

FEDERAL AND STATE PARITY LAWS:
TARGETED STRATEGIES TO IMPROVE ENFORCEMENT
AND ACCESS TO CARE

Ellen Weber

Legal Action Center

LEGAL ACTION CENTER

- National law and policy organization that works to fight discrimination against people with histories of addiction, HIV/AIDS or criminal records
- Coalition for Whole Health
 - Coalition of over 100 national, state and local organizations in the mental health and substance use disorder fields and allied organizations working to ensure health reform is successfully implement for individuals with mental health and substance use disorders
- LAC's Parity Guide <http://lac.org/wp-content/uploads/2016/06/LAC-Parity-Guide-2016.pdf>
- Parity In Practice Illinois – October 31 and November 1

PRESENTATION

- Parity Act Purpose and Standards – Brief Background
- Current Enforcement Strategies and Limitations
- Strategies to Improve Enforcement
- Federal Regulatory Activities
- Risks to Parity Act Under Federal Health Care Reform

PARITY ACT: GOALS AND STANDARDS

- Civil rights statute: End historic health insurance discrimination against individuals with mental health and substance use disorders
 - No mandate to cover MH/SUD benefits but, if covered, must be on par with medical/surgical benefits
- Scope of Parity Act
 - Private Insurance – individual, small and large (group) employer
 - Fully insured (commercial) and self-insured (often administered by carriers)
 - Medicaid – Medicaid managed care plans, Children’s Health Insurance (CHIP), all Medicaid Expansion
- Non-discrimination in all plan design features
 - Financial Requirements
 - Quantitative Treatment Limitations (QTLs) and Non-Quantitative Treatment Limitations (NQTLs)
 - Prescription Drugs

FINANCIAL REQUIREMENTS & QUANTITATIVE TREATMENT LIMITATIONS DEFINITIONS

- Financial Requirements (FR)
 - Deductibles, co-payments, co-insurance, out-of-pocket maximums
 - \$1000 deductible
 - \$50 copayment or 30% co-insurance
 - Lifetime and annual dollar limits (separate rules)
- Quantitative Treatment Limitations (QTL) – **numerical limitation** on scope or duration of treatment
 - Frequency of treatment, number of visits, days of coverage, days in a waiting period
 - 12 visits/year or 1 session /week

FINANCIAL REQUIREMENTS & QUANTITATIVE TREATMENT LIMITATIONS STANDARD

- No separate or more restrictive FR or QTL for MH and SUD benefits than medical/surgical benefits
- Comparisons based on 6 benefit classifications (4 for Medicaid)
 - In-patient (in and out of network); out-patient (in and out of network); prescription drugs; emergency care
- Standard: **Mathematical Calculation**
 - **Type** of FR or QTL must apply to 2/3 (substantially all) of medical/surgical benefits in classification to apply to MH or SUD benefits (not separate); and
 - **Value** of the FR or QTL – same or more favorable than the value that applies to 51% (predominant value) of medical/surgical benefits (no more restrictive).

NON-QUANTITATIVE TREATMENT LIMITATIONS DEFINITIONS

- Plan design features that limit scope or duration of treatment but not **expressed numerically**
- NQTL Examples
 - Medical management standards – medical necessity or appropriateness
 - Utilization management – prior authorization, concurrent or retrospective review
 - Fail first or step therapy protocols (failure at lower level or less expensive level of care before higher/more expensive level authorized)
 - Formulary design for prescription drugs
 - Network adequacy, network tier design, provider admission standards, including credentialing and contracting standards
 - Provider reimbursement rates and method for determining usual, customary and reasonable charges
 - Restrictions based on facility type, geographical location, provider specialty

NON-QUANTITATIVE TREATMENT LIMITATIONS PLAN EXAMPLES

- Medical necessity standard for hospitalization for mental illness – risk to self or others or suicidal
- Criteria for admission to network: practitioner of SUD services must demonstrate no substance use disorder treatment in past 5 years
- Prior authorization required for all outpatient SUD, with the exception of standard outpatient, and treatment plan must be submitted within 5 days for concurrent review
- Medications to treat opioid use disorders require prior authorization and are placed on more expensive formulary tiers
- Methadone treatment excluded from benefit coverage for SUD

