**Parity Task Force: Summary of Second Stakeholder Meeting**
**May 17, 2016**
**American Psychiatric Association Conference**
**Atlanta, Georgia**

At President Obama's direction, the Parity Task Force was established to improve awareness and understanding of federal parity law requirements and increase compliance. The Task Force is to holding a series of listening sessions with stakeholder groups, to better understand issues and best practices associated with parity implementation.

The second listening session was held in Atlanta on May 17, 2016. It focused on efforts by the American Psychiatric Association (APA) and its members to improve parity implementation, especially for non-quantitative treatment limits (NQTLs).

## Overview of Findings

APA representatives and meeting attendees outlined and provided many examples of their experiences with coverage being unequally applied to mental health and substance use disorder care compared to general medical services. Several issues related to NQTLs were discussed at length: prior authorizations, fail first, retrospective reviews, and disclosures.

Major Points Raised by Meeting Attendees:

- Prior authorizations are regularly required for mental health and substance use disorder emergency situations (e.g., actively suicidal patients) where hospitalization is standard medical practice for other types of emergency conditions.

- Insurers often require prior authorization even for generic mental health and substance use disorder medications while generic drugs for chronic medical issues—such as insulin for diabetes care—typically do not require prior authorizations.

- Some plans effectively operate on a "fail-first" basis, where patients are required to fail at partial hospitalization or an intensive outpatient program before they will be considered for residential treatment.

- Retrospective reviews create an additional burden in terms of responding to requests for clinical notes and records to justify services received.

- Plans do not fully disclose how NQTLs in particular will be applied, and transparency is lacking on the appeals process and rationale for decisions. This lack of information leaves providers and patients with little recourse for further appeal.

- The cycle of appeals and reviews takes more time and delays treatment. These delays in treatment can lead to relapses, overdoses, and even death.

- Approximately 20% to 30% of doctor time is used to obtain prior authorization.

- Enforcement cannot rely on a complaint-driven and appeals process given the consumer/provider–insurance provider information gap.

- In one example, a nurse actively prevented a suicide attempt, but approval for hospitalization was denied because the suicide attempt was averted.

- Insurance plan representatives are insufficiently familiar with mental health and substance use disorder care. When providers discuss authorization with plan representatives, the representatives do not seem to understand treatment and often use arbitrary checklists to inform plan decisions.

Recommendations by Meeting Attendees:

- Require disclosure of definitions of what will be considered medically necessary.

- Require disclosure of why care does not meet the medically necessary definitions.

- Issue guidance illustrating a "reasonable" denial.

- Require public reporting on investigations and metrics, for example:
    - Rates of coverage denials for mental health and substance use disorder compared to medical/surgical benefits;
    - Rates of retrospective review for mental health and substance use disorder compared to medical/surgical benefits; and
    - Percent of out-of-network claims for medical visits compared with behavioral health visits.

- Assess network adequacy based on time and distance standards but also out-of-network claims rates and claims actually filed.

- Require more transparency in reimbursement rate disparities between in and out-of-network reimbursement rates.

- Mandate that calls for prior authorization and review be recorded by the insurer and the treating doctor. In this way, the decision-making processes would be documented and in the open.

## Summary of Statements

### Opening Remarks

The session began with remarks by representatives of the APA, Irvin Muszynski, Colleen Coyle, and Immediate Past President, Renee Binder. Next, representatives of the Task Force, Phyllis Borzi, Assistant Secretary for Employee Benefits Security, United States Department of Labor, and Richard G. Frank, Assistant Secretary for Planning and Evaluation, Department of Health

and Human Services, gave opening remarks emphasizing that implementation of MHPAEA is a high priority and these listening sessions are intended to gather information on how the federal government can improve compliance. Finally, Rosalynn Carter and Former Representative Patrick Kennedy shared their experiences in getting the federal law enacted and some on-going concerns.

