



Equal Treatment: A Review of Mental Health Parity Enforcement in California

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Contents

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3 Introduction

3 Study Approach

4 The Legal Framework: Parity on Paper

Parity in Federal Law

Benefit Mandates and Parity in California Law

Assessing Parity Compliance Under MHPAEA

8 The DMHC Compliance Process

Initial Reviews

Ongoing Oversight

10 CDI MHPAEA Compliance Process

Form Filing

Enforcement Action

12 Findings from Stakeholder Interviews: Parity in Practice

Stakeholders Noted Progress in Meeting Parity in Financial Requirements and Quantitative Treatment Limitations

Significant Work Remains to Ensure Parity in Non-Quantitative Treatment Limitations

17 Considerations for Policymakers and Regulators

19 Conclusion

20 Appendix A. Results of MHPAEA Compliance Reviews

24 Endnotes

Introduction

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) sought to address the long-standing neglect of mental health and substance use disorder coverage under health insurance and employer-sponsored plans.¹ MHPAEA put care and treatment of mental health and substance use disorders on equal footing with physical health care, prohibiting insurers and health plans from imposing greater cost sharing or tighter limits on accessing care for behavioral health. Behavioral health coverage is essential for the one in five adults diagnosed with a mental illness and the almost 8% of people age 12 years and older diagnosed with a substance use disorder.²

California has been a leader among states enforcing protections under MHPAEA. State regulators were ahead of their peers in assessing compliance with the comprehensive federal law. But representatives for patients and providers say more recent enforcement efforts are falling short at a time when many Californians who need mental health care report having difficulty getting care.³ Californians have also said ensuring access to mental health care is the top health care issue they want state leaders to address in 2020.⁴ Since the start of the COVID-19 pandemic, mental health needs have become more acute. One in three people nationwide reports having symptoms of depression or anxiety.⁵

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Study Approach

This study assesses the effectiveness of mental health parity compliance enforcement in California. To inform our study, we conducted research on the federal and state laws and regulations governing MHPAEA compliance and collected relevant guidance and documentation, including compliance worksheets and enforcement reports made publicly available by state regulators. Regulation of health benefit plans in California that are not self-funded is split between two regulatory agencies — the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI). The DMHC primarily regulates health maintenance organizations (HMOs) and some preferred provider organizations (PPOs). CDI regulates all other types of health insurance policies, including indemnity plans and most PPO plans. DMHC-regulated plans cover about 14 million lives, whereas CDI-regulated policies cover about 1 million lives. For the purposes of this report, we refer to “DMHC-regulated plans” and “CDI-regulated policies/insurers” to maintain this distinction.⁶

To understand how California’s mental health parity compliance processes operate in practice, how they have evolved since MHPAEA and the Patient Protection and Affordable Care Act (ACA) went into effect, and if there are any potential areas for improvement, we conducted 22 structured interviews with a cross-section of stakeholders between November 22, 2019, and February 25, 2020. We interviewed state regulators and officials, health insurers and health plans, representatives for providers and consumers, and mental health parity experts. Neither the study nor this report includes state regulator activities authorized under the recently adopted 2020–21 California state budget.

The Legal Framework: Parity on Paper

A patchwork of federal and state laws governs the coverage of mental health and substance use disorder (MH/SUD) benefits by health care service plans and insurers in California. While the state already had a number of state benefit mandates requiring coverage of certain specific MH/SUD conditions before MHPAEA went into effect in 2009, the ACA's essential health benefit requirements, which went into effect in 2014, further expanded and strengthened coverage for MH/SUD benefits for the individual and small group markets. Beyond mandates requiring coverage of MH/SUD conditions, California's own state parity law, which is limited in scope to nine severe mental illnesses, works in tandem with federal parity law to require that the coverage for MH/SUD benefits be on par with the coverage for medical/surgical benefits.

Parity in Federal Law

The federal government first addressed the issue of "mental health parity" through the Mental Health Parity Act of 1996 (MHPA). This law prohibited large group health plans from imposing annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits on medical/surgical benefits. Building on this, in 2008, Congress passed MHPAEA, which is the latest and most comprehensive effort by the federal government to ensure parity of MH/SUD coverage. MHPAEA and its implementing regulations go further than the original law to prohibit large group health plans (defined as employers with 51 or more employees) that provide MH/SUD benefits

from imposing stricter limitations on MH/SUD benefits than the ones they impose on medical/surgical benefits with respect to financial requirements, quantitative treatment limitations (QTLs), and non-quantitative treatment limitations (NQTLs) (see Table 1).⁷ MHPAEA does not actually require the provision of MH/SUD benefits, but only requires any large group plan that chooses to provide MH/SUD benefits to provide them at parity with medical/surgical benefits.

The ACA, enacted in 2010, further expanded protections for mental health and substance use disorders. The ACA, along with its implementing regulations, established minimum coverage standards for non-grandfathered individual and small group insurance plans (defined as employers with 2 to 100 employees under California law),⁸ requiring these plans (starting in 2014) to cover 10 essential health benefit (EHB) categories, including MH/SUD benefits,⁹ and made those plans subject to the parity rules under MHPAEA.¹⁰ Individual states select a "benchmark plan" to define the scope of coverage for the 10 EHB categories, and non-grandfathered individual and small group insurance plans in the state are required to provide benefits that "are substantially equal to the EHB-benchmark plan."¹¹

The ACA EHB requirements that mandate the coverage of MH/SUD benefits do not apply to large group plans, self-funded plans, or grandfathered individual and small group insurance plans; MHPAEA applies to these plans only to the extent that they cover MH/SUD benefits. Further, self-funded small employers with 50 or fewer employees are exempt from MHPAEA even if they do choose to cover MH/SUD benefits.¹²

Table 1. Benefit Limitations Considered Under MHPAEA

EXAMPLES	
Financial requirements	Copays, co-insurance, deductibles, out-of-pocket limits
Treatment limits	
▶ Quantitative	▶ Number of visits, days of coverage
▶ Non-quantitative	▶ Medical management standards, prior authorization, provider compensation or contracting

Source: 29 U.S.C. § 1185a; and 45 C.F.R. § 146.136.

Benefit Mandates and Parity in California Law

Several key pieces of legislation shape the requirements for coverage of mental health and substance use disorder benefits in California (see Table 2).

MHPAEA encompasses both the MH/SUD diagnostic conditions covered under a plan as well as the services needed to treat those diagnoses. Under the ACA's essential health benefit requirement, the scope of coverage for each benefit category, including the diagnostic conditions covered, must be "substantially equal" to that set by the state benchmark plan.¹³ California's state benchmark plan defines mental health conditions, including substance use disorders, using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV),¹⁴ which is not the most current version of the DSM. Among other

changes made to reflect the latest scientific knowledge, the DSM-5 adds 15 new diagnostic conditions.

Individual and small group insurance plans and policies are required to comply with the ACA's robust EHB requirements and the state benchmark plan's standards for MH/SUD benefits, but EHB requirements do not apply to large group plans and policies. Under state law, fully insured large group plans and policies are subject to all of the legislation noted in Table 2 except the 2015 law incorporating the ACA's EHB requirements into state law. CDI-regulated group policies that cover disorders of the brain are also required to cover treatment of certain biologically based severe mental disorders "in the same manner."¹⁵ However, the state-enumerated conditions that apply to fully insured large group plans and policies do not require coverage of substance use disorders.

Table 2. Timeline of Key California Mental Health Legislation

1975	California enacted the Knox-Keene Health Care Service Plan Act, which requires health care plans to cover all medically necessary "basic health care services," defined as physician services, inpatient services, diagnostic services, home health services, preventive health services, and emergency health care services, including ambulance services. ¹⁶
1999	Following enactment of the federal Mental Health Parity Act of 1996, California passed the California Mental Health Parity Act, ¹⁷ requiring all health care plans regulated by the California Department of Managed Health Care (DMHC) and all health insurance policies regulated by the California Department of Insurance (CDI) to cover the diagnosis and medically necessary treatment of nine "severe mental illnesses of a person of any age" and "serious emotional disturbances of a child," as defined under state law, and to do so under the same terms and conditions applied to other medical conditions. State law defines "severe mental illnesses" to include nine specific mental health conditions: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa. "Serious emotional disturbances of a child" is defined as a child who has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders other than a primary substance use disorder or developmental disorder. ¹⁸
2012	All DMHC-regulated plans and CDI-regulated policies are required to cover behavioral health treatment for pervasive developmental disorder or autism. ¹⁹
2014	All DMHC-regulated plans are required to comply with the federal MHPAEA and all its implementing regulations. ²⁰
2015	After the enactment of the ACA, California enacted a law incorporating the ACA's essential health benefits requirements into state law. More specifically, the law does the following: ²¹ <ul style="list-style-type: none">▶ Codifies the state's chosen benchmark plan▶ Adds the preexisting state benefit mandates to the definition of EHBs▶ Reiterates the requirement that plans and policies have to comply with MHPAEA This law only applies to DMHC- and CDI-regulated, non-grandfathered individual and small group plans and policies.
2017	All CDI-regulated policies are required to comply with the federal MHPAEA and all its implementing regulations. ²²

Although state law limits the conditions that must be covered, either by reference to an outdated DSM or to the enumerated list of conditions under state law, state regulators may be able to use their authority under state or federal laws to require coverage of an MH/SUD condition that falls outside the scope of the EHB requirements or state benefit mandates. For individual and small group plans, the state may be able to require a plan or policy to cover the condition through the ACA's prohibition against discriminatory benefit design²³ (see Table 3).

