

POSITION STATEMENT 15: MENTAL HEALTH PARITY IN HEALTH INSURANCE

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This Position Statement is designed to provide a comprehensive view of the principal issues in parity implementation. It is not designed as a consumer guide. People in recovery from mental illnesses and substance use disorders who are experiencing health insurance barriers to effective treatment should consult the Kennedy Forum's publications and especially its Parity Partner Toolkit, <https://www.thekennedyforum.org/paritypartnertoolkit/> MHA affiliates may be able to provide further help and local referrals.

Policy

All Americans should have an enforceable right to essential health-care benefits, including behavioral health services. Mental Health America (MHA) calls on the federal and state

governments to ensure, as a matter of law, that public and private health plans afford people coverage for and access to needed behavioral health care and treatment on the same terms as surgical and other medical care, without regard to diagnosis, severity, or cause. MHA supports:

- Universal parity education,
- Extensive parity counselling of people in need of treatment who are affected by health insurance policies that impede access to care,
- Support of claimants in presenting persuasive parity evidence to insurers and regulators,
- Prospective and retrospective reviews of health insurance data and medical necessity criteria,
- Random audits of denials of coverage to ensure that decisions are transparent and evidence-based, and
- Vigorous advocacy and litigation as needed to make parity a reality.
- Congressional legislation to:
 - Appropriate funds to allow for randomized compliance audits, rather than just responding to complaints
 - Subject Medicare to parity
 - Eliminate Medicare’s arbitrary 190-day lifetime limit on inpatient psychiatric hospital care—a restriction that does not exist for any other inpatient Medicare service.
 - Authorize the DOL to collect civil monetary penalties for parity violations
 - Subject non-ERISA plans to the same disclosure requirements as ERISA plans
 - Eliminate the HIPAA provision allowing self-insured state and local governments to opt out of parity requirements
 - Subject ERISA and fee-for-service Medicaid plans to the same standard of proof as any other health insurance plan.
- State legislation to improve state regulation of parity

This position statement illustrates the significant progress that the mental health and substance use advocacy community is making toward those goals and suggests the long road ahead. MHA aspires to support parity in everything it does.

Executive Summary

Historical Process. MHA has struggled to establish parity of health insurance coverage between mental health and substance use disorders and general medical conditions for forty years. Beginning with federal legislation in 1996, limited to mental health, the implementation of the statute proved frustrating and futile. The continuing practice of providing inferior behavioral health coverage compared to other medical coverage not only limited access to needed care, but subjected many Americans to the risk of major losses from out-of-pocket costs and diminished income and quality of life.

Employers lost valuable workers and incurred major expenses for leave. A landmark 2005 report by the National Business Group on Health recommended that employers equalize their medical and behavioral benefit structures given the over-whelming evidence that parity yields significant clinical benefits without increasing overall healthcare costs. Mental Health America and other mental health advocates then forged a coalition with business to support improved insurance-parity legislation, which finally culminated in passage of the Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”). Improvements, including mandating mental health and substance use coverage, were made through the Affordable Care Act (“ACA”) of 2010. Thus, the statutes must be read together.

NQTLs. The greatest difficulty with the implementation of the MHPAEA has been the comparison of non-quantitative treatment limitations (“NQTLs”). As passed, the MHPAEA definition of NQTL proved unworkable, and the implementing regulation effectively rewrote the statute. Under the regulation, “...[H]ealth insurance coverage may not impose an [NQTL] with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the ...health insurance coverage... as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to mental health or substance use disorder [“MH/SUD”] benefits in the classification are **comparable** to, and are **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.” (emphasis supplied)

Tools. The position statement describes the implementation of the MHPAEA, focusing on the tools that have been developed for comparison of NQTLs. MHA takes the position that cross-walking comparison of general/medical conditions and MH/SUD conditions is appropriate, that evidence-based standards must be applied to both, and that transparent medical necessity decisions are the key to enforcing parity in individual cases. Although many other tools and FAQs are cited, MHA favors the “Six Steps” analytical framework that it participated in creating and the online tool developed by the ClearHealth Quality Institute Online Parity Tool which provides a proactive and effective solution to achieve effective NQTL comparison.

Several additional tools exist that can help promote parity compliance including the U.S. DOL Self-Compliance Tool, and the CMS Parity Compliance Toolkit for Medicaid/CHIP addition, CHQI is beta testing the only MH/SUD Parity Accreditation Program in the marketplace. As implementation of the MHPAEA and the ACA proceed, ParityTrack’s analysis of state enforcement through legislation, consent decrees, and over 50 individual appeals has forged a comprehensive data base that can be used to fight insurer limitations on coverage of MH/SUD conditions and as a template for state parity legislation. An excerpt is provided in Appendix II. A growing number of states are doing parity market conduct exams, though the methodology that they use is not consistent from one state to the next. The NAIC is developing a model parity

market conduct exam that should make such exams more uniform, though early drafts have been heavily criticized.

The position statement focuses on three areas of ongoing MHA concern: The potential over-institutionalization inherent in the medical model of care, to which MH/SUD treatment is to be compared, the ongoing difficulties with medical necessity standards and disclosure, and especially the hope that parity may serve to provide more appropriate MH/SUD care than the current reliance on drug therapy. Drugs have become the dominant treatment for MH/SUD conditions, despite improvements in more specialized care that may better meet the needs of MH/SUD patients. Access to specialty mental healthcare services is constrained due to benefit design with substantial NQTLs -- higher co-pays, visit limits, and management of utilization. These additional financial limitations are not applied to psychotropic drug benefits or to many behavioral health interventions delivered in the general healthcare setting. This has created a perverse incentive for patients to (1) access mental healthcare from general healthcare providers (where there are no visit limitations and co-pays are significantly lower) and to (2) rely on psychotropic medication as an exclusive method of treatment. Thus, enforcement of NQTL parity is essential to reform of the MH/SUD system of care.