NON-QUANTITATIVE TREATMENT LIMITATIONS STANDARD

- Comparison of standards between MH, SUD and medical/surgical by classification and evaluated both **as written and in operation**
- The “rules” for imposing and applying the NQTL on the MH or SUD benefit must be **comparable to and applied no more stringently** than the rules for imposing and applying the NQTL on medical/surgical benefits in the classification.
 - Examine the processes, strategies, evidentiary standards and other factors used by the carrier to **impose** the NQTL and the process for **implementing** the NQTL
 - Are those standards comparable across the MH or SUD benefit and medical/surgical benefits?

NON-QUANTITATIVE TREATMENT LIMITATIONS COMPARABILITY EXAMPLES

Mental Health or Substance Use Disorder	Medical/Surgical
Hospital Admission – Danger to Self or Others	Hospital Admission – Health condition requires 24 hour observation and monitoring
Network Admission SUD practitioner – no substance use disorder treatment in past 5 years	Network Admission Physicians – no requirement regarding treatment for substance use disorder in past 5 years
Outpatient SUD Treatment – prior authorization required for all services other than standard outpatient and concurrent review every 5 days with treatment plan submission	Outpatient Medical Treatment – prior authorization required for limited number of services, concurrent review on case-by-case basis, and treatment plan not required for concurrent review
Medications for Opioid Use Disorders – prior authorization required for all medications and placed on more expensive tiers even if generic drug	Medications for medical conditions – prior authorization not required, for example, for all opioid medications and placed on lowest cost tier if generic drug
Methadone maintenance treatment excluded from coverage for SUD	Methadone covered for treatment of pain and full scope of services covered for pain management

PRESCRIPTION DRUG BENEFITS

- Single drug formulary with multiple tiers that apply different financial requirements (not classification based)
 - Tiering based on reasonable factors including cost, efficacy, generic v. brand, mail order v. pharmacy pick-up
 - Tiering cannot be based on whether drug is used for a MH/SUD or medical condition
- NQTLs apply to prescription drug limitations
 - Tier placement
 - Prior authorization and continuing review
 - Dosage limits
 - Fail First

PLAN DISCLOSURE REQUIREMENTS PRIVATE INSURANCE STANDARDS

- Required Disclosures
 - Medical necessity criteria – available upon request by current or potential plan participant or contracting provider
 - Reason for any denial of coverage or reimbursement to participant
 - Documents that relate to plan compliance with Parity Act (private insurance and specifically ERISA plans)
 - Information must be made available within 30 days of request
- Plan information for **medical benefits** must be also disclosed for comparability test
- Carrier cannot withhold plans documents based on **proprietary** information

MEDICAID & CHILDREN'S HEALTH INSURANCE PROGRAM PARITY RULE HIGHLIGHTS

- Parity protections apply to all individuals who receive *any* Medicaid services through a managed care organization and all CHIP beneficiaries.
 - Parity Rules do not apply to purely fee-for-service delivery/financing, except for:
 - **Expansion population** – parity applies to Alternative Benefit Plans regardless of delivery/financing system (managed care or non-managed care)
- Core standards – same as private insurance rules regardless of Medicaid delivery/financing system (minor modifications based on Medicaid program)
 - 4 classifications – no out-of-network classification
 - Disclosure – medical necessity criteria and reasons for denial

MEDICAID & CHIP PARITY RULE COMPLIANCE PROCESS

- Enforcement Mechanism
 - All State contracts with MCOs must require compliance with Parity regulations
 - States using delivery system other than fully MCOs must demonstrate how Parity compliance achieved with submission of MCO contracts to Centers for Medicare and Medicaid Services
- Entity responsible for compliance review
 - MCO: MH/SUD services provided by MCO through carve-in with medical/surgical benefits
 - State: MH/SUD services provided in full or part through a carve-out delivery system
- **Compliance Deadline – October 2, 2017**
 - 18 months for states to bring benefits into compliance and address budget implications of adding necessary services and amending state plan
 - State compliance document to be posted on State website

