Mental Health Parity and Substance Use Disorder Task Force
The Center for Consumer Information & Insurance Oversight (CCIIO)
Listening Session
August 8, 2016, 4 pm

Opening Remarks

On August 8, 2016, the CMS Center for Consumer Information & Insurance Oversight devoted the State Insurance Regulators' conference call, held jointly with the National Association of Insurance Commissioners (NAIC), to host the fifth listening session for the interagency Mental Health Parity and Substance Use Disorder Task Force. This session focused on listening to state insurance regulators and staff. Federal staff attending included the CCIIO Deputy Administrator and Director, Kevin Counihan; Assistant Secretary of Labor for the Employee Benefit Security Administration (EBSA), Phyllis Borzi; and White House Domestic Policy Council member, Carole Johnson.

Federal Staff Comments

James Mayhew of CCIIO opened and moderated the discussion. The Parity Task Force has created a website and provided an e-mail address through which written comments can be provided. The website is http://www.hhs.gov/about/agencies/advisory-committees/parity/feedback.html, and the e-mail address is parity@hhs.gov.

Three federal representatives provided opening comments: CCIIO Deputy Administrator and Director, Kevin Counihan; Assistant Secretary of Labor for EBSA, Phyllis Borzi; and White House Domestic Policy Council member, Carole Johnson. The introductory remarks addressed the history of the Task Force and acknowledged the progress made to date. Parity issues are important to the administration given the recent opioid epidemic, increasing suicide completion rates, and the need for further support for substance abuse and mental health treatment. This listening session with representatives from state insurance commissions was noted as being particularly vital. Insurance regulation is largely a state matter, and so states are on the front line of implementing parity efforts. The goals for the session are to (1) understand issues on parity through open conversation, (2) share best practices that states have developed, and (3) identify ways federal agencies can continue to support the states.

Meeting Summary

State regulators and representatives from 7 states shared their experiences with implementing and enforcing the federal parity regulations. The following topics were shared and discussed.

Awareness

Many discussants noted a lack of awareness and understanding of parity across insurers, state regulators, providers, and consumers as a barrier to implementing parity. One discussant noted that stigma and misunderstanding about behavioral health in general was connected to a routine denial of behavioral health services. Another noted the need to increase awareness and understanding of parity even within the state regulatory agency itself. With the complexity of the parity laws, additional support in training state staff to review plans for parity compliance and enforcement is needed, even though this training may be expensive.

For providers and consumers, further education on parity is also needed. Providers often lack the capacity to understand the rights afforded under parity, especially when combined with other changes accompanying the Affordable Care Act. For example, states have had to work closely with providers to explain the parity differences between Medicaid and commercial insurance plans. In other cases, providers may not have billed private insurance in the past, and it can take time for these providers to learn how to work successfully with insurers.

Educating providers on parity regulations was also discussed as a way to support consumers, because providers are often in a better position to advocate for consumers' rights. Consumer awareness and education is also vital as complaints often drive further investigations and post-market reviews. Discussants noted how consumers need further education on their rights to external review when claims are denied for medically necessary reasons.

Enforcement

State discussants noted that there are challenges identifying parity violations and enforcing parity regulations once a violation is identified. Violations may be difficult to identify, particularly Non-Quantitative Treatment Limitations (NQTLs). Because many NQTLs are not comprehensively and consistently in plan documents, they may not be assessed using plan documents. Instead, states often rely on consumer complaints about potential violations and then identify violations by performing post-market review of plans and plan guidelines. Because complaints are difficult to collect and track, post-market reviews can be burdensome for some state regulatory agencies.

Several discussants noted that external reviews can be especially challenging in determining medical necessity. When a service is denied by an insurer, part of the appeals process may involve external review, when qualified health professionals assess the service need; medical necessity refers to the reason for being able to bill insurance for a particular service. However, external review is hampered when insurers provide little information for that review, qualified reviewers are not available, and behavioral health treatment is not standardized. One discussant noted that external review was available in the state, but it

can take time to transition reviews to include behavioral health as external reviews prior to parity tended to focus on inpatient medical services.

One example highlighted the difficulty in identifying and therefore appropriately enforcing parity. A reviewed insurance plan offered home health visits for medical and surgical but did not offer home health visits for behavioral health. This violated the parity law, but it is unclear whether it was a simple violation or required further action based on Quantitative Treatment Limits (QTLs).