## Comments by Meeting Attendees

### Non-Quantitative Treatment Limits

*Fail First*

A psychiatrist and medical director at a private not-for-profit psychiatric hospital that runs a young adult mood disorder program commented that for utilization review of opioid inpatient detoxification, insurers do not recognize that every patient is different and has different needs. Getting patients in residential treatment is a challenge as insurers are repeatedly pushing for a lower level of care. If a partial program (e.g., intensive outpatient) is available and even when a partial program is not realistic or located more than 1.5 hours from the patient, insurers still ask if the patient has tried a partial program. The plan effectively operates on a "fail-first" basis, where patients are required to fail at a partial program before they are considered for residential treatment. This is especially difficult for patients finally addressing addiction while facing withdrawal symptoms. Although parity helped bring these patients in the door, after 1 week of residential detoxification, insurers will push back. The insurers often claim that the patient no longer meets the in-patient detoxification criteria when the same patient met these criteria the previous week. One week of care cannot achieve the goals of inpatient treatment, yet insurers are already looking to reduce coverage.

*Prior Authorization*

A child psychiatrist working in youth mental health shared that 1 in 5 youth deal with mental health in a lifetime, and 75% of adults with mental health issues develop issues in their early 20s. It is medically necessary to treat mental health issues early, but insurers create barriers to treatment access. Depression is a biological condition, and suicide with intent is a medical emergency. It takes 45 to 60 minutes to get authorization for inpatient care if approved. If not authorized, and it happens often, youth face increased substance abuse risks, poor performance in school, increased criminal justice involvement, and possibly even death by suicide or overdose. Hospitalization must be supported by insurers at the same rate as for medical issues.

An emergency department psychiatrist discussed an NQTL issue in the region served by the hospital regarding hospital admission processes and managed care that created limited access to mental health care. When an actively suicidal patient presents at the emergency department in Massachusetts, certain insurers require that a third-party contractor conduct a mental health assessment, even if the hospital has in-house specialty psychiatric care. The contractor is typically a masters-level person without certification from the hospital. This process creates delays because it often takes 3 to 4 hours for the third-party assessment to be completed and denies patients the specialty psychiatric care they may need as the third-party assessor

determines the needed level of care. This process creates sub-optimal care and bad patient outcomes.

A psychiatrist in the audience noted that medical care is provided immediately if the patient is in medical crisis but not if the patient is facing a psychiatric crisis. A person suffering a heart attack is treated, whereas a patient attempting suicide is evaluated and assessed by insurers before treatment is considered.

A psychiatrist in the audience shared an example where a nurse actively prevented a patient's suicide attempt. Approval for hospitalization was denied because the patient's suicide attempt was stopped.

A Massachusetts psychiatrist in the audience discussed the division between the carve-in and carve-out plans. Massachusetts enacted legislation 224 to work with all carriers to have a single two page prior authorization for all services. Insurers with carve- out plans were reluctant to implement the reduced paperwork. The process brought the practices of carve-out insurers to light and helped simplify prior authorization and hospitalization. Medicaid plans, however, are adding to the simplified prior authorization form, which in turn increases the amount of paperwork and again raises the original concern.

A New Hampshire private substance abuse treatment provider who prescribes buprenorphine discussed the challenges that prior authorization requirements presented to providing buprenorphine. Medicaid managed care organizations and the largest private managed care providers in New Hampshire require prior authorization for buprenorphine every 3 months, but that frequency is not required for insulin or Lipitor, for example. To obtain authorization, it often takes the provider about 20 minutes of phone calls with an insurer claims representative, who does not have a behavioral health background. The representative uses a check list to determine whether the prior authorization should be approved. The best outcome is that, after 20 to 30 minutes on the phone, prior authorization is provided and treatment continues. The worst outcome is that coverage is denied, and then a cycle of appeals and reviews begins, which takes more time and delays treatment. These delays in treatment can lead to relapses, overdoses, and even death. Approximately 20% to 30% of doctor time is used to obtain prior authorizations.

An outpatient psychiatrist for adults in Wisconsin shared that whereas prior authorization is needed to prescribe generic behavioral health medications, it is not needed for any other specialty. Insurance restrictions and tiering of medications created a challenging situation. Re-tiering of generic medications increased the patient costs for extended release stimulants from about $15 to $60. Because of the concern about cost to the patient, the psychiatrist chose to prescribe instant release stimulants, which remained in the lower tier. Instant release medications are more likely to be abused, especially in a college town.

A psychiatrist in the audience discussed how prior authorizations restrict care, and noted that it is getting worse. Even a generic drug for a schizophrenic patient was not approved.

A psychiatrist from Maryland in the audience shared challenges with a bipolar patient with a history of violent episodes who experienced a 6-week delay in a generic medication approval because the dose was higher than usual.

