Implementing Parity: Investing in Behavioral Health

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> There's no way to completely dismantle the stigma associated with mental illness. But there was a way for us to change the law. And that's what we did. And by changing the law, we began to dismantle the stigma because we made it illegal for people to discriminate. In doing so, we're starting to change the practice of delivering mental health coverage and mental health services. For people like me who suffer from mental illness, this is about lifting the cloud of stigma and shame associated with our illness. As much as we have come forward as *stigma-busters*, it's hard to not feel the tinge of judgment that people make on mental illness.
> —*U.S. Rep. Patrick Kennedy*

More than a year after the enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the Departments of Labor, Health and Human Services, and Treasury issued interim final rules (IFR) prohibiting group health plans and insurance from applying more restrictions on mental health or substance use disorder benefits than they do for medical/surgical benefits. The MHPAEA, signed into law on October 3, 2008, does not apply to group health plans with 50 or fewer employees, and the law does not require plans to provide behavioral health coverage.

In the absence of formal guidance until the publication of the IFR and with the MHPAEA requiring compliance for plan years starting on or after October 3, 2009, many group health plans have been operating under a good-faith compliance standard. The IFR from the federal agencies provides significant guidance in some areas, and several of the requirements will necessitate additional steps to ensure compliance. The IFR, published in February 2010, generally applies to plan years beginning on or after July 1, 2010 (with a delayed effective date available for collectively bargained plans).

Understanding how the IFR may affect the business of behavioral healthcare and the decisions that follow will be of great importance to all interested parties, including health insurance companies, health plans, employers, providers, and consumers of behavioral healthcare.

AREAS CLARIFIED BY THE REGULATIONS

The IFR brings clarity to several uncertain issues raised by the MHPAEA:

Deductibles and Out-of-Pocket Limits. The federal agencies take the position that prohibiting separately accumulating financial restrictions and quantitative treatment limitations is more consistent with the MHPAEA's policy goals. Consequently, a plan must apply a single deductible or out-of-pocket maximum to cover both mental health/substance use disorder benefits and medical/surgical benefits. This requires separate claim systems for behavioral healthcare benefits and medical/surgical benefits to be interfaced. This provision remains a controversial issue for some organizations and has been cited in a lawsuit filed against the federal agencies. [Coalition for Parity v. Sebelius, U.S. District Court for the District of Columbia, No. 1:10-cv-00527-CKK, filed 3/31/2010.]

EAP as Gatekeepers. A plan that offers an employee assistance program (EAP) in addition to the benefits of a major medical program that otherwise complies with the parity rules would not violate MHPAEA. However, if the plan demands that participants exhaust the EAP mental health or substance use disorder counseling sessions before they are eligible for the major medical program's mental health or substance use disorder benefits, the plan would violate MHPAEA.

Separate Coverages or Benefit Packages. The parity requirements apply separately to each combination of medical/surgical coverage and mental health or substance use disorder coverage that any participant can simultaneously receive, and all such combinations constitute a single group health plan. If, for example, an employer offered three medical/surgical plan options (Gold, Silver, and Bronze) and a mental health and substance use disorder benefit (Healthy Mind) that could be combined with each plan option, then each combination must satisfy the parity requirements (Gold + Healthy Mind, Silver + Healthy Mind, and Bronze + Healthy Mind). And if the Gold plan option also had separate Gold Plus and Gold Standard options, each of these would also have to satisfy the parity requirements when combined with the Healthy Mind benefits.

Behavioral Healthcare Providers, Specialists, or Primary Care. The IFR does not allow for the separate classification of generalists and specialists in determining the predominant financial requirement that applies to substantially all medical/surgical benefits. Therefore, a plan cannot just set copays for behavioral healthcare specialists equal to the copays for medical/surgical specialists; rather, it must complete the determination of *substantially all* and *predominant* tests for the various financial requirements and quantitative treatment limitations for medical/surgical benefits (see below).