The combined effect of federal and state laws is that parity protections extend to millions of Californians in plans and policies overseen by DMHC or CDI. While MHPAEA only requires those large group plans that cover MH/SUD to do so in parity with medical/surgical benefits, the ACA requires all individual and small group plans to cover MH/SUD and to do so in parity with medical/surgical benefits, and state law requires fully insured large group plans to cover certain conditions and services.

Assessing Parity Compliance Under MHPAEA

The MHPAEA statute and regulations implementing the law outline an approach to assessing parity between MH/SUD and medical/surgical benefits in terms of financial requirements, quantitative treatment limitations, and non-quantitative treatment limitations. To begin, issuers and health plans are required to ensure that all MH/SUD benefits that fall within any one of the six classifications below are provided at parity with the medical/surgical benefits that fall within that same classification. Furthermore, if an MH or SUD benefit is covered in any one of six classifications, it must be covered in all classifications in which medical/surgical benefits are covered. The classifications are as follows:²⁴

- ▶ Inpatient, in-network
- ▶ Inpatient, out-of-network
- ▶ Outpatient, in-network (can be further subclassified into office visits and all other outpatient items and services)

Table 3. Key State and Federal Laws Setting Standards for Coverage of MH/SUD

	FULLY INSURED PLANS TO WHICH THE REQUIREMENT APPLIES	STATE REGULATOR ENFORCING THE REQUIREMENT
MHPAEA	Individual, small group, and large group health plans and health insurance policies	DMHC, CDI
ACA's EHB requirement	Individual and small group health plans and health insurance policies (non-grandfathered)	DMHC, CDI
Knox-Keene Health Care Service Plan Act (requiring coverage of "basic health care services")	<ul style="list-style-type: none"> ▶ Individual, small group, and large group health plans ▶ Individual and small group health insurance policies (non-grandfathered) 	DMHC CDI
California Mental Health Parity Act	Individual, small group, and large group health plans and health insurance policies	DMHC, CDI
State law requiring coverage of:		
<ul style="list-style-type: none"> ▶ Behavioral health treatment for pervasive developmental disorder or autism ▶ Treatment for certain biologically based severe mental disorders if the policy covers disorders of the brain 	<ul style="list-style-type: none"> ▶ Individual, small group, and large group health plans and health insurance policies ▶ Small group and large group health insurance policies 	DMHC, CDI CDI

Source: Author analysis of state and federal law.

- ▶ Outpatient, out-of-network (can be further subclassified into office visits and all other outpatient items and services)
- ▶ Emergency care
- ▶ Prescription drug

Financial Requirements and Quantitative Treatment Limitations

MHPAEA regulations set out a test, commonly known as the “substantially all / predominant test,” to compare financial requirements (FRs), such as copays, and quantitative treatment limitations, such as visit limits, within the six classifications described above. Instead of requiring issuers to compare FRs/QTLs between specific MH/SUD and medical/surgical benefits, MHPAEA requires that the FRs/QTLs applicable to MH/SUD benefits within each classification be no more restrictive than the predominant level of FR/QTL applicable to substantially all medical/surgical benefits within that classification.²⁵

Applying the Substantially All / Predominant Test

A type of FR/QTL is considered to apply to *substantially all* medical/surgical benefits within a classification if it applies to at least two-thirds of all medical/surgical benefits in that classification. If a type of FR/QTL does not apply to at least two-thirds of all medical/surgical benefits within a classification, then that type of FR/QTL cannot be applied to any MH/SUD benefits in that classification.

When a plan applies a type of FR/QTL to substantially all medical/surgical benefits as described above, the level of the FR/QTL the plan applies to more than half of those medical/surgical benefits is considered the *predominant* level. If there is no single FR/QTL level that applies to more than half of the benefits as described above, the plan can combine the levels until the combination of levels applies to more than half of the medical/surgical benefits subject to the FR/QTL, and the least restrictive level within the combination is considered the predominant level of that type within that classification. A plan is allowed to combine the least restrictive levels first.

Non-Quantitative Treatment Limitations

A plan must ensure that any nonnumerical limits on the scope or duration of benefits — the non-quantitative treatment limitations — for MH/SUD benefits are no more restrictive than those applied to medical/surgical benefits, both as written and in operation. As with financial requirements and quantitative treatment limitations, the assessment of NQTLs is measured within each benefit classification to ensure NQTLs are no more stringent than those applied to medical/surgical benefits in the same classification. The federal regulation implementing MHPAEA contains an inexhaustive list of what classifies as an NQTL:²⁶

- ▶ Medical management standards (such as prior authorization requirements) limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental
- ▶ Formulary design for prescription drugs
- ▶ Scope of services²⁷
- ▶ Network adequacy²⁸
- ▶ Network tier design
- ▶ Standards for provider admission to participate in a network, including reimbursement rates
- ▶ Plan methods for determining usual, customary, and reasonable charges
- ▶ Fail-first policies or step therapy protocols
- ▶ Exclusions based on failure to complete a course of treatment
- ▶ Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan

The standard for NQTLs to comply with MHPAEA is that a plan may not impose an NQTL on MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards,

or other factors used in applying the limitation to medical/surgical benefits in the same classification. Furthermore, MHPAEA specifically requires plans to cover out-of-network benefits for MH/SUD and medical/surgical benefits in a similar manner. While a plan may be able to demonstrate compliance with MHPAEA by articulating “comparable and no more stringently applied processes, evidentiary standards, or other factors” to exclude out-of-network MH/SUD benefits under specific circumstances, it may not “unequivocally exclude” all out-of-network treatment for MH/SUD benefits if it allows the use of out-of-network providers for medical/surgical services.²⁹

The DMHC Compliance Process

Initial Reviews

Following the release of the federal MHPAEA final rules in 2013, DMHC conducted an initial compliance review of all 25 commercial health care service plans subject to MHPAEA. The compliance review occurred in two phases.

Phase One

During the first phase, which occurred from 2014 to 2015, the DMHC conducted reviews of health plans’ benefits and policies to verify whether the plans were in compliance with MHPAEA. This included a comprehensive review of the plans’ methodologies for determining MHPAEA compliance in financial requirements, QTLs, and NQTLs in commercial products (individual, small group, large group, PPO, and HMO).

To assist with the review process, DMHC issued detailed instructions, hosted a webinar and in-person teleconferences to explain the applicable law, and developed worksheets for health care service plans to submit required documentation for each benefit design plan. Plans were not required to use the DMHC-developed worksheets so long as they submitted the requisite information. The worksheets and the purposes they served are as follows:

Tables 1–4: MHPAEA classification and cost-sharing worksheet.³⁰ Health care service plans use this worksheet to report financial requirements (including deductibles, out-of-pocket maximums, and copayment and/or co-insurance) for both medical/surgical and mental health/substance use disorder services in each of the following benefit classifications:

- ▶ Inpatient: in-network and out-of-network
- ▶ Outpatient office visit: in-network and out-of-network
- ▶ Outpatient other items and services: in-network and out-of-network
- ▶ Emergency visit
- ▶ Prescription drug

The worksheet includes a table for reporting QTLs for the above services. Health care service plans can use a separate worksheet to automatically calculate the substantially all / predominant test for financial requirements and quantitative treatment limitations based on the plan’s data.³¹

Table 5: Non-quantitative treatment limitations (NQTLs). Health care service plans use this to report on non-quantitative treatment limitations. These include plan definitions of medical necessity (and how they are used to approve both medical/surgical and MH/SUD treatment), services that use an automatic approval process, services for which prior or concurrent authorization is required, retrospective review policies, standards for provider credentialing, and prescription drug formulary design.³²

Table 6: List of exhibits to be filed and supporting documentation. For each benefit plan, health care service plans are required to list supporting documents for data reported in Tables 1–5, including methodologies, evidences of coverage, policies and procedures, disclosure forms, applicable contracts, and an attestation executed by a health plan officer that the analyses of the financial requirements and quantitative treatment limitations have been calculated in accordance with MHPAEA regulations.

