

**MENTAL HEALTH PARITY:**  
Ensuring Compliance in the Era  
of an Rx Drug Abuse Epidemic  
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**Legal Disclaimer**

- ▶ This presentation does not constitute, and is not intended to represent legal or regulatory advice or guidance. The information presented represents our best understanding of Mental Health Parity regulations and important areas of impact as of the presentation date. All information is subject to change.
- ▶ This presentation is for educational purposes only. Individuals and Organizations should consult with their own legal counsel for guidance and direction related to MHPAEA and other laws or regulations.
- ▶ The views and opinions expressed and contained herein are solely those of the presenters and do not represent the views or opinions of Capital BlueCross.

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**Agenda**

- ▶ Background
- ▶ Mental Health Parity Defined
- ▶ Legal Considerations
- ▶ Compliance Concerns & Oversight
- ▶ Q & A

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### Facts on Mental Illness and/or Substance Use Disorders

- ▶ Approximately 1 in 5 adults in the U.S. (43.8 million or 18.5%) experiences mental illness in a given year.
- ▶ An estimated 26% of homeless adults staying in shelters live with serious mental illness, and an estimated 46% live with severe mental illness and/or substance use disorders.
- ▶ Mental health care is costly, with 45 percent of the untreated citing cost as a barrier.
- ▶ Access to mental health care is worse than other types of medical services. However, when accessible, it usually leads to appropriate treatment and, more often than not, treatment leads to improvement.
- ▶ Recent federal legislation requires more expansive insurance coverage for mental health services.

The State of Mental Health in America. (2015). Retrieved from <http://www.mentalhealthamerica.net/issues/state-mental-health-america>  
<http://www.nimh.nih.gov/learn-more/about-mental-health-by-the-numbers>  
<https://www.washingtonpost.com/news/health/wp/2012/12/17/seven-facts-about-mental-health-care-system/>  
 Accessed 10/24/2016 @ 3:17 pm

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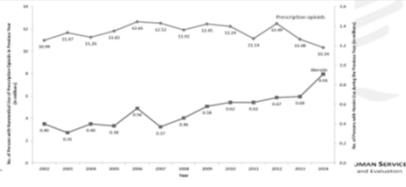
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### Statistics of Opioid and Heroin Use

Past year nonmedical use of prescription opioids and heroin use



Source: SAMHSA, NSDUH 2003-2014 PUF  
 Source: SAMHSA, NSDUH 2003-2014 PUF  
 Accessed 10/24/2016 @ 1:35 PM

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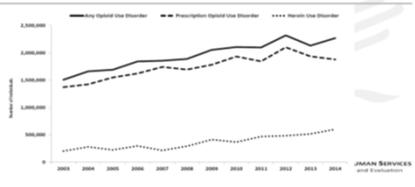
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### Opioid Use Disorders in U.S from 2003 to 2014

Past year opioid use disorders, US, 2003-2014



Source: SAMHSA, NSDUH 2003-2014 PUF  
 Accessed 10/24/2016 @ 1:50 PM

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### Fatal Addictions: Drug Deaths from 1999 to 2014



Prescription in several states drives the increasing number of drug-related deaths on greater use of heroin and synthetic opioids, health officials say.

<https://www.cnn.com/2014/09/13/health/heroin-opioid-drug-overdose-deaths-usual-guide/>  
Monday 10/24/2016 @ 3:16 Pm

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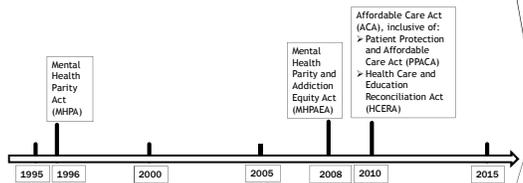
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### MHP: How Did We Get Here?



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### MHP Pre-ACA

- ▶ **Mental Health Parity Act of 1996 (MHPA)**
  - ▶ Required parity in aggregate lifetime and annual dollar limits for mental health (MH) benefits and medical/surgical benefits
  - ▶ Applied to employment-related group health plans and health insurance coverage offered in connection with a group plan - large group plans
- ▶ **Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)**
  - ▶ Extends parity requirements to substance use disorders (SUD)
  - ▶ Does not mandate coverage for MH/SUD
  - ▶ Applies to large group health plans and health insurance issuers that choose to include MH/SUD in benefits

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### Affordable Care Act

- ▶ Patient Protection and Affordable Care Act of 2010 (ACA)
  - ▶ Extends MHPAEA applicability to individual health insurance market
  - ▶ Defines 10 components of coverage as Essential Health Benefits (EHB) - includes MH/SUD as one component
  - ▶ Requires health insurance on- or off-Exchange to comply with MHPAEA requirements to satisfy EHB requirements
- ▶ Exemptions
  - ▶ Self-funded non-Federal governmental plans
  - ▶ Small group grandfathered plans
  - ▶ Medicare

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### MHP: So Where Are We Now?