ILLINOIS PARITY LAW HB I (2015)

- **Benefit Coverage**
 - Continuum of services, including licensed residential treatment as inpatient service, acute treatment services, clinical stabilization services, at least one opioid antagonist and, for Medicaid, all FDA approved medications for SUDs
- **Utilization Review**
 - ASAM criteria required for SUD medical necessity decisions and for external review determinations
 - No prior authorization for SUD medications in Medicaid
- **Application of Federal Parity Act standards** to individual, group and qualified health plans and incorporation of NQTL standards and disclosure requirements
- **Consumer Education Campaign** with funding source (Parity Education Fund) and Stakeholder Workgroup
- **Complaint Process**
 - Consumer hotline
 - Provide Request for External Review Form with notice of right to external review

PROVIDER ROLE PARITY ACT ENFORCEMENT

- Improving Patient Access to Treatment
 - Front line knowledge of benefit exclusions, prior authorization and fail first requirements, burdensome utilization management processes, medical necessity standards that are inconsistent with evidence-based practices
 - Front line communications with carriers
- Improving Treatment Capacity – Provider Participation in Networks
 - Network adequacy standards – carrier rules for meeting enrollee health care needs in network
 - Standards for network credentialing and placement in tiers if multi-tier provider networks
 - Exclusions of provider types (e.g. residential treatment; SUD provider if no mental health center)
 - Reimbursement rates and negotiation; process for contracting including facility and non-facility contracts

PARITY ACT VIOLATIONS IN PRACTICE

- Illinois Provider Survey to flag potential violations
- Potential issues
 - Failure to disclose required information – always a violation and no additional evaluation needed
 - Network credentialing – lengthy process: are comparable requirements and procedures used?
 - Reimbursement/coverage denials for intermediate levels of care (IOP, PHP and residential treatment) – if the rates of denial reveal disparities with medical services, underlying medical necessity standards and utilization review criteria and procedures may violate law

PARITY ACT RED FLAGS

- Prior authorization and notification
 - Pre-authorization for all MH/SUD services
 - Pre-notification ASAP for non-scheduled MH/SUD admissions and reimbursement reduced for failure to provide
 - Excessive pre-notification for all MH/SUD inpatient, IOP and extended OP visits beyond 45-50 minutes
 - Concurrent care review every 10 days for MH/SUD but not for medical/surgical benefits
 - Medical necessity review authority – attending physician conducts for medical/surgical benefits, but medical management entity conducts for SUD/MH

Departments of Labor and Health and Human Services – issued “Warning Signs” to flag practices that require close scrutiny for compliance
<https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>

PARITY ACT RED FLAGS

- Fail-first protocols
 - IOP – must fail in less intensive level of care
 - Residential treatment – must try 2 forms of outpatient care
- Probability of Improvement
 - Coverage limited to services that result in measurable and substantial improvement in mental health status in 90 days
- Geographical exclusions for SUD services but not medical/surgical
- Written treatment plan requirements
 - Plan completed in seven days with numerous elements based on bio-psychosocial evaluation

BARRIERS TO PARITY ACT TRADITIONAL ENFORCEMENT SCHEME

- **Regulator Oversight**
 - Form review – plan approval process with a review of compliance with wide range of state and federal standards
 - Checklist of whether documentation exists
 - Some model contract language – Ex: benefit coverage
 - Review agent (entities conducting utilization management) compliance with law
 - Market Conduct Examinations – investigate carrier compliance with specific laws
- **Consumer Complaints**

