed in Phase 1, 24 were out of compliance for MH/SUD financial requirements, 3 were out of compliance for MH/SUD day and visit limits, and 12 were out of compliance for NQTLs.
 - The final focused surveys found that 11 plans were MHPAEA-compliant and 14 plans were non-compliant for either NQTLs (7 plans), QTLs (2 plans), or both (5 plans).
- All plans were asked to produce the same number of UM files, but some plans did not have either approval or denial files to produce for some categories of services. Plans were found to be using a variety of UM criteria, including internal guidelines, Milliman care guidelines, InterQual, and behavioral health delegate-specific criteria.



DMHC's Ongoing Reviews

- DMHC conducts a comprehensive review for new plans and a focused review when a plan makes a significant change that would affect MHPAEA compliance.
- Scope of MHPAEA review depends on scope of change being made; for example:
 - Adding a new product (e.g., adding a PPO product when only HMO was previously approved) would trigger a new analysis of estimated claims for the “substantially all / predominant” test.
 - Changing behavioral health vendors would trigger a full NQTL review.
- DMHC has incorporated compliance and enforcement of mental health parity in its ongoing oversight, including its routine surveys and review of DMHC Help Center consumer complaints.



DMHC's Enforcement Activity

- Ongoing reviews have resulted in plans having to take corrective action, including:
 - 7 health plans that were required to recalculate cost sharing for enrollees after DMHC found that the plans had applied cost sharing for mental health and substance use disorder services that differed from cost sharing for medical services, resulting in enrollees being reimbursed a total of \$517,375.
 - 2 prosecutions specific to MHPAEA involving one plan that did not implement MHPAEA-compliant cost sharing and another involving a plan that wrongfully denied residential treatment at parity as required by MHPAEA. Both enforcement actions included corrective action plans and \$20,000 penalties paid by the plans.
 - Additional prosecutions under the state's parity law, including denial of residential treatment for a severe mental health condition, and failure to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age and of serious emotional disturbances of a child.



CDI's Enforcement Approach

- As part of an annual form-filing process, insurers are asked to complete:
 - Mental Health Parity analysis workbook with cost sharing and projected payments for all covered non-emergent medical/surgical services, including preventive care
 - Supporting documentation for each plan:
 - List of MH/SUD services subject to NQTLs
 - Explanation of methodology demonstrating quantitative parity
 - Classification chart that describes how the insurer determines classification of services, including the factors, standards, and criteria used to determine how benefits are assigned to classification
 - This initial filing is used to identify potential issues and flag areas of concern that CDI will then follow up on with additional information requests and questions, including, where indicated, a demonstration that an NQTL was applied to MH/SUD benefits in compliance with MHPAEA.



CDI's Enforcement Approach, *continued*

- CDI must conduct comprehensive market conduct exams every five years. A MHPAEA review is part of that process and includes:
 - Review of clinical policies for claims involving medical necessity determinations
 - Documentation of the company's bases for determinations (memos of instruction, clinical policy bulletins, sources used in consideration of medical necessity claims)
 - Policies and procedures for conducting utilization management and whether they were followed with respect to a claim under investigation
- CDI has authority to conduct targeted exams focused solely on MHPAEA for a specific insurer or issue, though it has not done so yet.
- CDI is in the process of ongoing, regularly scheduled market conduct exams of health insurers, with a focus on MH/SUD claims, though these exams are not yet complete.



CDI's Enforcement Activity

- CDI has published one report for a market conduct exam that included a MHPAEA review of claims from May 2015 through April 2016.
 - The [report for Blue Shield](#), published December 2019, found multiple violations, including claims denials based on diagnosis and failure to obtain prior authorization for emergency services for major depressive disorder (search “Blue Shield of California Life & Health Insurance Company” at the link).
- CDI recently completed an [examination of Aetna](#) covering a review period of February 1, 2016, through January 31, 2017, that included a review of a sample of 90 mental health claims. The report of findings is due to be published by CDI in mid-August (search “Aetna Life Insurance Company” at the link).



Stakeholder Views



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Regulators Have Made Considerable Progress on Parity Enforcement, Particularly on Quantitative Treatment Limits and Financial Requirements

- Stakeholders recognized DMHC’s early efforts, noting an “innovative” tool it developed in 2014 to assess NQTLs before other states were doing these reviews but said CDI, which began parity reviews in 2016, is now conducting what some consider “more granular” oversight that aligns with the US Dept. of Labor compliance tool released in 2018.
- Stakeholders generally agreed that progress has been made on assessing compliance for QTLs and FRs, though challenges remain. Health plans and insurers said comparing all services within the classifications is difficult, in part because there are many more medical/surgical services compared to services for MH/SUD.
- Both departments were recognized for using expanded resources to step up enforcement, but some stakeholders said recent court cases have shown deficiencies in oversight of NQTLs.



Significant Work Remains to Ensure Compliance with Non-quantitative Treatment Limits

- Universal agreement among stakeholders that achieving parity on NQTLs continues to be the dominant challenge. Patient and provider representatives said NQTLs present significant barriers to accessing necessary care, noting that the complexity of NQTLs gives health plans and insurers flexibility to apply limits that don't apply to medical/surgical benefits.
- Stakeholders identified three areas of persistent problems:
 - **Utilization management:** including prior authorization, disputes over the appropriate level of care, and continuous review to determine number of days of care to be covered
 - **Medical necessity:** plan definitions and application of medical necessity criteria, which can be uneven and restrict access to care
 - **Network adequacy:** reimbursement rates and burdensome contracting terms



NQTL Challenge: Utilization Management

- Payers say they rely more heavily on UM for MH/SUD inpatient care than for medical/surgical inpatient care because for the latter, they can use diagnostic related groups (DRGs) to establish inpatient reimbursement rates based on long-standing calculations, but there are no DRGs for MH/SUD services.
- Providers said payers regularly use concurrent review — a payer’s ongoing review of care currently being provided — to determine whether continued services are medically necessary. Providers said when payers deny additional days of hospital care, it may result in readmission to another hospital that wouldn’t be detected in regulator reviews.
- Prior authorization and concurrent review impose administrative burdens on providers, particularly because health plan and insurer requirements vary greatly.
- Health plans’ use of delegates — entities (e.g., behavioral health organizations) contracting with the plans to carry out certain functions — can exacerbate problems with UM and make it more difficult for plans to coordinate across delegates using different UM protocols.