Interaction with State Insurance Laws. MHPAEA requirements do not supersede a state law unless it prevents the application of a MHPAEA requirement. A state law that, for example, mandates

a minimum coverage amount of $50,000 for autism does not prevent the application of MHPAEA. However, an insurer subject to MHPAEA may be required to provide mental health or substance use disorder benefits beyond the state law minimum in order to comply with MHPAEA.

MHPA 1996 Impact. MHPAEA expands the requirements of the 1996 Mental Health Parity Act (MHPA) for aggregate lifetime and annual dollar limits to include protections for substance use disorder benefits. Plans with low lifetime limits for substance use disorder benefits will have to make significant changes to those benefits.

A CONTROVERSIAL ADDITION TO THE REQUIREMENTS

Non-quantitative Treatment Limitations. The IFR makes a distinction between quantitative treatment limitations (e.g., a limit of 50 annual outpatient visits or other limitations that can be expressed numerically, as discussed below) and non-quantitative treatment limitations (e.g., a limit not expressed numerically that otherwise limits the scope or duration of benefits). Non-quantitative treatment limits (NQTLs) include, but are not limited to, medical management standards; prescription drug formulary designs; standards for provider admission to participate in a network; determination of usual, customary, and reasonable amounts; requirements for using lower-cost therapies before a plan will cover more expensive therapies; and conditional benefits based on completion of a course of treatment. Under the IFR, any process or standard a plan uses to apply non-quantitative treatment limitations to mental health/substance use disorder benefits *must be comparable to, and applied no more stringently than*, those used for medical/surgical benefits. This enables a plan to apply, for example, separate utilization management processes for behavioral healthcare benefits as long as they are no more stringent than for medical/surgical care. Disparate results produced by this application do not mean that the treatment limitations do not comply with parity.

This requirement for non-quantitative treatment limitations in the IFR may be one of the most unexpected new requirements by many plans and employers. Some argue that non-quantitative treatment limits such as prior authorization requirements are just as limiting as quantity limits on services and should be required under parity. Others argue that some of these processes should be different between mental health/substance use disorders and medical/surgical conditions, and that it should be up to the plan to determine these processes.

Another area of uncertainty is how the *substantially all* test for quantitative treatment limitations applies here. Some argue that this test naturally extends to NQTLs, while others argue for the complete removal of the NQTLs from the parity requirements.

AREAS OF REQUESTED INPUT WITHIN THE REGULATIONS

The IFR invites comments on specific issues that the federal agencies are likely to address in future guidance. Among the areas of interest are:

- Additional examples to illustrate the application of the non-quantitative treatment limitation rule to other features of medical management or general plan design
- The extent to which guidance is needed where treatments or treatment settings for mental health conditions or substance use disorders have no analogous treatments for medical/surgical conditions (scope of service issue)
- The new requirements for the increased cost exemption under MHPAEA, in light of the IFR's withdrawal of previously published guidance

DETERMINING COMPLIANCE: QUANTITATIVE FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS

To ensure that a plan does not misclassify a benefit to avoid complying with the parity rule, the IFR requires that plan terms defining mental health or substance use disorder benefits be consistent with generally recognized independent standards of current medical practice. A plan may specify the benefits it will cover, but they must generally be accepted in the relevant medical community. Applying a national standard is not necessary; sample sources include the most current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the most current version of the *International Classification of Diseases* (ICD), or a state guideline.

The IFR defines certain terms:

Classification of Benefits: Six benefit classifications are specified, each of which requires parity compliance: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs. If a plan has no network of providers, all benefits in the classification are characterized as out-of-network. The six classifications are the only ones used for purposes of satisfying the MHPAEA's parity requirements. A seventh class cannot be created in order to gain compliance that otherwise would not be present.

Type: This refers to financial requirements and treatment limitations of the same nature. Different types include copayments, coinsurance, annual visit limits, and episode visit limits. A financial requirement or treatment limitation must be compared only to financial requirements or treatment limitations of the same type within a classification (e.g., copayments only compared to other copayments, annual visit limits only compared to other annual visit limits). The IFR requirement to separate copays and coinsurance in testing is a major problem for some plan designs—more on that below.