WHY TRADITIONAL ENFORCEMENT SCHEME DOESN'T WORK FOR PARITY

- Parity Act
 - Complex standards requiring **comparison** of standards and plan design across all benefits in **writing and operation**
 - Fundamental change in practice: requires non-discrimination in an industry that is based on risk distinctions and has historically discriminated against MH/SUD services
- Regulators
 - Incomplete understanding of standards
 - Limited resources, competing demands and threats
 - Don't get information about NQTLs from carriers or Medicaid MCOs
 - Varying levels of interest in enforcement and different from traditional enforcement process
 - Market Conduct Exams – time-consuming and no real-time enforcement

BARRIERS TO ENFORCEMENT PROVIDERS AND CONSUMERS

What obstacles do providers face?

What obstacles do consumers face?

STRATEGIES TO IMPROVE ENFORCEMENT ADJUSTMENTS TO TRADITIONAL INSURANCE SCHEME

- Carriers – Demonstrate Parity Compliance for Approval to Offer Plan
 - Non-compliant plans cannot be offered under law
 - **Parity Act Transparency and Compliance Report:** submission of all relevant documents and plan analysis to demonstrate that MH/SUD standards are comparable **by entity that has the information and legal obligation**
- **Regulator Oversight**
 - Conduct robust prospective review using Transparency and Compliance Report
 - Data collection and analysis – disparate trends that reveal underlying violations
- **Model Contracts**
 - Identification and full description of MH/SUD services and covered drugs
 - Identification of all levels of utilization management
 - Identification of Parity Act rights and where and how to get help and file complaints/get assistance

STRATEGIES TO IMPROVE ENFORCEMENT ENHANCING PROVIDER CAPACITY

- Provider Technical Assistance (Provider Parity Academies)
 - Application of parity standards in practice
 - Contracting and reimbursement strategies and guidance on carrier practices
 - Complaint process – tips to facilitate filing formal complaints and informing state regulators and Attorney General
- Network Adequacy Standards
 - Implement **quantitative network adequacy standards** for geographical distance and travel time and appointment wait times can standardize rules and achieve parity
- **Your Suggestions**

INITIATIVES TO IMPROVE ENFORCEMENT LEGISLATION

- Illinois House Bill 68 – Strengthening State Parity Law Enforcement
- **Compliance requirements for Insurance Department and Dept. of Healthcare and Family Services**
 - Maintain and review consumer complaint log
 - Perform pre-market and post-market conduct examinations of key NQTLs and make findings public
 - Disclosure of plan information, upon request, including plan analysis of NQTL compliance
 - **Prohibition on certifying policies of carriers that do not submit annual data report**
- **Reporting Requirements to General Assembly**
 - Description of State agency compliance methodologies
 - Description of market conduct examinations
 - Educational and corrective actions

INITIATIVES TO IMPROVE ENFORCEMENT ILLINOIS HOUSE BILL 68

- **Carrier Annual Data Reporting** – enables regulators to identify disparities in service delivery across MH, SUD and medical benefits
 - Financial requirements, treatment limitations, and denials of services based on authorization standards or medical necessity, out-of-network claims, accuracy of provider directories
 - Plan analysis for parity compliance for all NQTLs
- **Consumer Protections**
 - Private right of action to enforce parity standards in courts without completing administrative actions or arbitration
 - \$5,000 penalty for each violation, injunctive relief, damages, restitution of premium and attorney's fees
 - Creation of Office of Consumer Advocate in Attorney General's Office
 - Ensure compliance
 - Address claims problems
 - Consumer education and assistance

ENFORCEMENT STRATEGIES OTHER STATE ACTIVITIES – PRIVATE MARKET

- Prospective Review
 - All Parity Standards – CA
 - Financial Requirements (compliance demonstration or certification) – CT, WA,
 - Form Review Checklists that identify Parity Act standards – AL,VA,WA; Less explicit DE, IN, MD, NE, OR, PA, UT
- Retrospective Certification of Plan Compliance - MA
- Market Conduct Surveys – CT, MD, NH, NY
- Data Collection and Analysis – CT, MA,VT,
- Attorney General Investigations – NY and interest in other States