*Medical necessity reviews*

A doctor from Pennsylvania who is the medical director of psychiatric emergency department commented on how surgical/medical patients are treated differently than mental health patients at the hospital. Patients with life-threatening suicidal ideation often face significant questions from insurance companies prior to hospitalization. No such requirements exist on the medical side. Furthermore, insurers continue with ongoing review of treatment throughout the suicidal patient's stay. It is a common practice to request medical utilization reviews every few days during a standard 7- to 10-day hospitalization for actively suicidal patients. The increased rate of medical utilization reviews requires psychiatric wards to overstaff utilization nurses for psychiatric beds at rates almost double those of similar medical wards with similar medical utilization (40 to 60 beds per utilization nurse in psychiatric wards versus 80 beds in medical wards). This leads to psychiatric beds that are too costly to operate as rates are lower with higher regulation and review. This happens while there is growing need for mental health services.

***Disclosure***

An attendee stated that psychiatrists often have only a basic understanding of parity because they do not see the limits and reimbursements on the medical side and cannot readily compare. A psychiatrist from Maryland shared an example of a colleague working under contract with an insurance issuer and, through network leasing with another issuer. Network leasing allows insurers to have larger networks while actually reducing the time providers can devote to either provider network. Furthermore, providers under network leasing have little to no legal recourse if claims are disputed or denied. Often, the rationale provided for disputed or denied claims varies across cases and is not based on any clinically accepted standard of care. One patient could have review and management sessions every 6 weeks, whereas another could have them every 12 weeks. This example points to a corporate practice of medicine. In this case, even with APA assistance, one of the issuers would not provide a clear definition. The example provider in this case stopped taking new patients from that issuer and continues to see existing patients for free. This is not an isolated case and was cited as causing psychiatrists to leave networks to paradoxically improve patient access to their care.

Someone who is counsel to a Florida mental health provider highlighted that enforcement hinges on plan disclosure and provided data to demonstrate the argument. Despite the MHPAEA, Affordable Care Act, and regulations on disclosure, several insurance plans from most major insurance companies do not respond to parity compliance disclosure requests. This contravenes the intent of the mental health parity law. Federal agencies need to help with regard to audits and focused review to understand why plans continue to fail to disclose.

**Enforcement**

A representative of the APA shared that the organization and its members generally feel like there is a good set of regulations, rules, and FAQs, but insurance companies ignore them. He claimed that insurers use the FAQs as safe harbors to excuse their policies.

He also shared that in off-the-record conversations with insurers with mental health carve-out plans, he has heard that the primary insurer will not provide information regarding parity compliance to the carve-out insurer, so the carve-out insurers simply guess at parity being met.

The following examples of state efforts to improve parity compliance were given:

- New York has been very proactive through their Attorney General's office and found that use of NQTLs looked equal on paper but was not equal in practice.

- Maryland has also taken legal actions against insurers that have resulted in a number of insurers being fined for parity-related violations.

- California has strict parity requirements, but this has not yielded parity. In a study, 23 out 25 insurance plans had incomplete parity plans, 16 did not use the benefit classifications called for in the final rule, 8 did not understand the predominant rule,9 plans had a serious failure, and only 6 plans were found in general compliance within 1 year.

A psychiatrist in the audience shared experiences of insurers requesting chart notes to help determine whether a patient is eligible for coverage. By disputing chart entries insurers sometimes determine treatment does not meet medically necessary standards creating a cycle of appeals and paperwork. This is rationing by inconvenience. Patients are forced to drop out of treatment or pay out of pocket to avoid the hassle of working through insurance. A recent NBC News investigation on California insurers was raised, noting the state's Independent Medical Review found that 48% of behavioral health claims initially denied by insurers were reversed on review.

A professor in the audience noted that the Institute of Medicine Quality Chasm Report has clearly identified that there are social determinants of mental health where certain subpopulations are more likely to suffer particular mental health challenges. These subpopulations are already sicker and marginalized, which reduces the likelihood that a patient will dispute coverage with an insurer. Without insurance coverage, these patients are pushed to the community; community mental health centers may be able to handle these patients, but resources will be stretched thin and ultimately threaten the whole system with collapse.

A psychiatrist from Memphis in the audience shared how medical inequality is the most shocking. APA speaks out for patients on the lack of parity especially for already vulnerable populations that face even greater barriers to care. These barriers to parity effectively limit access to any care for vulnerable populations.