- ▶ MH/SUD benefits not mandated
  - ▶ BUT
- ▶ EHB = MH/SUD benefits required for non-grandfathered health plans in individual and small group markets
  - ▶ AND
- ▶ MH/SUD benefits must comply with MHPAEA regulations



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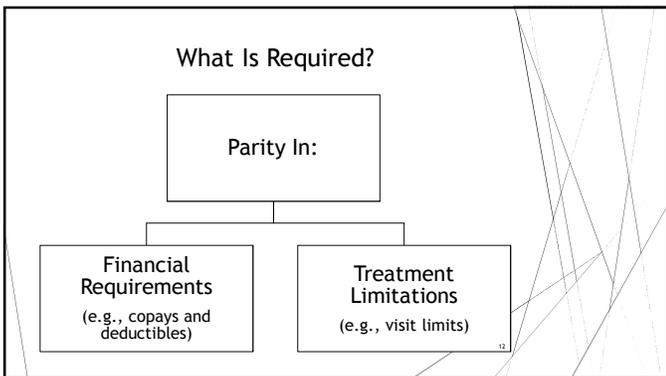
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### Parity Applies to Each Classification of Benefits

- ▶ A plan or issuer may not apply any financial requirement or quantitative treatment limitation to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

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### Benefit Classifications

- ▶ Inpatient, in-network
- ▶ Inpatient, out-of-network
- ▶ Outpatient, in-network
- ▶ Outpatient, out-of-network
- ▶ Emergency care
- ▶ Prescription drugs



❖ If a plan provides MH/SUD benefits in any classification, MH/SUD must be provided in every classification in which med/surg benefits are provided



❖ Intermediate levels of services (e.g., skilled nursing, home health, residential treatment) must be treated consistently between med/surg and MH/SUD benefits

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### Permitted Sub-Classifications

- ▶ Two sub-classifications permitted:
  - ▶ Office visits (e.g. physician visits), and
  - ▶ All other outpatient items/services (e.g. outpatient surgery, facility charges for day treatment centers, lab charges)
- ▶ No other sub-classifications are permitted (e.g. generalists /specialists)

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### Quantitative Treatment Limitations

- ▶ Financial requirements or quantitative treatment limitations can only be applied to MH/SUD benefits only if **substantially all** (i.e., at least 2/3) med/surg benefits in a classification apply to that type of financial requirement of QTL.
- ▶ Then, if allowed, the financial requirement or QTL cannot be more restrictive than the **predominant level** (i.e., applies to more than ½) med/surg benefits in that classification.

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### Quantitative Treatment Limitations

- ▶ Tests are based on the **dollar amount of all plan payments** for the med/surg benefits in the classification expected to be paid under the plan for the plan year.
- ▶ Any reasonable method may be used to determine the dollar amount expected to be paid under a plan.
- ▶ Cannot apply cumulative QTLs for MH/SUD benefits in a classification separately from any established for med/surg benefits in the same classification.

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### Non-Quantitative Treatment Limitations (NQTLs)

- ▶ Non-quantitative treatment limitations (e.g., UM, medical necessity criteria, step therapy, pre-auth) must be "comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification."

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### NQTLs- What Are They?

- ▶ Medical management standards limiting benefits based on medical necessity or an exclusion for experimental/investigational treatments
- ▶ Prescription drug formulary design
- ▶ Standards for determining provider admission in a network, including reimbursement rates
- ▶ Determinations of usual and customary charges
- ▶ Refusal to pay for higher cost therapies until lower cost therapies are used (fail-first policies or step therapy protocols)
- ▶ Conditioning benefits on completion of 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 provide under the plan or coverage

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### Plan Disclosures

- ▶ Criteria for medical necessity determinations made with respect to MH/SUD benefits must be made available to current or potential participants, beneficiaries, or contracting providers upon request.
- ▶ Reasons for denial of benefits must be made available upon request and free of charge.

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### Enforcement

- ▶ DOL and the IRS generally have enforcement authority over private sector employment-based plans that are subject to ERISA.
- ▶ HHS has direct enforcement authority with respect to self-funded non-Federal governmental plans.
- ▶ State insurance commissioners have primary authority over issuers in the large group; HHS has secondary enforcement authority.
- ▶ \$100 per member per day penalties for non-compliance

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### MHPAEA Violations

- ▶ Insufficient benefits
- ▶ Higher financial requirements
- ▶ More restrictive quantitative treatment limitations
- ▶ More restrictive non-quantitative treatment limitations (NQTLs)
- ▶ Inadequate disclosures

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### The Parity Debate

Consumers/Advocates

Insurers/Issuers



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### Increased MHP Focus by Regulating Agencies

- ▶ Media focus
- ▶ Bipartisan political support to address
- ▶ Increased incidences - year over year escalation
- ▶ Non-biased socio-economic impact
- ▶ Public outcry
- ▶ Insurers = prime subject of focus to show "impact"
  - ▶ Regulated entity
  - ▶ Payer
  - ▶ "Gatekeeper" to access to care

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### Compliance Concerns & Oversight

- ▶ Parity Assurance
  - ▶ Reasonableness
  - ▶ Benefit configuration review and testing
  - ▶ Special rules - multi-tiered Rx benefits
- ▶ Policies & Procedures
  - ▶ Benefits Administration
  - ▶ Medical Necessity
  - ▶ Creation and discontinuation
  - ▶ Annual review
- ▶ Contract Compliance

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### Responding To An Audit

- ▶ DOL audits increasing
  - ▶ Fully insured / ASO
    - ▶ Consistent, Concise, Correct and On Time
      - ▶ Fully understand the scope of audit request.
      - ▶ If ASO, request original DOL documentation, to extent reasonable.
      - ▶ Identify internal units and team members responsible for deliverables prior to receipt of any audit.
      - ▶ Create "template" audit deliverable package - modify, as needed.
      - ▶ Work back from deliverable date or request extension, with suggested deliverable date, if needed.

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### Partner Departments

- ▶ Actuary
- ▶ Business Intelligence/ Analytics & Research
- ▶ Customer Service
- ▶ Finance
- ▶ Legal
- ▶ Operations
- ▶ Pharmacy
- ▶ Product
- ▶ Sales

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### Questions?

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