Phase one submissions were reviewed by the DMHC Office of Plan Licensing, Office of Financial Review, and clinical consultants (a psychologist and a former medical group manager). During this period, DMHC issued comments to the health care service plan within 30 days of review, and gave the plan up to 30 days to respond. This back-and-forth continued until all outstanding issues were resolved and the review was complete. Upon completion of the phase one review, health care service plans were sent a “closing letter,” which summarized all of the changes the plan was required to make to its financial requirements, quantitative treatment limitations, and non-quantitative treatment limitations for mental health and substance use disorder services. Of the 25 plans reviewed in phase one, 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. Health care service plans were required to notify enrollees of required changes to QTL and NQTL services for the 2016 calendar year. The initial compliance review resulted in 24 out of the 25 reviewed plans lowering cost sharing for MH/SUD services beginning in the 2016 calendar year.

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Phase Two

Beginning in 2016 and continuing through 2017, phase two consisted of on-site surveys (audits) of the same 25 plans with a focus on non-quantitative treatment limitations, conducted by the DMHC’s Division of Plan Surveys and a clinical consulting team. These were referred to as “focused MHPAEA surveys” and are different from the medical surveys that DMHC is required to complete for all medical plans at least once every three years. During phase two, DMHC

confirmed that the plan made the required changes from phase one and reviewed additional documents, including evidence of coverage, summary of benefits, and utilization management (UM) files, which document approval, denial, and modifications of requests for services.³³

Health care service plans must submit UM files from the primary plan and any delegates performing utilization review. However, for plans with a high number of delegated entities, DMHC took a sample of UM files from a subset of delegates with over 1,000 enrollees. The on-site survey also consisted of interviews with plan staff, including the medical director, utilization managers, and credentialing staff — and, if applicable, the medical director of the behavioral health plan and any other delegates under contract. Findings from the UM review and interviews are summarized in the final focused survey.

Final Focused Survey

Based on the results of a review of whether the plan implemented requested changes from phase one, and the documentation and interviews conducted in phase two, DMHC produced a “Final Focused Survey Report” addressing the plan’s approach to non-quantitative treatment limitations, quantitative treatment limitations, and overall experience implementing MHPAEA, including delegation oversight and an assessment of the plan’s ability to maintain parity. These reports were released on a rolling basis in late 2017 and throughout 2018.

The surveys found 11 plans were MHPAEA compliant, while 14 plans were noncompliant in either NQTLs (seven plans), QTLs (two plans), or both (five plans). As a result of the DMHC’s focused compliance review, many health plans were required to update their policies and procedures and/or revise cost sharing for services and treatment. Seven health plans were required to recalculate cost sharing for enrollees after the DMHC found the plans had applied cost sharing for mental health and substance use disorder services that were not compliant with MHPAEA. This resulted in enrollees being reimbursed a total of \$517,375.

Ongoing Oversight

Targeted Exams

Since their initial review, DMHC has conducted comprehensive desk assessments of newly licensed plans' compliance with MHPAEA and targeted reviews when plans adopt changes substantial enough to require another review — for example, whenever they offer commercial coverage in a new market, add exclusive provider organization or PPO coverage to their previously approved HMO coverage, change their behavioral health plan, or make other significant changes to their license. These “targeted reviews” vary based on the scope of the change being requested; for example, a request to change behavioral health vendors would trigger a full NQTL review, while a request to add PPO coverage would trigger a new analysis of estimated claims to ensure that the substantially all / predominant test was calculated correctly.

In addition to these targeted efforts, the DMHC has incorporated compliance and enforcement of mental health parity in its oversight activities. This includes reviewing compliance during the DMHC's routine medical surveys of health plans and reviewing DMHC Help Center complaints.

Enforcement Action

When DMHC finds a violation, the director of DMHC is authorized to take actions, including the assessment of administrative penalties or cease-and-desist orders.³⁴ Enforcement actions may be initiated by different means, including through the DMHC's surveys of health plans, financial solvency and claims payment examinations, consumer complaints to the DMHC Help Center, whistleblower reports, and news articles.

The DMHC has taken enforcement action under state and federal parity laws. The DMHC completed two 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 of these enforcement actions included corrective action plans and \$20,000 penalties paid by the plans.³⁵ With respect to the state's parity law, the

DMHC has prosecuted a number of actions, including a \$10,000 penalty for denial of inpatient residential treatment for a severe mental health condition.³⁶ Additionally, DMHC has levied administrative penalties for other mental health violations, including a violation for 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, as specified, under the same terms and conditions applied to other medical conditions, and failure to cover mental illness and emotional disturbance.³⁷

DMHC recently concluded an investigation of Ventura Health Plan that began in 2017 and resulted in MHPAEA-related enforcement actions. DMHC issued a Letter of Agreement to Ventura Health Plan in July 2020.³⁸

CDI MHPAEA Compliance Process

Form Filing

CDI integrates mental health parity documentation during the form-filing process for individual and small group policies and student health plans, which is conducted annually, as well as for large group plans as they are received.³⁹ These reviews during the form-filing process began with policies filed for 2015 coverage. Specific filing requirements may change from year to year, based on trends or to target particular areas, but plans must submit the following documentation each year:

Mental Health Parity Analysis Workbook.⁴⁰ For each benefit plan included in the filing, the insurer is required to fill out the mental health parity analysis workbook, listing all medical/surgical benefits covered, together with total payments, copays, co-insurance, and deductibles in the following benefit categories:

- ▶ Inpatient: in-network and out-of-network
- ▶ Outpatient: in-network and out-of-network

- ▶ Outpatient office visit: in-network and out-of-network
- ▶ Outpatient other items and services: in-network and out-of-network
- ▶ Emergency visit
- ▶ Prescription drug

This information is used to calculate the substantially all / predominant test. Insurers are then required to separately list cost-sharing levels for in-network and out-of-network MH/SUD services, to demonstrate that they align with the substantially all / predominant test.⁴¹

Mental Health Parity Supporting Documentation.⁴²

This template consists of three distinct sections, filled out for each product and plans within that product being reviewed:

- ▶ *MH/SUD non-quantitative treatment limitations (NQTLs).* CDI requires plans to list out all MH/SUD benefits subject to NQTLs in each category of benefits. In contrast to DMHC's NQTL worksheet (Table 5), the CDI worksheet does not require an explanation of processes or evidentiary standards.
- ▶ *Explanations of methodology.* For each benefit plan being filed, the insurer is required to submit an explanation of methodology, demonstrating that the plan's quantitative parity analysis was prepared in compliance with the federal rule's methodological requirements. This includes a description of the underlying data used to determine the total payments of each benefit in the quantitative analyses, and a description of the methodology used to perform the quantitative mental health parity analysis of each cost-sharing type.
- ▶ *Classification chart.* For each benefit plan, an insurer is required to describe how it determines classification of services for each category of benefits, including specific factors, standards, and criteria used to determine which benefits belong in this classification. The insurer is also required to create side-by-side lists of which medical/surgical and

mental health and substance use disorder services are covered within each benefit classification.

CDI states that they use this initial form filing as a basis to identify potential issues and flag areas of concern. Following the submission of form-filing documents, CDI will engage in a back-and-forth with the insurer to request additional information and ask specific follow-up questions. CDI uses additional tools to collect information on prescription drug formularies, network adequacy reviews, and a separate workbook that evaluates MHPAEA compliance for FRs and QTLs.

In addition, CDI conducts MHPAEA compliance through its statutorily required market conduct exams, which must occur once every five years. CDI stated that it will conduct additional targeted exams that focus on a specific company or issue; high volume or trends in consumer complaints were cited as potential triggers for these reviews. Additionally, CDI staff stated that they are conducting regularly scheduled market conduct exams of health insurers, with a focus on mental health and substance use disorder claims, though these exams are not yet complete.

Enforcement Action

CDI tracks complaints from both consumers and providers through its consumer services division, which addresses these complaints directly with insurers. A high volume of complaints, or a particular trend, can prompt CDI to do a targeted review. For repeat offenders, CDI has the authority to levy financial penalties through the Unfair Insurance Practices Act. It can also take administrative enforcement actions, such as issuing an Order to Show Cause to compel a company to take action or face a penalty. In severe cases, the department can revoke certificates of authority or withdraw approval of policy forms, but these are not undertaken as a matter of routine.