Level: This refers to the magnitude of a type of financial requirement or treatment limitation (such as the dollar, percentage, day, or visit amount).

Coverage Unit: This refers to how a plan designates individuals when determining benefits, premiums, or contributions (such as single participant, participant plus spouse, participant plus children, or family).

The IFR requires that the MHPAEA's general parity requirement for financial requirements and treatment limitations be applied separately for each classification of benefits and for each coverage unit.

The regulations do not define inpatient, outpatient, or emergency care. These terms are subject to plan design and their meanings may differ from plan to plan. Additionally, state health insurance laws may define these terms.

MEASURING PLAN BENEFITS FOR COMPLIANCE TESTING

The portion of plan payments subject to a financial requirement or quantitative treatment limitation is based on the dollar amount of all plan payments for medical/surgical benefits in a classification to be paid in the plan year. Any reasonable method may be used to determine the expected paid dollar amount under the plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation.

For deductibles, the dollar amount of plan payments includes all payments for claims that would be subject to the deductible if it had not been satisfied. For out-of-pocket maximums, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that were taken into account toward the out-of-pocket maximum, as well as all plan payments associated with out-of-pocket payments that would have been made toward the out-of-pocket maximum if it had not been satisfied. Other threshold requirements are treated similarly.

The first step in complying with the MHPAEA is to determine whether a financial requirement or quantitative treatment limitation applies to *substantially all* medical/surgical benefits in a classification. Under the IFR, the term means the financial requirement or treatment limitation applies to *at least two-thirds* of the benefits in that classification. Benefits expressed as subject to a zero level of a type of financial requirement or an unlimited quantitative treatment limitation are treated the same as benefits that are not subject to that requirement or limitation (i.e., a $0 copayment for a benefit, such as well baby care, is treated as not subject to a copayment).

If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of the medical/surgical benefits in a classification, that type of requirement or limitation *cannot be applied* to mental health or substance use disorder benefits in that classification. If a single level of a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of the medical/surgical benefits in a classification, then it is also the predominant level, and that is the end of the comparative analysis.

If the financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification but has multiple levels and no single level applies to at least two-thirds of all medical/surgical benefits in the classification, then an additional analysis is required—determining which level of the financial requirement or quantitative treatment limitation is considered *predominant*.

The MHPAEA provides that a financial requirement or treatment limitation is predominant if it is the most common or frequent of a type of limit or requirement and applies to *more than one-half* of medical/surgical benefits subject to the financial requirement or treatment limitation in that classification. If a single level of a type of financial requirement or quantitative treatment limitation applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in a classification (based on plan costs), the plan may not apply that particular financial requirement of quantitative treatment limitation to mental health and substance use disorder benefits at a level that is more restrictive than the level that has been determined to be predominant.

If no single level applies to more than one-half of medical/surgical benefits subject to a financial requirement or quantitative treatment limitation in a classification, plan payments for multiple levels can be combined until the portion of plan payments subject to the financial requirement or quantitative treatment limitation *exceeds* one-half. Then the plan may not apply that particular financial requirement or quantitative treatment limitation to mental health or substance use disorder benefits at a level that is more restrictive than the *least restrictive level* within that combination. The plan may combine plan payments for the most restrictive levels first, with each less restrictive level added until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.

When a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of medical/surgical benefits in a classification, but no single level applies to more than one-half of the medical/surgical benefits, a plan is permitted to treat the least restrictive level of the financial requirement or quantitative treatment limitation applied to medical/surgical benefits in that classification as the predominant level. Determining the predominant level of a particular financial requirement or quantitative treatment limitation must be done separately for each coverage unit.

Prescription Drug Benefits. If a plan does not distinguish prescription drugs used for mental health/substance use disorder and medical/surgical benefits, the classification of benefits parity requirement will be satisfied if the plan imposes different levels of financial requirements on different tiers of prescription drugs based on reasonable factors (such as cost, efficacy, generic vs. brand name, and mail order vs. pharmacy pick-up) determined in accordance with the rules for non-quantitative treatment limitations. This special rule for prescription drugs, in effect, allows a plan or issuer to subdivide the prescription drug classification into tiers and apply the general parity requirement separately to each tier of prescription drug benefits.