NQTL Challenge: Medical Necessity

- Most patient and provider representatives said regulators need to take a closer look at medical necessity criteria, which are the basis for health plan and insurer determinations of whether care will be covered.
 - Recent litigation has shown that health plans and insurers can use criteria that is more restrictive than generally accepted medical standards.
 - Some criteria limit care to addressing acute crises or alleviating symptoms but don't allow for long-term treatment and recovery.
- Health plans and insurers may use internally developed criteria, but patient and provider representatives recommend the use of scientifically evaluated criteria such as Level of Care Utilization System (LOCUS) or criteria developed by the American Society of Addiction Medicine (ASAM).
- Some stakeholders recommended the state establish a uniform medical necessity definition; others suggested regulators require health plans and insurers to demonstrate how their guidelines reflect generally accepted medical standards.



NQTL Challenge: Provider Networks

- Patient and provider representatives overwhelmingly cited a lack of in-network MH/SUD providers as a significant barrier to accessing care and as an area largely overlooked by regulators.
- Low reimbursement rates, onerous health plan and insurer processes for authorizing payment, and burdensome contracting terms are dominant reasons for the shortage of in-network MH/SUD providers.
- Regulators have clear authority under MHPAEA to review the application of standards for provider admission to networks — including reimbursement rates — as an NQTL.
- Health plans and insurers, as well as some provider representatives, said lack of oversight or strong standards for SUD treatment facilities has driven changes to health plan and insurer credentialing practices. However, licensing standards and oversight of providers falls outside the purview of regulators who assess parity compliance.



Policy Considerations



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Improve Oversight of Utilization Management

- Greater standardization and specificity of UM programs, and more specifically, medical necessity criteria, is needed to ensure that patients with the same profile aren't treated differently based on how strictly their health plan or insurer applies medical necessity criteria.
- CDI said stronger legal standards for medical necessity, plus additional resources to retain clinical experts to help with reviews and exams, would strengthen their oversight.
- Health plans and insurers should be required to demonstrate that their medical necessity criteria are consistent with generally accepted standards of care and to use recognized tools, such as LOCUS or the ASAM criteria, to determine the appropriate level of care for patients given their individual circumstances.



Evaluate Provider Networks for Parity

- Federal guidance makes clear that provider networks should be part of a parity analysis, noting:
 - “Standards for provider admission to participate in a network, including reimbursement rates” are an NQTL.
 - A provider network that includes far fewer MH/SUD providers than medical/surgical providers is a “red flag” for a potential NQTL violation.
- Researchers have documented [differences in reimbursement rates](#) for MH/SUD and medical/surgical providers in California and nationally (Milliman, 2019).
- Although regulators review plans for network adequacy, they said they don’t currently review networks for potential NQTL violations; for example, disparate incentives for providers to contract with a health plan, including reimbursement rates. Regulators cited a lack of resources and, in the case of DMHC, the difficulty of comparing capitated rates used by the managed care plans they regulate.
- Regulators should incorporate provider networks into MHPAEA enforcement.



Establish Clear Authority to Enforce Coverage of All Diagnoses in DSM

- Under the EHB requirement, the scope of coverage under a health plan or policy – both the benefits and conditions to be covered – must be “substantially equal” to that of the state’s EHB benchmark plan. California’s EHB benchmark plan, codified in law, defines conditions using an outdated version of the *Diagnostic and Statistical Manual (DSM)*.
- Regulators said health plans and insurers have not relied on the older *DSM* to exclude conditions from coverage, and regulators have been able to use benefit design nondiscrimination standards to prohibit exclusions.
- However, regulators should have clear authority to define conditions covered using the most recent version of the *DSM*.



Establish Clear Expectations for Insurers and Health Plans That Use Delegates

- Multiple stakeholders said health plans' use of delegates can exacerbate problems with UM.
 - Health plans may contract with many delegates beyond behavioral health vendors, each potentially with its own medical necessity criteria.
- Regulators should reinforce the requirement that plans are solely responsible for ensuring compliance with MHPAEA across all delegates, including behavioral health vendors, and must provide sufficient documentation to demonstrate that NQTLs, in particular, meet parity requirements.



Improve Process for Getting Provider Input

- Both departments indicated they receive, code, and use complaints from consumers and providers to identify potential parity violations.
- Providers are often in a better position than their patients to see potential parity violations and can be key allies in identifying trends and issues that warrant closer scrutiny.
- Providers were helpful in identifying potential parity violations for DMHC's initial compliance reviews, but more could be done to encourage reports from providers.
- Regulators should undertake greater outreach to providers; for example, through a survey or regular consultation.



Collect Claims Data

- Claims data can be an indicator of potential NQTL violations. For example, higher rates of denial for MH/SUD claims than for medical/surgical claims could indicate a potential parity issue with the medical necessity criteria used to review claims.
- Regulators obtain claims data as part of their reviews (DMHC) and market conduct exams (CDI), but ongoing data collection can help focus regulator resources on potential problem areas.
- Regulators should have clear authority to collect claims data on a regular basis to allow for analysis that informs ongoing oversight.



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