CDI recently completed an examination of Aetna Life Insurance Company, 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 was due mid-August 2020.⁴³

Findings from Stakeholder Interviews: Parity in Practice

Stakeholders were nearly universal in noting that the DMHC was well ahead of other states in developing its approach to reviewing plans for MHPAEA compliance, particularly on the NQTLs, and did so soon after federal final regulations were issued in 2013 and before the US Department of Labor (DOL) toolkit was released in 2018. One stakeholder said California is a “pace car state” that brought attention to the MHPAEA issues and revealed practices that weren’t in compliance. DMHC was also recognized for its early collaboration with providers as regulators developed their enforcement tools for the initial reviews. However, patient and provider representatives said that DMHC’s more recent engagement with them, including through the Help Line that takes complaints, has been less successful. Of CDI’s efforts, most stakeholders said the department, which received a federal grant for MHPAEA enforcement in 2016, has developed “granular” tools that more closely adhere to the approach taken in the DOL toolkit. In contrast, DMHC uses open-ended questions in their worksheets, which regulators say they use to inform follow-up discussions with health plans.

Both DMHC and CDI are still ahead of most states, said multiple stakeholders with knowledge of enforcement efforts in other states. But interviews reveal that some stakeholders are still disappointed with California regulators’ enforcement of NQTLs, which they believe has allowed health plans and insurers to effectively maintain barriers to accessing care.

Stakeholders Noted Progress in Meeting Parity in Financial Requirements and Quantitative Treatment Limitations

Regulators, health plans, and insurers noted that progress has been made in assessing compliance for financial requirements and quantitative treatment limitations and that plans and insurers have “for the

most part, [been] compliant with the[se] standards.” Patient and provider representatives mostly agreed with this assessment. However, health plan and insurer representatives noted challenges that remain. One payer stated that the whole concept of comparing all the services within each classification, as required by MHPAEA, is unworkable in practice. Payers pointed to the difficulty of comparing hundreds of outpatient services on the medical/surgical side to the relatively few outpatient services on the MH/SUD side, with implications for cost sharing. For example, a payer said they interpret MHPAEA to require that they cover certain expensive MH/SUD benefits, like applied behavioral analysis for autism, at no cost sharing because MHPAEA requires the cost sharing to align with that for home health visits on the medical/surgical side. Another payer pointed out that the ACA’s requirement to cover preventive services without cost sharing enhances benefits on the medical/surgical side and therefore requires a review of all the financial requirements applicable to MH/SUD services to ensure compliance with MHPAEA’s standard for financial requirements. One regulator confirmed that in their reviews of MHPAEA compliance documentation, they have encountered a “lack of a workable, neutral standard for subclassifying outpatient benefits, and inconsistent application of the standard.”

Significant Work Remains to Ensure Parity in Non-Quantitative Treatment Limitations

There was universal agreement among representatives of each stakeholder group interviewed that achieving parity with respect to non-quantitative treatment limitations continues to be the dominant challenge in complying with MHPAEA. Patient and provider representatives expressed frustration over how the lack of compliance with NQTL standards is creating barriers to accessing necessary care and adversely affecting mental health outcomes, noting that the complexity of NQTLs gives insurers flexibility to apply limits that wouldn’t apply to medical/surgical benefits. Health plans and insurers, on the other hand, expressed a need for more concrete guidance from regulators on how to comply with MHPAEA’s NQTL requirements.

As one said of the DOL's "red flags" guidance for NQTLs,⁴⁴ "Where are the green flags?" Most stakeholders primarily raised issues with respect to three types of NQTLs: utilization management, medical necessity, and network adequacy.

Utilization Management

Utilization management is the use of techniques like prior authorization, concurrent review, and retrospective review (see box below) to allow plans and insurers 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. Health plans and insurers are expected to use evidence-based criteria and guidelines to develop these techniques. To comply with parity law, these techniques must be applied no more strictly to MH/SUD benefits than they are to medical/surgical benefits.

CDI pointed out ongoing issues with plans and insurers being unable to produce NQTL comparative analyses demonstrating that application of prior authorization requirements to outpatient MH/SUD benefits complies with the NQTL rule. As a result, insurers have, for the most part, eliminated prior authorization for outpatient MH/SUD benefits from policy forms. However, according to provider and patient representatives, prior authorization continues to be an issue. Two provider and one patient representative gave examples of prior authorization being required for emergency behavioral health care. In California, as in

most states, insurers cannot deny payment in cases of emergency because of lack of prior authorization. However, a patient advocate gave a real-life example of a patient who went to the emergency room with an MH/SUD crisis and was told they would not be able to receive treatment until the insurer provided approval. A behavioral health hospital representative gave the example of an insurer who "routinely denies care" for psychiatric emergencies if authorization is not obtained within 24 hours of admission, even if the admission occurs over a weekend when UM staff are unavailable. While the provider mentioned that they are able to get these decisions overturned through the appeals process, repeatedly having to deal with situations like these creates undue burden on providers and patients.

One payer stated that for medical/surgical services, hospitals usually rely on diagnostic-related groups (DRGs) to establish in-patient reimbursement rates based on long-standing calculations, but because DRGs do not exist for MH/SUD benefits, payers are more reliant on utilization management to determine payment. One provider noted that it would be reasonable given the average length of in-patient stays to allow for a seven-day hospital stay for mental health conditions without prior authorization; however, others expressed the opposite view. A payer said standardizing care by imposing minimum stays would remove the incentive to provide individualized care, and a representative of SUD providers said the SUD field is moving away from the "28-day inpatient model" of care.

Understanding Utilization Management: Key Terms

Prior authorization. When a payer requires a provider to seek authorization for providing a service beforehand. If a payer requires prior authorization for a service and the provider does not obtain it, the payer may deny the provider's claim for that service.

Concurrent review. When a payer requires ongoing review of care currently being provided to determine whether continued services or benefits, such as additional days in a hospital or sessions of therapy, are medically necessary.

Retrospective review. When a payer looks at a service that has already been provided to determine whether the service was covered by the patient's plan and/or is medically necessary. If the payer determines that the service was not covered or not medically necessary, the payer may deny the provider's claim for that service.

Beyond prior authorization, plans and insurers also use concurrent review to evaluate medical necessity of care on an ongoing basis and require providers to confer with a doctor on the plan or insurer's staff who determines whether additional days of care will be covered. One provider representative expressed worry that when payers deny additional days of service through their concurrent review process, patients get discharged too soon only to then be potentially readmitted later. However, given that the patient might be readmitted to a facility other than the one that provided the initial care, the payer is the only entity with data on patient relapse as a result of its denial of continued service. Currently, readmission data are not reviewed as part of the MHPAEA compliance process.

While denials for care on the basis of prior authorization requests and concurrent review continue to be a source of concern, most providers and patients also expressed frustration over the administrative burdens that these requirements impose. Providers found that procedures vary widely, with some plans and insurers approving care day by day and others allowing for three days of care or one to two visits at a time. Providers' representatives said a significant amount of their time at work is spent keeping track of the different requirements each plan and insurer imposes and going through appeals processes for denials. One hospital representative said that they have had to "call to beg" and haggle over appropriate level of care for their patients with the plan or insurer. One provider representative pointed out that these requirements are particularly burdensome for smaller practices that do not have the resources to dedicate to these regular interactions with health plans and insurers, but another provider representative said even larger hospitals with dedicated utilization management departments found it to be a resource-intensive process given the widely divergent standards set by the different payers.

Furthermore, these heightened administrative burdens produce a higher probability for administrative denials — denials based not on the lack of medical necessity but because the provider or patient failed to meet certain protocols set by the insurer. However,

administrative denials are currently not reviewed as part of either regulator's MHPAEA compliance process.

Multiple stakeholders said health plans' use of delegates — entities contracting with the plans to provide care (e.g., large medical groups) or carry out certain functions (e.g., behavioral health organizations that manage the MH/SUD coverage or conduct utilization review and authorize payment of claims) can exacerbate problems with utilization management. Each delegate may have its own utilization management program and protocols, and though the health plan is responsible for ensuring MHPAEA compliance across all delegates with which it contracts, coordination and oversight of utilization management under those delegates can be difficult. For example, one health plan said their delegates may have a practice of subjecting certain providers who have demonstrated effective utilization to less stringent prior authorization for some procedures, but that practice is not captured in the UM policies the plan evaluates for compliance with MHPAEA. If a similar practice is not applied to MH/SUD providers that demonstrate effective utilization, it could be a potential parity violation.

Medical Necessity

The criteria used for assessing medical necessity is an NQTL itself, separate from how these criteria are applied through utilization management processes. When providers reach out to insurers to obtain authorization for care, the insurer assesses the medical necessity of the treatment or services being requested using generally accepted medical standards. However, as demonstrated by the recent landmark case *Wit v. United Behavioral Health*, insurers and their vendors can use their own internally developed level-of-care and coverage determination guidelines, which can be, as they were in the case of United Behavioral Health, much more restrictive than generally accepted medical standards.⁴⁵ One patient advocate stated that "medical necessity is the most significant means by which insurers deny claims," with some stakeholders saying the *Wit* decision revealed deficiencies in the regulators' approach in California.