For any tier, the financial requirements and treatment limitations imposed with respect to the drugs prescribed for medical/surgical conditions are the same as the financial requirements and treatment limitations imposed with respect to the drugs prescribed for mental health conditions and substance use disorder benefits in the tier. Moreover, because the financial requirements and treatment limitations apply to 100% of the medical/surgical drug benefits in the

tier, they are the predominant financial requirements and treatment limitations that apply to substantially all of the medical/surgical drug benefits in the tier.

AREAS NEEDING ADDITIONAL GUIDANCE FROM FEDERAL AGENCIES

There are several issues that need further guidance from the federal agencies:

Separate Testing of Coinsurance and Copays. It is possible for nearly all of the medical/surgical benefits within a classification to require member out-of-pocket payments and still have a plan fail the *substantially all* test. This is often the result for *hybrid* plans that use a combination of coinsurance, copays, and free benefits in a class, commonly the in-network outpatient class. If some of the plan payments are subject to copays, some are subject to coinsurance, and some (e.g., free preventive services) have neither copay nor coinsurance, in many cases neither the copay nor coinsurance types would meet the *substantially all* requirement, resulting in no copays or coinsurance for behavioral healthcare benefits under the rules. This does not seem to be a reasonable development of parity benefits (resulting in 100% coverage of behavioral benefits while most medical/surgical benefits require member out-of-pocket payments).

The use of actuarial equivalence (to convert copays to effective coinsurance or vice versa) and combining the testing of copays and coinsurance could solve this problem. Another potential solution is the creation of separate outpatient classifications for hospital services (which often have coinsurance and deductibles) and professional services (which often have copays only).

Determining the Dollar Amounts Expected to Be *Paid*. There has been some confusion on whether paid claims or allowed claims are appropriate for parity compliance testing. The IFR description for handling deductibles and out-of-pocket limits suggests that allowed claims (prior to member payment responsibilities) are appropriate. However, the IFR does use the phrase *expected to be paid under the plan* when measuring plan benefits. Many actuaries believe that using allowed costs makes more sense when testing for the prevalence of financial requirements (an extreme example of the problem with using paid costs would be a benefit with a copay that was the same size as the allowed charge, which would result in zero paid claims for that benefit, causing it to be excluded from the calculation). The IFR also states that *…any reasonable method may be used to determine the dollar amount…*; the use of allowed dollars in the testing is reasonable.

Episodic Copays. Some plans charge one copay for all of the services that a patient receives in an office visit with a provider. These services could include the office visit, an x-ray, some lab work, and other services. In completing the testing for *substantially all* and in determining *predominant* levels, guidance is needed on whether all of these different types of medical/surgical services are considered subject to the copay, or if only the office visit itself is subject to the copay.

Tiered Networks. Some plans use tiered networks in their plan designs, offering two different levels of in-network benefits with different levels of copays or coinsurance. The IFR doesn't provide for a special test under these types of benefit designs. The standard approach would require that the different tiers be included in the testing of each in-network classification, with costs by service category separated between the provider tiers to properly handle the different levels of financial requirements. This would be similar to the handling of different copays or coinsurance for primary care providers and medical/surgical specialists. However, an option to use different classifications for each tier would be helpful.

State Mandates for Autism. Some states mandate specific dollar amounts for the treatment of autism and pervasive developmental disorders (PDDs). Are benefits paid for treatment of autism/PDDs a combination of different medical and behavioral benefits? Can employers and plans craft separate sections of benefit coverage for these disorders from other behavioral disorders and comply (essentially excluding them from the behavioral benefit provisions)? If they cannot do this, and coverage becomes extremely expensive, do they then meet the cost exemption and then opt out of parity in subsequent (alternate) years?