Network Adequacy

Network adequacy refers to the number of service providers who are available and covered by insurance. Related issues include workforce and provider shortages, chronically low reimbursement rates for behavioral health providers, arbitrary limits placed on networks by insurers, and burdensome review standards. States recognize that insurers cannot be responsible for the absence of providers, but some states' experiences suggest that insurers are exacerbating existing workforce shortages.

One discussant from a state with a high suicide rate reported that the state has a chronic behavioral health workforce shortage with large areas of the state without psychiatric and specialty outpatient care. These shortages are made acute by reimbursement below Medicaid/Medicare rates, claims by insurers that networks are full, denial rates around 50% to 60%, across the board 90-day limits on treatment, and medical reviews every 35 days.

These issues have led to child behavioral health providers in the state refusing to work with commercial insurance, although they continue to work with Medicaid. A separate example highlighted the lack of behavioral health facilities as being a primary barrier to improving access for consumers.

Reimbursement rates were reported to be of particular concern in several instances. In one state, demand is high for mental health providers with an established client base, so providers will not enter into contracts with insurers unless rates are raised. In some states, insurers will not contract with higher-cost providers (e.g., PhD-level psychiatrist) if the level of care can be provided by a lower-cost provider (e.g., MA-level counselor), even in cases where no lower cost provider exists. Higher qualified providers are not typically willing to contract with insurers at the lower rates.

It is difficult to measure network adequacy. One state has an all-payers claims database and uses it to help define the universe of providers, measure where consumers are actually receiving care compared to where they live, and keep provider lists up-to-date. The state regulator used measures of substance abuse treatment provider reimbursement rates to show that average rates were below Medicaid. These data-based approaches defined network adequacy and reimbursement in concrete terms allowing the state regulator to address them directly.

Finally, some states with severe behavioral health workforce shortages are exploring using tele-health and further integration of behavioral health into primary health settings to help improve network adequacy.

Clarity on Parity Regulations and Guidance

All states expressed interest in further clarity on parity regulation and recently released guidance. One discussant identified specific issues with the mental health parity tool, whereby some parts are too specific and other parts are too broad. Issues included the need to split out ambulatory care from other categories of care, the ability to compare across treatment categories, and what action to take when the tool indicates behavioral health coverage is superior to the comparable medical/surgical coverage. Furthermore, states expressed concerns that their comments and suggestions were not adequately addressed in tools and guidance. States would like their suggestions and their own tools included in the tools if warranted.

Other discussants expressed the need for additional clarity around NQTLs and what is considered a parity issue. State legislatures may need to create specific requirements. An example was given of one state requiring that both providers and insurers use the American Society of Addiction Medicine (ASAM) guidelines when determining treatment and making medically necessary determinations.

Integrating Parity with State Regulations

The cost of analyzing and integrating the law with the state regulatory approach is significant for states. For states without state-level parity laws, state regulators are dependent on federal enforcement efforts. Moreover, regardless of whether a state has its own parity regulations, the complexity of the federal parity law makes integrating its provisions into state regulations time-consuming. For example, a discussant noted the challenge of harmonizing NQTLs with state regulations and the need for additional guidance from federal agencies on what constitutes an NQTL.

Parity Strategies

David DeVoursney from SAMHSA shared five key strategies from a recent report based on interviews with seven insurance commissioners:

1. Maintain open channels of communication within state departments and across insurance carriers. Creating actionable guidance is best achieved when all parties involved cooperate.
2. Clarify language used and terms of coverage. States worked with insurance carriers to standardize terms so regulatory staff, insurers, and providers could discuss issues clearly.
3. Standardize materials for assessing parity. Some states have developed templates for workbooks and other tools.

4. Conduct network adequacy assessments and market conduct examinations. Steps may include ensuring that provider directories are up to date.
5. Coordinate the work of multiple stakeholders. Collaborations among state behavioral health departments and consumer advocacy groups are important to connecting with providers and consumers.

Closing Remarks

James Mayhew closed the session by thanking the speakers for their comments and commitment to implementing parity. He asked attendees to provide written comments at the federal parity website.