Medical necessity determinations may include days and level of care that will be covered. Health plans talked about the need to move away from prescribed minimum days of inpatient care and to instead rely on individualized care that may use a lower level-of-care setting. A behavioral health plan provided the example of patients with eating disorders who are treated in outpatient family therapy programs that are more successful than residential treatment programs when the

standard of success is weight gain. On the other hand, a hospital representative said it can be difficult to get approval for post-hospital care in a lower level-of-care setting, comparing it to denying someone physical therapy following hip surgery.

Most patient and provider representatives said regulators must take a closer look at medical necessity criteria for potential parity violations, with some saying

The *Wit* Decision and Implications for MHPAEA

Wit v. United Behavioral Health is a case brought under the Employee Retirement Income Security Act of 1974 (ERISA), not MHPAEA, and the decision applies to enrollees covered under ERISA plans overseen by the US Department of Labor. But the issues raised are those that could also be considered violations of MHPAEA. For example, if UnitedHealthcare adopted and applied medical necessity criteria that comply with generally accepted standards of care for medical/surgical benefits and didn't do that for MH/SUD benefits, that would be a parity violation. Furthermore, some of the plaintiffs in the class were enrolled in health plans regulated by states other than California. The case is therefore seen by many as an indicator of insurer practices that are ripe for close review by state regulators.

* * * * *

In *Wit v. United Behavioral Health*, No. 14-cv-02346-JCS, 2019 U.S. Dist. LEXIS 35205 (N.D. Cal. Feb. 28, 2019), 11 plaintiffs filed a class action lawsuit on behalf of 50,000 individuals whose claims were denied, alleging that United Behavioral Health (UBH), the entity that manages behavioral health services for UnitedHealthcare and other health insurers, breached its fiduciary duty under ERISA by developing and implementing clinical policies and coverage guidelines that were inconsistent with generally accepted standards of care, and that they prioritized cost savings over members' interests. UBH claimed that it covered the care that was medically necessary according to generally accepted medical standards.

The court took into account the criteria and guidelines published by industry groups and the Centers for Medicare & Medicaid Services (CMS) as well as expert opinions and ruled that UBH's own level-of-care and coverage determination guidelines were more restrictive than generally accepted medical standards and "infected" by financial incentives. Based on the evidence presented to the court, it additionally identified eight generally accepted standards for treating mental health and substance use disorders:

1. Treatment must address underlying conditions and not be limited to alleviating current symptoms.
2. Treatment should consider and address co-occurring behavioral and medical conditions in a coordinated manner.
3. Treatment should take place at the least intensive and restrictive level of care that is safe and effective.
4. When there is ambiguity, the practitioner should err on the side of caution by placing the patient in a higher level of care.
5. Treatment should include services needed to maintain functioning or prevent deterioration.
6. Appropriate duration of treatment should be based on the individual needs of the patient without specific limits on the duration of such treatment.
7. Unique needs of children and adolescents must be taken into account when making level-of-care decisions.
8. Determination of the appropriate level of care should be made on the basis of a multidimensional assessment.

regulators are not “equipped” to assess medical necessity criteria for MH/SUD. A patient advocate said regulators do not challenge criteria, including those that limit care to addressing acute crises or alleviating symptoms but don’t allow for long-term treatment and recovery. One provider representative likened certain mental health disorders to chronic conditions like diabetes that require both acute interventions and ongoing treatment to maintain health. As with the challenges noted with utilization management, some health plans said ensuring parity compliance can be more challenging with delegates that may each use their own medical necessity criteria.

While some recommended that the state establish a uniform definition, others suggested that regulators require health plans to demonstrate how their guidelines reflect generally accepted medical standards. However, one provider representative said that there is no “magic pill,” specifically with respect to treatment guidelines for substance use disorders, making it more challenging to create and apply treatment criteria. At least one payer we spoke to said they use internally developed criteria, but a few patient and provider advocates recommend the use of scientifically evaluated criteria like the Level of Care Utilization for Psychiatric and Addiction Services (LOCUS) developed by the American Association of Community Psychiatrists to guide medical necessity determinations.⁴⁶

Provider Networks

Patient and provider representatives overwhelmingly cited a dearth of in-network providers as a significant barrier to accessing mental health services — an issue that is not unique to California. A recent report documenting MH/SUD network problems nationwide found that in California, inpatient behavioral health care was 7.8 times more likely to be out-of-network, and behavioral health office visits were 4.2 times more likely to be out-of-network than medical/surgical care.⁴⁷ California’s network adequacy requirements include standards for plans to ensure enrollees can obtain services within a reasonable time and distance, and in 2016, the state implemented stringent

minimum standards for provider directories, requiring health plans and insurers to reach out to providers to verify a variety of information on a quarterly basis. However, one provider representative said his organization conducted a study of health plan provider directories and found many to include inaccurate listings and few mental health providers who could meet the time standards for obtaining an appointment. Inaccurate provider directories also affect patient cost. A recent study found that the prevalence of inaccurate provider directories increases the likelihood that patients will use out-of-network mental health care, making them four times as likely to receive a surprise bill for the added cost of out-of-network care.⁴⁸

The patient and provider representatives we spoke to said inadequate networks with respect to MH/SUD providers is an area that has largely been overlooked by regulators in California. According to provider and patient representatives, low reimbursement rates, onerous health plan processes for authorizing payment, and burdensome contracting terms are the dominant reasons for the shortage of in-network mental health providers, all of which are NQTLs subject to review under MHPAEA. The Milliman report cited above also showed significantly lower reimbursement rates for in-network services by behavioral providers versus medical/surgical providers, with the gap widening over time.⁴⁹

Provider representatives also expressed concerns related to the administrative burden involved in processing the paperwork required for utilization management and the appeals processes post-denial. Given how hard it is to get paid for services rendered, provider representatives say there is a lack of incentive to join plan and insurer networks. Yet another issue that providers raised was that health plans and insurers seem to be tightening credentialing requirements for providers. One provider representative stated that health plans and insurers will repeatedly change their credentialing rules, requiring providers to go through the process multiple times.

The regulation implementing MHPAEA specifically includes standards for provider admission to participate in a network, including reimbursement rates, in the list of NQTLs covered by MHPAEA.⁵⁰ The 21st Century Cures Act enacted in 2016 requires the Department of Labor, the Department of Health and Human Services, and the Department of the Treasury to issue clarifying information on the development and application of NQTLs such as factors used in provider reimbursement methodologies. The three agencies issued guidance stating: “Standards for provider admission to participate in a network, including reimbursement rates, are an NQTL. . . . Greatly disparate results — for example, a network that includes far fewer MH/SUD providers than medical/surgical providers — are a red flag that a plan or issuer may be imposing an impermissible NQTL.”⁵¹ While differences in reimbursement rates are not, on their own, a violation of MHPAEA, they are an indication of a potential violation that should prompt a review of a health plan’s or issuer’s reimbursement methodologies.

Another plan standard that affects whether a provider joins a network is provider credentialing. Payers claim that the proliferation of low-quality providers, particularly related to addiction treatment, is driving their changes to credentialing processes. Representatives for health plans and insurers as well as an addiction treatment provider we spoke to expressed concern about fraud and poor-quality MH and SUD service providers, particularly gray-area providers like “sober houses.” One provider representative stated that there is lack of oversight, particularly over substance use treatment facilities, and that a number of these facilities have been involved in poor marketing practices, poor-quality treatment, and balance billing (wherein an out-of-network provider bills the patient for an outstanding balance after the insurance company pays its portion of the bill). The representative called California the “Wild West” for licensure, and while it is important for states to step in and standardize licensing processes, this falls outside the purview of regulators who assess parity compliance.

Considerations for Policymakers and Regulators

Stakeholders and the regulators we interviewed identified opportunities to improve oversight and compliance. Some of the recommendations directly address the areas most frequently cited as recurring problems that limit access to behavioral health care — utilization management, medical necessity criteria, and provider networks. Others would strengthen regulators’ authority and processes.

Improved oversight of utilization management. The dominant issue identified by stakeholders representing providers and patients was inadequate oversight of insurer and health plan utilization management programs and, more specifically, the medical necessity criteria used to make coverage determinations. Provider and patient representatives said greater standardization and specificity is needed to ensure patients with the same profile aren’t treated differently based on how strictly their insurer or health plan applies medical necessity criteria. Insurers and health plans 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 the American Society of Addiction Medicine (ASAM) criteria or LOCUS to identify the level of care most appropriate for patients given their individual circumstances. Some states have recently enacted legislation establishing requirements for medical necessity standards. New York, for example, requires insurers to use evidence-based criteria that are approved for use by the state Office of Mental Health.⁵² Other states have enacted requirements that medical necessity determinations for substance use disorder be consistent with criteria established by ASAM (Illinois, Delaware, and Maryland).⁵³ CDI said stronger legal standards for medical necessity and additional resources to retain clinical experts to help with health plan reviews and insurer exams would help strengthen oversight.