SCOPE OF SERVICES

The IFR did not address the scope of services issue. The federal agencies received many comments addressing this *continuum of care* issue. Some requested that the regulations clarify that a plan is not required to provide benefits for any particular treatment or treatment setting if benefits for the treatment or treatment setting are not provided for medical/surgical benefits (such as non-hospital residential treatment of partial hospital services). Others requested that beneficiaries should have access to the full scope of medically appropriate services to treat mental disorders and substance use disorders if the plan covers the full scope of medically appropriate services to treat medical/surgical conditions.

A key element here is the need for medically appropriate services, and the provision of such services by properly qualified, licensed, and credentialed providers. There can be a wide range in the qualifications and credentials of behavioral healthcare providers, and some payors have historically reacted to this by limiting what they will consider as covered healthcare benefits.

One solution to this *scope of services* issue is the use of specific care guidelines for behavioral disorders that use a full spectrum of treatment options in an effort to achieve high quality and efficient healthcare spending for medically necessary care. The *Milliman Care Guidelines*® identify benchmark patient care and recovery as one means of enhancing the delivery of quality healthcare and promoting more efficient resource management across the continuum of care. Consistent with that continuum-of-care approach, *Behavioral Health Guidelines* provides guidelines for in-depth treatment of major psychiatric disorders ranging from anorexia and anxiety disorders to schizophrenia and substance use disorders. The appropriateness of specific psychological, behavioral, and pharmacologic therapies is addressed, and indications are presented at five different levels of care (inpatient care, residential care, partial hospital program,

intensive outpatient program, and acute outpatient care) to define the optimal level of care for effective, efficient behavioral health therapy. The guidelines can assist case managers and other mental healthcare professionals in developing outpatient alternatives to higher levels of care, facilitate the progress of patients whose recoveries are delayed, and prepare comprehensive plans for transition of patients from one level of care to another.

DON'T IGNORE NON-QUANTITATIVE TREATMENT LIMITATIONS

While the IFR is quite specific in many ways about the testing procedure for MHPAEA compliance of quantitative financial requirements and treatment limitations, it is less so on non-quantitative treatment limitations. However, compliance failure in this area is just as severe as compliance failure on benefit design under the IFR. Here are some issues to consider regarding non-quantitative treatment limitations.

The IFR uses the *must be comparable to, and applied no more stringently than* terminology in comparing mental health and substance use disorder and medical/surgical benefits processes, strategies, evidentiary standards, and other factors in comparing non-quantitative treatment limitations after addressing the quantitative limits via the *substantially all* and *predominant* tests. This may be interpreted to mean that any such non-quantitative limits (1) must apply to substantially all medical/surgical benefits, (2) must be the predominant treatment limitation, and (3) must be applied no more restrictively than the medical/surgical limits.

Medical Management Standards. The processes for the development of medical necessity criteria must be comparable for medical/surgical benefits and behavioral healthcare benefits. Additionally, the application of these medical necessity criteria to healthcare being delivered to plan participants must be comparable between medical/surgical conditions and behavioral conditions. More stringent application of such criteria to behavioral conditions than substantially all medical/surgical conditions would seem to result in noncompliance.

Prescription Drug Formulary Design. Pharmacy and therapeutics (P&T) committees need to be consistent in how they place prescription drugs in formulary tiers between medical/surgical and behavioral conditions. Limiting the number and types of psychotropic drugs in lower-cost tiers would be noncompliant if this is not comparable to the treatment of substantially all prescription drugs for medical/surgical conditions. Additionally, quantity limits or prior authorization requirements that apply to drugs for mental or substance use disorders that do not apply to substantially all drugs for medical/surgical conditions would likely be noncompliant.

Network Adequacy. While not specified directly in the IFR, does the MHPAEA require access to mental health and substance use disorders treatment providers that is comparable to substantially all medical/surgical providers through the non-quantitative treatment limitation language? Is access within 10 days to substantially all medical/surgical specialists and access within 30 days to a mental health or substance use disorder specialist *comparable*? Plans and employers may need to review network adequacy between medical/surgical and behavioral healthcare providers for *comparable* access.