ENFORCEMENT STRATEGIES FUTURE STATE ACTIVITIES – PRIVATE MARKET

- Federal funding to enhance Parity Act compliance awarded to 19 States and DC in 2016
 - Prospective Review – CO, IL, PA (compliance worksheets and data submission)
 - Form Review Enhancement – DC, HI, IN, MI, MN, MS, NY, NC, NE, PA
 - Market Conduct Exam and Audits – MA, MD, MN, NH, NY, OR, RI
 - Data Analysis – NH, NM
- Parity Policy Academies – 19 States (Commercial) and 10 States (Medicaid)

ENFORCEMENT STRATEGIES STATE ACTIVITIES – PUBLIC MARKET

- Tennessee's Medicaid Program: MCO Annual Reporting Requirement Based on Parity Act Standards (SB 837 – Effective July 1, 2017)
 - Frequency prior authorization is imposed on all MH/SUD and medical benefits and services in previous calendar year
 - Process for developing medical necessity criteria
 - Identification of all NQTLs and results of analysis (findings and conclusions) demonstrating parity compliance, consistent with federal standards and guidance
 - Rates and reasons for denial of claims in all classifications
 - TennCare bureau required to monitor claims denial and request data if significant discrepancies exist between MH/SUD and medical/surgical benefits

PENDING FEDERAL ACTIVITIES

- Medicaid Compliance – October 2, 2017 Deadline
- President Trump's Commission on Combating Drug Addiction and the Opioid Crisis – Interim Report Recommendations
 - Enforce Parity Act with standardized parity compliance tool
 - DOL – aggressive enforcement, impose penalties and inform public of violations

CURES ACT PARITY COMPLIANCE STANDARDS

- Listening Session – Improve coordination between federal and state enforcement (July 2017) and Action Plan to be issued within 6 months
- Compliance Program Guidance – Improve Parity Act Enforcement (Due by Dec. 13, 2017)
 - Must include previous findings by federal agencies of compliance and non-compliance
 - Update every 2 years
- Public Comments on Compliance with Disclosure Requirements (Sept. 13, 2017)
 - Public feedback on disclosure tools to be shared with National Assoc. of Insurance Commissioners (NAIC) for development of and voluntary use of common templates
- Guidance to Issuers on Disclosure (Due by Dec. 13, 2017 and subject to public comment before final)
 - Clarify disclosure of information related to compliance, including NQTLs
 - Examples of compliant NQTLs

PENDING FEDERAL ACTIVITIES

- CURES Act (con't)
 - Federal Audit for group health plans or issuer plans that have violated Parity Act standards at least 5 times
 - Federal regulators report to Congress results of all closed investigations completed in previous 12 months. Due Dec. 2017 and annually for 5 years.
 - GAO report on compliance – no later than Dec. 2019
- Mental Health & Substance Use Disorder Parity Task Force (Obama Administration)
 - Outstanding Recommendations to be considered for CURES Action Plan
 - Review of SUD benefits under Federal Employee Health Benefits Program
 - Review of Medicare Advantage plans for compliance and other Medicare benefits
 - Legislative authority for federal regulators to assess civil penalties for violations

RISK TO PARITY ACT HEALTH CARE REFORM PROPOSALS

- Financing of and access to MH/SUD care in public and private insurance would be dramatically cut and de-stabilized by proposed bills
- Parity Act not directly affected but:
 - Removal of EHB standard for Medicaid expansion could eliminate coverage for MH/SUD benefits and would remove Parity Act requirements for services delivered under non-MCO delivery system.
 - Option to waive EHB for qualified health plans and small group could remove parity compliance requirement for small group plans
- Incorporation of Parity Act standards in state legislation important safeguard

QUESTIONS AND DISCUSSION

What would be most useful for Parity In Practice training?

CONTACT

Ellen Weber, Vice President for Health Initiatives, Legal
Action Center

eweber@lac.org

202-544-5478 Ext. 307