Evaluating provider networks for parity. Stronger medical necessity standards and improved oversight of utilization management would help address some of the issues providers identify as reasons for their low participation in networks — administrative burdens associated with getting care approved and reimbursed. However, credentialing requirements and low reimbursement rates are other factors that discourage providers from participating in networks. Regulators in California review provider networks for compliance with regulatory standards regarding timely access to appointments, geographic access, and ratios of providers to enrollees, but they do not currently review provider networks for compliance with MHPAEA’s NQTL requirements. Some insurers and health plans suggested that regulator reviews for network access standards were sufficient and no additional reviews were needed for parity purposes. But federal regulations make clear that provider networks may violate NQTL rules, separate from any network adequacy requirements. Unjustified differences in reimbursement rates and unequal efforts to incentivize network participation — for example, through increased reimbursement and an accelerated process for network participation — are potential parity violations. DMHC said a comparison of reimbursement rates would be difficult because of the capitated rates used by the managed care plans they regulate. Regulators at DMHC also indicated that they do not have the authority to review provider reimbursement rates. Their authority to enforce MHPAEA, however, may provide inherent authority to review provider reimbursement rates for NQTL compliance. Few states have examined provider networks under MHPAEA, but three recent examples of enforcement actions based at least in part on disparate reimbursement practices — in Maryland, Massachusetts, and New Hampshire — may provide models.⁵⁴

Clearer authority to enforce coverage of all diagnoses in the DSM. MHPAEA applies when MH and SUD benefits are covered under a plan. California law requiring coverage of only designated MH conditions in large employer plans is more limited in scope than that applicable to small group and individual

market plans subject to the ACA’s EHB requirement. Furthermore, the state’s law designating the EHB benchmark plan references an outdated version of the DSM. Though regulators did not indicate health plans and insurers were able to use these limits to exclude diagnoses from coverage, regulators confirmed that it would be helpful to have clear authority to require coverage of all diagnoses in the most recent version of the DSM.

Clearer expectations for insurers and health plans that use delegates. Under MHPAEA, health plans and insurers are responsible for ensuring compliance with the law, regardless of whether some functions are delegated to other entities. California law includes the same requirement.⁵⁵ Some insurers and health plans indicated that the use of delegates — whether for medical/surgical or MH/SUD care — complicated efforts to monitor for compliance. Regulators have clear authority to place the burden on plans for them to ensure compliance across all delegates.⁵⁶

Improved processes for getting input from providers. Providers are in a better position than their patients to see potential parity violations and can be key allies to regulators in identifying trends and issues that warrant close scrutiny. CDI and DMHC each have a dedicated portal through which providers can bring potential parity violations to the attention of regulators. DMHC noted that providers have been helpful in identifying potential parity violations, particularly when regulators reached out to providers prior to conducting their initial reviews of health plans beginning in 2014. However, some provider representatives said they’ve found it more difficult since that early outreach to get issues addressed at DMHC. Regulators could undertake greater outreach to providers to obtain information that could help inform targeted reviews and exams. For example, Pennsylvania’s insurance department, working with other state agencies, released a survey to obtain input from providers on barriers to accessing mental health and substance use disorder services.⁵⁷

Implementation of DOL's NQTL analysis. While CDI's documentation requirements seem to align with the five-step analysis specified in the DOL compliance toolkit, DMHC's requirements for documentation don't appear to address how plans use evidentiary standards in developing the NQTL factors and the thresholds that trigger the application of an NQTL. This information is needed to determine if an NQTL conforms with the required MHPAEA standard.

Greater use of claims data. Claims data can be an indicator of potential NQTL violations. For example, if the rate of denial is much higher for MH/SUD claims than for medical/surgical claims, it could indicate a potential parity violation with the medical necessity standard. Use of these data can allow regulators to focus their attention and limited resources on potential problem areas. The departments need specific authority to collect claims data on a regular basis to allow for such an analysis.

Conclusion

Enactment of MHPAEA significantly strengthened the requirements for health plans' and insurers' coverage of mental health and substance use disorder illnesses. MHPAEA's comprehensive approach to coverage rules — requiring coverage on par with medical and surgical benefits not just in out-of-pocket costs and visit limits, but also for those plan rules that aren't as easily measured — promises improved access to essential services. But there are limits to the law. MHPAEA does not guarantee that services and treatments for mental health and substance use disorders will be affordable, easily accessed, or comprehensive. The law merely sets standards for ensuring that coverage is at least as good as the coverage of medical and surgical care.

Within the scope of MHPAEA, however, stakeholders identified areas where problems persist and enforcement must be strengthened if the law's promise is to be met for California's consumers. Though regulators have made considerable progress in ensuring compliance with MHPAEA's rules for financial requirements

and treatment limitations, non-quantitative treatment limitations too often impose substantial barriers to obtaining care.

California regulators were early leaders in parity enforcement, and the state is still among a relatively small number of states undertaking substantive enforcement efforts. But there is growing interest among some states to strengthen their efforts, reflected in a workgroup at the National Association of Insurance Commissioners to facilitate states and experts sharing enforcement tools and resources. California regulators can build on their early efforts and potentially learn from other states to strengthen their oversight and make progress toward fulfilling the promise of parity.

Appendix A. Results of MHPAEA Compliance Reviews

Following the release of federal regulations implementing the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2014, the California Department of Managed Health Care (DMHC) conducted an initial compliance review of 25 commercial health care service plans. In 2019, the California Department of Insurance (CDI) released a report from a market conduct exam of Blue Shield of California Life and Health Insurance Company.

Below is a summary of the DMHC’s findings, based on our analysis of the final focused survey reports published on the DMHC website from late 2017 through 2018⁵⁸ and interviews with department staff. The summary of CDI’s exam is based on the report.⁵⁹

Analysis of DMHC Final Focused Surveys

Our analysis of the 25 health care service plans (HCSPs) included in the DMHC’s initial review of MHPAEA compliance filings showed that 11 plans were in compliance for quantitative treatment limitations (QTLs) and the non-quantitative treatment limitations (NQTLs) examined in the reviews. Seven plans were out of compliance for NQTLs, 2 were out of compliance for QTLs, and 5 were out of compliance for both NQTLs and QTLs (see Table A1).

Plans submitted a wide range of utilization management (UM) files, covering specific claims for care provided in a variety of settings — inpatient, residential treatment / skilled nursing, office visit, other outpatient, and emergency care — for medical/surgical (M/S), mental health (MH), and substance use disorder (SUD) services. DMHC asked all plans to produce the same number of UM files, for both MH/SUD

Table A1. Compliance with MHPAEA in Initial Review of DMHC Health Care Service Plans (HCSPs)

HCSPs IN FULL COMPLIANCE	HCSPs IN NONCOMPLIANCE		
	ON NQTLs	ON QTLs	FOR NQTLs AND QTLs
Aetna Health of California	Alameda Alliance for Health	Chinese Community Health Plan	L.A. Care Health Plan
Blue Cross of California/ Anthem Blue Cross	California’s Physician Services / Blue Shield of California	Kaiser Foundation Health Plan / Kaiser Permanente	Joint Powers Authority
Cigna Healthcare of California	Contra Costa County Medical Services / Contra Costa Health Care		Local Initiative Health Authority for Los Angeles County / L.A. Health Care Plan
Community Care Health Plan	San Mateo Health Commission / Health Plan of San Mateo		Sharp Health Plan
Health Net of California	Santa Cruz / Monterey / Merced Managed Medical Care Commission / Central California Alliance for Health		Ventura County Health / Ventura County Health Plan
MediExcel Health Plan	Seaside Health Care		Western Health Advantage
Molina Health Care of California	UHC California / UnitedHealthcare of California		
San Francisco Health Authority / San Francisco Health Plan			
Santa Clara County / Valley Health Plan			
Sistemas Medicos Nacionales / SIMSA Health Plan			
Sutter Place Health			

Source: Author analysis of the final focused survey reports published on the DMHC website from late 2017 through 2018 and interviews with department staff.

and medical/surgical services, in inpatient, outpatient, and other services categories. However, the number of files documented in each report varied because some plans did not have either approval or denial files to produce for review in the three service categories. As a result, the total count of files submitted ranged from 152 UM files for one health care service plan, to zero UM files submitted by a small plan with few mental health claims, for which the DMHC cited the plan for a deficiency in UM. DMHC noted that, while they looked at both approval and denial files, state law does not require plans to document the reasons for a UM approval in the same way they must document the clinical reasons for a UM denial, which sometimes made it difficult to assess plans' UM approval processes.

The reports include information from DMHC's interviews with health care service plan staff to confirm processes described in UM files or the phase one worksheets, and provide clarification on specific processes. In some cases, department staff note that an explanation offered was sufficient to show compliance even where documentation wasn't provided."⁶⁰

Plans reported using a variety of UM criteria, including internal guidelines, Milliman Care Guidelines (MCG), InterQual, and behavioral health delegate-specific criteria.