Usual, Customary, and Reasonable Provider Fees. Can health plans and employers continue to use networks that are based on negotiated contracted rates that pay medical/surgical providers differently than behavioral providers? It would seem that normal business practices allow for negotiation on network rates separately for different types of providers. Signed provider contracts are an agreement between both parties as to specific payment rates in return for network participation. But if this leads to network access differences between medical/surgical providers and behavioral providers, could this be a non-quantitative treatment limitation? For out-of-network providers, it would seem clear that usual and customary rates paid to behavioral providers need to be comparable to those paid to substantially all medical/surgical providers.

Step Therapies. Required use of a specific lower-cost treatment option (with a failure to achieve positive outcomes) before covering higher-cost treatment options for mental illnesses or substance use disorders would likely be noncompliant if such requirements do not exist for substantially all medical/surgical treatment options.

BEYOND THE REGULATIONS

Complying with the regulations is definitely a priority for employers and health plans. However, in the big picture of investing in behavioral health, this is just a first step. There are several additional areas that merit careful consideration for employers and health plans not to just comply with rules, but to make important changes in other elements of medical and behavioral healthcare to ultimately achieve significantly improved clinical and financial outcomes. Here are some of these considerations.

Access to Specialists. Providing more comprehensive behavioral healthcare benefits will not mean much if access to the behavioral specialists who can deliver effective behavioral healthcare services is limited. There are many areas across the country where there are problems in obtaining care. Research has shown that the longer the wait for diagnostic and therapeutic services for people with mental illnesses or substance use disorders, the higher the no-show rate for such services. If one of the elements of success in behavioral health is getting the right treatment by the right provider at the right time, provider networks must be established to accomplish that goal. Employers and health plans should review their behavioral healthcare provider network capacity at all levels—MDs, PhDs, MSWs, other counselors, addiction specialists, etc.—to ensure that they have the capacity to provide effective treatment under the expanded parity benefits.

Support of Primary Care. There will be geographic areas where maintaining a sufficient behavioral specialty network to provide the desired access and clinical outcomes will be impossible. Patients will then rely on their primary care providers (PCPs) for behavioral healthcare. Systems of support will need to be developed to help PCPs improve their diagnostic and treatment capabilities of behavioral disorders. This could include increased funding for care management of behavioral illnesses provided through

nurse practitioners, increased funding of diagnostic behavioral screening/testing in primary care settings, and increased support for work processes that improve clinical outcomes. There is a huge opportunity for such improvement in primary care settings.

Care Quality and Outcomes. Employers and health plans should evaluate the clinical outcomes obtained through the various behavioral healthcare providers and programs. These could include psychiatric symptom ratings, daily functioning, member/family satisfaction rates, psychotropic treatment adherence, psychotherapy treatment completion, follow-up visits after facility discharges, and financial outcomes (i.e., cost effectiveness).

Preventive Care. Many preventive care services within medical benefits have small or no copays associated with them. Consider providing screenings for mental illness and substance use disorders as preventive care, with the same level of copays used for preventive medical services (and be careful with compliance testing if you do so).

Pay for Performance. Consider the prospect of rewarding providers for achieving targeted outcomes in their treatment of behavioral illnesses. This could come in the form of additional payments to providers for treated patients that hit medication adherence objectives or therapeutic objectives through counseling. Incentives could be paid to facility-based programs for effective clinical outcomes that continue over time.

Group health plans and insurance must take steps to ensure compliance with MHPAEA and the IFR by the July 1, 2010, possible effective date for some plans, and by the January 1, 2011, applicability date for most plans. Although additional guidance is needed in some key areas, the broad scope of the law is in place and much of the testing, modeling, cost analysis, and administrative preparations can be performed now. Milliman has helped many of our clients get started with MHPAEA compliance testing and we are well-equipped to help employers and health plans both effectively complete quantitative MHPAEA compliance testing, as well as process and business reviews that could impact non-quantitative treatment limitation compliance. Finally, we can help employers and health plans *invest* in behavioral healthcare and obtain favorable clinical and financial outcomes in the course of developing MHPAEA benefits plans and management processes.

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