**Reimbursement**

A psychiatrist and researcher works under a 1,500 physician plan, including psychiatrists. Rates for psychiatrist reimbursement were often lower than for general medical care. Outpatient psychiatric care should be reimbursed fairly, on par with medical services, because there is a chronic lack of available outpatient care. Psychiatrists have been disappointed in the implementation of parity. The different CPT codes show that for increasing session lengths, the psychiatry-general medical disparity increases from about 40% to over 200%.

Another attending stated that counseling is not affordable, and psychiatrist rates are lower than a social worker consult. To make providing psychotherapy possible, patients have to come to multiple visits to ensure that multiple codes can be charged. This, in turn, violates parity. For example, for a dermatology consult, the patient does not have to come back for a second visit to get a biopsy and thus pay a co-pay a second time. However, psychiatric patients have to return once authorized for treatment and pay a co-pay a second time. This puts a burden on the patient and limits access to care. Moreover, complex cases are avoided; instead, time is spent on creating complex and creative ways to bill for services.

A family practice doctor from New Hampshire in the audience noted that he provides behavioral health care out of necessity as dedicated behavioral health providers in the area are very limited. Fifty-five percent of behavioral health care is provided in primary care, while reimbursement for mental health care provided in primary care is declining; this situation will greatly limit access to mental health care. For substance abuse care, insurers limit medications and treatment and effectively prescribe without a license.

An insurance billing company staff person shared how her work allows her to see the differences between medical and mental health providers and billing daily. Insurance providers create a complex system of billing that effectively limits the provision of mental health care. Many insurance companies have outsourced mental health claims to third-party carriers (e.g., a separate behavioral health payer). Claims coded with a primary medical complaint and secondary mental health complaints are often rejected because the mental health complaint is not primary. Ultimately, this can lead to psychiatric providers not being paid.

## Recommendations by Meeting Attendees

An APA representative asserted that the key to achieving parity is in the NQTLs requirements. But, enforcement cannot rely on a complaint-driven and appeals process given the consumer/provider–insurance provider information gap.

According to him, APA's efforts with their members to bring legal actions against insurers are insufficient, e.g., the APA suit against an issuer in Connecticut over parity-related issues was dismissed because APA was ruled as not having standing.

This representative also asserted that state insurance commissioners do not have the resources, knowledge, or political will, and state attorneys might also lack the political will, the capacity,

and sometimes the legal jurisdiction to fight insurers. Patients do not have the resources to fight insurance companies.

He claimed that more frequent audits are needed and that these audits should be based on a system of performance metrics that would trigger a full audit of the insurance plan or insurer.

He recommended the following metrics be used as a first step in identifying plans that may not be in compliance and triggering a fuller investigation:

- Medical necessity denial rates.
- Prior authorizations: Insurers need to report when prior authorizations are required for mental health/substance abuse treatment.
- Reimbursement rate disparities: Insurers need to report when reimbursement rates are lower for out-of-network providers.
- Retrospective review rates: Insurers need to report the rate at which behavioral health and medical cases are retrospectively reviewed.
- A measure of network adequacy based on out-of-network claims rates for mental health and substance use disorder compared to medical/surgical benefits.

He recommended assessing networks on claims actually filed to identify phantom networks. One study found that of all claims files by psychiatrists, 46% of claims were from out-of-network providers whereas for other specialists and primary care doctors, out-of-network providers only accounted for 6-7% of claims.

He also stated that an FAQ illustrating a "reasonable" denial and more public reporting on investigations and metrics are needed because consumers need to be aware of what they are purchasing when they buy insurance.

Another attendee stated that, if just one thing could be done, the federal government should mandate that prior authorization and review calls be recorded by the insurer and the treating doctor to ensure that decision-making processes are documented and in the open.

**Concluding Statements**

**Phyllis Borzi** thanked everyone for the interesting and helpful session. The DOL has 13 offices throughout the country, and if the insurance plan is a private sector plan covered by the Employee Retirement Income Security Act, DOL can support parity-related issues. DOL has relationships with state-level insurance commissions, which have jurisdiction where DOL does not.

**Richard G. Frank** asked for suggestions that do not require legislation. Suggestions can be provided via website at www.hhs.gov/parity and e-mail: parity@hhs.gov.