As evidenced in Table A1, there was a much lower incidence of QTL noncompliance compared to NQTL noncompliance, with only seven total plans demonstrating QTL noncompliance. The reports point to specific instances of noncompliance. For example, one health care service plan was cited for a benefit plan that charged a copayment for psychological testing when comparable services on the M/S side were charged co-insurance.⁶¹ Several of the plans cited had revised their QTL standards prior to the publication of the final report, in response to the "closing letter" sent following the end of phase one.⁶²

The delegation of medical/surgical and mental health / substance use disorder utilization management to separate vendors was a frequent thread throughout

the reports and in discussion with DMHC. Of the plans that did not meet the compliance threshold for NQTLs, eight either delegated UM to a behavioral health vendor (such as HAI/Magellan, Optum Behavioral Services, or Beacon/CHIPA) or used criteria provided by a behavioral health vendor when making MH/SUD benefit determinations.⁶³ Five plans that delegated UM to a behavioral health vendor met the compliance threshold.⁶⁴

In several final reports, it was noted that some delegated medical groups used criteria or practices for assessing utilization management for M/S that were different from the criteria or practices used by MH/SUD vendors when making UM decisions. Examples include the following:

- ▶ One health care service plan provided documentation showing that delegated medical groups used auto-authorization lists, policies, and procedures, while the plan's behavioral health vendor confirmed that no mental health / substance use disorder services were auto-authorized.⁶⁵
- ▶ Two reports showed that the health care service plans' delegated behavioral health vendors had 24/7 utilization management staff, whereas the delegated medical groups relied on auto-approvals in lieu of weekend staffing. This resulted in weekend auto-approval processes for M/S services that were not provided for MH/SUD services.⁶⁶
- ▶ Several reports showed that health care service plans delegated M/S services to vendors that relied on a wide range of criteria for making UM decisions, while the MH/SUD vendor was limited to strict, specific criteria. For example, one report states: "Review of M/S Inpatient files from the Plan and two of its delegates revealed that, in practice, the Plan and its delegates apply a combination of MCG, InterQual, individual medical group criteria, and clinical judgment to approve requested M/S services. . . . However, the Department's review established the Plan strictly relies upon Magellan guidelines to approve MH/SUD services."⁶⁷

For health care service plans that delegate to a behavioral health vendor that did meet the compliance threshold for NQTLs, reports noted that the plan either used the same UM process for M/S and MH/SUD services, or utilized the same clinical criteria when making benefit decisions.⁶⁸

Follow-up reports. For plans that did not meet the compliance threshold for QTLs or NQTLs, DMHC issued follow-up reports in early 2019, assessing the health care service plan’s response to the outstanding noncompliant findings from the final focused survey. Health care service plans submitted both revised worksheets and documentation to show evidence of corrective action.⁶⁹ Plans that do not take corrective action in the follow-up report are directed to DMHC Office of Enforcement for further investigation.⁷⁰

Analysis of CDI Market Conduct Exam of Blue Shield

CDI conducted a market conduct exam⁷¹ of Blue Shield that targeted the plan’s claims-handling practices, with a particular focus on claims handling of mental health claims in the individual and group market (see Table A2). The exam report, published in December 2019, focuses on a yearlong period in 2015–16.⁷² The examination includes a review of the following:

- ▶ Guidelines, training programs, forms, and procedures maintained by the plan.
- ▶ Sample claims and individual records, to determine application of plan guidelines. For the

purposes of the exam, examiners randomly selected 160 individual and group disability health claim files, 90 individual and group disability mental health claim files, and 25 pharmacy claim files.

- ▶ CDI market analysis results, as well as any consumer complaints from the review period. CDI identified 345 consumer complaints for the review period, and determined 131 were justified.
- ▶ The company’s response to a CDI questionnaire pertaining to company procedures during the review period for complying with the California Mental Health Parity Act and coverage for essential health benefits pursuant to the Patient Protection and Affordable Care Act.

Examples of violations that specifically pertain to mental health include the following:

- ▶ Two instances where providers unintentionally submitted mental health claims directly to the insurance company, even though mental health benefit administration for the plan is delegated to Magellan Health and providers are instructed to send claims directly to Magellan. These initial claims were denied, with the providers instructed to send the claim to Magellan. Claims that were not resubmitted within 90 days of the original procedure were improperly denied for untimely filing.

Table A2. Summary of Sample Claims Review

	MEDICAL CLAIMS REVIEW		MENTAL HEALTH CLAIMS REVIEW	
	SAMPLE	ELECTRONIC	SAMPLE	ELECTRONIC
Total claims	3,659,071	1,775,228	50,978	40,260
Number of claims in sample	185	N/A	90	N/A
Number of CDI alleged violations	106	38,498*	71	1,014*

*The total number of alleged violations identified in the electronic review also include those alleged violations identified in the actual claim review.

Source: Author compilation.

- ▶ One instance where the insurance company wrongly denied mental health services for major depressive disorder, even though the California Mental Health Parity Act requires coverage to be provided for this condition.
- ▶ Two instances where the company failed to ensure accurate accounting between themselves and Magellan, resulting in miscalculation of yearly maximum copayments/co-insurance, insured's deductibles, and out-of-pocket maximum amounts.
- ▶ One instance where an emergency service for a mental health condition was improperly denied for lack of prior authorization; the company stated that the initial denial was an error, and they reminded Magellan that prior authorization was not required for emergency admission.
- ▶ There were several examples where confusion regarding diagnostic codes led to denied claims. In one example, the insurance company denied a claim due to invalid diagnosis codes even though the provided codes were correct; the company stated that the Magellan processor did not recognize the code and improperly denied the claim. In another example, the company improperly denied a claim on the premise that charges did not match the diagnosis for which the authorization was issued, even though the company had in fact issued an authorization for the diagnostic code and services rendered. The improper denial was due to a mismatch between actual diagnosis codes and the generic code entered into the Magellan system.
- ▶ There was also at least one example of Magellan denying a claim based on failure to obtain prior authorization in a manner that was inconsistent with similar claims for this insurance company.

Endnotes

1. Richard G. Frank, "Reflections on the Mental Health Parity and Addiction Equity Act After 10 Years," *The Milbank Quarterly* 96, no. 4 (December 2018).
2. *Mental Health and Substance Use: State and Federal Oversight of Compliance with Parity Requirements Varies* (PDF), US Government Accountability Office, December 2019.
3. Eran Ben-Porath et al., "Mental Health Tops Californians' Health Care Priorities in Statewide Poll," California Health Care Foundation, February 13, 2020.
4. Ben-Porath et al., "Mental Health."
5. "Mental Health: Household Pulse Survey," Centers for Disease Control and Prevention, National Center for Health Statistics, July 29, 2020.
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7. 29 U.S.C. § 1185a; and 45 C.F.R. § 146.136.
8. Cal. Health & Safety Code § 1357.500. Cal. Ins. Code § 10753.
9. 42 U.S.C. § 18022; and 45 C.F.R. § 156.100 et seq.
10. ACA implementing regulations: 45 C.F.R. §§ 156.115(a)(3), 147.160. MHPAEA implementing regulation: 45 C.F.R. § 146.136.
11. Ibid.
12. "The Mental Health Parity and Addiction Equity Act (MHPAEA): Exceptions," Centers for Medicare & Medicaid Services (CMS), accessed September 2, 2020.
13. 45 C.F.R. § 156.115.
14. Cal. Code Regs. tit. 28, § 1300.67.005.
15. Cal. Ins. Code § 10123.15.
16. Cal. Health & Safety Code §§ 1367, 1345(b).
17. Cal. Health & Safety Code § 1374.72; and Cal. Ins. Code § 10144.5.
18. Ibid.
19. Cal. Health & Safety Code § 1374.73; and Cal. Ins. Code § 10144.51.
20. Cal. Health & Safety Code § 1374.76.
21. Cal. Health & Safety Code § 1367.005; and Cal. Ins. Code § 10112.27.
22. Cal. Ins. Code § 10144.4.
23. 42 U.S.C. § 18022(b)(4)(B); and 45 C.F.R. § 147.104(e).
24. 45 C.F.R. § 146.136.(c)(2)(ii); and 29 C.F.R. § 2590.712(c)(2)(ii).
25. 42 U.S.C. § 300gg-26; and 45 C.F.R. § 146.136(c)(2)(ii)(A).
26. 45 C.F.R. § 146.136(c)(4)(ii).
27. These NQTLs are discussed in the preamble to the MHPAEA implementing regulation. 78 Fed. Reg. 68239 (Nov. 13, 2013).
28. Ibid.
29. *FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39* (PDF), CMS, 11, September 5, 2019.
30. "Exhibit J-11-A, Tables 1-4 Classifications," DMHC, August 2018. Data provided to author upon request.
31. "Exhibit J-11-B FR-QTL Calculation Worksheet," DMHC, August 2018. Data provided to author upon request.
32. "Exhibit J-12-A NQTLs (Table 5)," DMHC, August 2018. Data provided to author upon request.
33. *Final Report: Focused Survey of Mental Health Parity and Addiction Equity Act (MHPAEA) Implementation of Blue Cross of California DBA Anthem Blue Cross* (PDF), DMHC, June 24, 2018.
34. "Enforcement Action Database," DMHC, accessed September 2, 2020.
35. Drew Brereton (deputy dir. and chief counsel, Office of Enforcement, DMHC) to Melissa Cook (president/CEO, Sharp Health Plan), *Letter of Agreement: Enforcement Matter Number: 16-1717* (PDF), January 16, 2019; and Drew Brereton (deputy dir. and chief counsel, Office of Enforcement, DMHC) to Joy O. Higa (reg. VP, UHC of California), *Letter of Agreement: Enforcement Matter Number: 16-1653* (PDF), September 28, 2018.
36. Drew Brereton (deputy dir. and chief counsel, Office of Enforcement, DMHC) to William S. Jameson (secretary and counsel, Cigna Healthcare of California), *Letter of Agreement: Enforcement Matter Number: 15-382* (PDF), June 19, 2017.
37. Drew Brereton (deputy dir. and chief counsel, Office of Enforcement, DMHC) to Ann Warren (chief regulatory and human resources officer, Community Health Group), *Letter of Agreement: Enforcement Matter Number: 17-807* (PDF), March 12, 2018. For additional enforcement actions, consult the [DMHC Enforcement Action Database](#).
38. Sonia R. Fernandes (deputy dir. and chief counsel, Office of Enforcement, DMHC) to Dee Pupa (health plan administrator, Ventura County Health), *Letter of Agreement: Enforcement Matter Number: 18-1157* (PDF), July 17, 2020.
39. *Form Filing Instructions for 2021 Non-Grandfathered Individual and Small Group Health Insurance and Exchange Dental Products* (PDF), accessed September 2, 2020.
40. "Mental Health Parity Analysis Workbook," CDI, last updated April 5, 2019.
41. "Mental Health Parity Supporting Documentation Template," CDI, last updated April 5, 2019.

42. "Supporting Documentation," CDI.
43. Once published, the report may be found at the following link by entering the insurance company's name in the search box: publishing.insurance.ca.gov.
44. [Warning Signs — Plan or Policy Non-Quantitative Treatment Limitations \(NQTLs\) That Require Additional Analysis to Determine Mental Health Parity Compliance](#) (PDF), US Department of Labor and US Department of Health and Human Services, accessed September 2, 2020.
45. *Wit v. United Behavioral Health*, No. 14-cv-02346-JCS, 2019 U.S. Dist. LEXIS 35205 (N.D. Cal. Feb. 28, 2019).
46. C. George, W. Sowers, and K. Thompson, "Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS): A Preliminary Assessment of Reliability and Validity," *Community Mental Health Journal* 35, no. 6 (December 1999): 545–63.
47. S. Davenport, T.J. Grey, and S.P. Melek, "Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement," *Milliman Research Report*, November 20, 2019.
48. S. H. Busch and K. A. Kyanko, "Incorrect Provider Directories Associated with Out-of-Network Mental Health Care and Outpatient Surprise Bills," *Health Affairs* 39, no. 6 (June 2020): 975–83.
49. "Form Filing Instructions," CDI.
50. 45 C.F.R. § 146.136(c)(4)(ii).
51. *FAQs About Mental Health*, CMS 10.
52. N.Y. Ins. Law § 4902; N.Y. Pub. Health Law § 4902. New York requires health maintenance organizations and insurers and their contracted utilization review agents to "utilize evidence-based and peer reviewed clinical review criteria that are appropriate to the age of the patient and which have been deemed appropriate and approved for use in determining health care coverage for the treatment of mental health conditions" by the Commissioner of the NYS Office of Mental Health, in consultation with the Commissioner of Health and the Superintendent of Financial Services.
53. [H.B. 3249, 101st Leg. Sess., First 2019 Gen. Revisory \(II 2019\)](#); [H.B. 220, 150th Leg. Sess., Reg. Sess. 2019 \(Dec. 2019\)](#); and [MD Ins. Art. § 15-802\(d\)\(5\)](#) (PDF).
54. The New Hampshire Department of Insurance conducted an 18-month market conduct exam of their three health insurance companies and found two were unable to substantiate documented differences in provider reimbursements. Earlier this year, the department entered agreements with the two carriers and is requiring them to develop and apply a framework for reimbursement rates that will comply with MHPAEA. See Tyler Brannen, [Mental Health Parity Examinations](#) (PDF), New Hampshire Insurance Dept., February 14, 2020. In February 2020, the Massachusetts attorney general reached agreements with five health insurance companies and two behavioral health organizations regarding their provider reimbursement rate-setting practices and inaccurate provider directories. See ["Attorney General's Office Behavioral Health Parity Agreements,"](#) Commonwealth of Massachusetts, n.d. The Maryland Insurance Administration issued an order against UnitedHealthcare for violations of reimbursement rate-setting practices in their HMO plans. See *Maryland Insurance Administration v. Optimum Choice, Inc., UnitedHealthcare Ins. Co., and UnitedHealthcare of the Mid-Atlantic*, Case Nos. MIA-2020-04-039, MIA-2020-04-040, and MIA-2020-04-041 (April 2020).
55. Cal. Health & Safety Code § 1367.
56. "Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program," 78 Fed. Reg. 68239 (Nov. 13, 2013).
57. "Reach Out PA: Wolf Administration Seeks Input from Providers on Barriers to Mental Health and Substance Use Disorder Treatment," Pennsylvania Pressroom, February 7, 2020.
58. "Health Plan Compliance/Medical Survey," DMHC, accessed September 2, 2020.
59. [Website Published Report of the Market Conduct Examination of the Claims Practices of Blue Shield of California Life & Health Insurance Company](#) (PDF), CDI, December 20, 2019.
60. [Final Report: Focused Survey of Mental Health Parity and Addiction Equity Act \(MHPAEA\) Implementation of Molina Healthcare of California](#) (PDF), DMHC, October 23, 2017.
61. [Final Report: Focused Survey of Mental Health Parity and Addiction Equity Act \(MHPAEA\) Implementation of Local Initiative Health Authority for Los Angeles County Plan DBA L.A. Care Health Plan](#) (PDF), DMHC, July 18, 2018.
62. [Final Report: Focused Survey of Mental Health Parity and Addiction Equity Act \(MHPAEA\) Implementation of Chinese Community Health Plan](#) (PDF), DMHC, May 2, 2018; and [Final Report: Focused Survey of Mental Health Parity and Addiction Equity Act \(MHPAEA\) Implementation of Sharp Health Plan](#) (PDF), DMHC, September 24, 2018.
63. Health care services plans in this category include Alameda Health Care System, California Physician Services, L.A. Care, Sharp, Santa Cruz/Monterey/Merced Managed Medical Care Commission, UnitedHealthcare, Ventura County Health Plan, and Western Health Advantage.
64. Health care service plans in this category include Aetna, Anthem Blue Cross, Cigna, Health Net of California, and Sutter Place Health.
65. [Final Report: L.A. Care Health Plan](#), DMHC.
66. [Final Report: L.A. Care Health Plan](#), DMHC; and [Final Report: Focused Survey of Mental Health Parity and Addiction Equity Act \(MHPAEA\) Implementation of Alameda Alliance for Health](#) (PDF), DMHC, February 16, 2018.

67. *Final Report: Sharp Health Plan*, DMHC.
68. *Final Report: Focused Survey of Mental Health Parity and Addiction Equity Act (MHPAEA) Implementation of Cigna Health Care of California Inc.* (PDF), DMHC, December 26, 2017.
69. *Follow-Up Report: Focused Survey of Mental Health Parity and Addiction Equity Act (MHPAEA) Implementation of Western Health Advantage* (PDF), DMHC, January 22, 2019.
70. *Follow-Up Report: Focused Survey of Mental Health Parity and Addiction Equity Act (MHPAEA) Implementation of Ventura County Health DBA: Ventura County Health Care Plan* (PDF), DMHC, January 23, 2019.
71. CDI has conducted targeted health exams for compliance with the California Mental Health Parity Act and autism behavioral health treatment. This report includes a review of the market conduct exam of Blue Shield because it was the most recently published exam report at the time of this study and includes substantial review of MH/SUD claims handling for compliance with MHPAEA.
72. *Website Published Report of Blue Shield*, CDI.