Applicability, ERISA, and the *Wit* case. The position statement describes the applicability of the MHPAEA to various plans and the evidentiary barriers to enforcing parity in ERISA-governed plans, which includes most large employer plans. In a section on litigation and in Appendix I, the position statement describes in detail the recent landmark decision in *Wit and Alexander v. United Behavioral Health*. The case is still at the District Court level, pending a decision on the remedy to be applied in light of the Court's far-reaching decision for the plaintiffs. The essential finding was the United's inadequate internal guidelines violated its fiduciary duty under ERISA. Although the MHPAEA was only cited twice in passing, the standards analysis is integral to the Six Steps MHPAEA analysis, as emphasized in an endnote.

The *Wit* Court found the following to be the eight generally accepted standards for behavioral healthcare from which United's Guidelines deviated:

- *More than Symptom-Based.* It is a generally accepted standard of care that effective treatment requires treatment of the individual's underlying condition and is not limited to alleviation of the individual's current symptoms.
- *Co-Occurring Conditions.* It is a generally accepted standard of care that effective treatment requires treatment of co-occurring behavioral health disorders and/or medical conditions in a coordinated manner that considers the interactions of the disorders and conditions and their implications for determining the appropriate level of care.
- *Safe and Effective Threshold Requirements.* It is a generally accepted standard of care that patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective – the fact that a lower level of care is less restrictive or intensive does not justify selecting that level if it is also expected

to be less effective. Placement in a less restrictive environment is appropriate only if it is likely to be safe and *just as* effective as treatment at a higher level of care in addressing a patient’s overall condition, including underlying and co-occurring conditions.

- *Erring on the Side of Caution.* It is a generally accepted standard of care that when there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care.
- *Maintaining Function or Preventing Deterioration.* It is a generally accepted standard of care that effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration.
- *No Default Time Limits.* It is a generally accepted standard of care that the appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment.
- *Factoring in the Needs of Young Patients.* It is a generally accepted standard of care that the unique needs of children and adolescents must be considered when making level of care decisions involving their treatment for mental health or substance use disorders.
- *The Need for a Multidimensional Assessment.* It is a generally accepted standard of care that the determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made based on a multidimensional assessment that considers a wide variety of information about the patient.

In addition to the standard of care analysis, the Court pointed out a significant NQTL that United applies to MH/SUD treatment concerning the likelihood of improvement. This cost/benefit calculation is rarely applied to coverage determinations for medical/surgical treatment. This raises the potential of a parity violation because it is highly doubtful that United or any other health insurer applies the same requirement to most medical/surgical conditions when making coverage determinations.

The position statement closes with an analysis of reviewers’ advice about improving the appeal process and a four-page Call to Action for MHA, its affiliates, and other advocates.

Background

With striking scientific advances over the last half century, behavioral health problems (hereafter, mental health and substance use disorder conditions – “MH/SUD”) are now more reliably

“Concerns about the cost of care – concerns made worse by the disparity in insurance coverage for mental disorders in contrast to other illnesses – are among the foremost reasons why people do not seek needed mental health care.”

Mental Health: A Report of the Surgeon General (1999)

diagnosed, and there is a range of evidence-based treatments for virtually every disorder. Those treatments have efficacy rates comparable to or exceeding those for many medical and surgical conditions. Yet all too often people with diagnosable mental and substance use disorders do not seek treatment. “Concerns about the cost of care – concerns made worse by the disparity in insurance coverage for mental disorders in contrast to other illnesses – are among the foremost reasons why people do not seek needed mental health care.”¹

The Mental Health Parity Act of 1996 was the breakthrough law that established the principle that there should be no disparity between mental health and general medical treatment in health insurance benefits. Larger emphasis on cost sharing, primarily implemented through higher copayments, deductibles, and out-of-pocket maximums, was the main strategy used by insurers to evade parity. As the General Accounting Office (GAO) reported in a 2000 review of the 1996 Act’s implementation, the vast majority of employers it surveyed substituted new restrictions and limitations on mental health benefits.² Insurers and plan administrators routinely limited mental health benefits more severely than medical and surgical coverage, most often by restricting the number of covered outpatient visits and hospital days, and by imposing much higher cost-sharing requirements.³

No rational basis supports these discriminatory health-insurance practices, which drew criticism from voices ranging from former President George W. Bush to Fortune 50 chief executive officers.⁴ A landmark report by the National Business Group on Health recommended that employers equalize their medical and behavioral benefit structures given the over-whelming evidence that parity yields significant clinical benefits without increasing overall healthcare costs.⁵

Most states have adopted laws requiring parity between mental health and general health benefits in group health insurance, but have provided parity protection to only certain diagnoses. Most states have also addressed substance use disorders, without providing the required funding. But state laws vary widely in scope and, under federal ERISA statute (The Employer Retirement Income Security Act), do not govern the health plans of the many employers who elect to self-insure by paying claims directly, using an insurance company only to administer the plan. ERISA plans are regulated by the U.S. Department of Labor (“DOL”), rather than by state regulators.⁶ Although state parity laws were welcomed as a helpful advance in the past, and state regulation of both group and individual plans remains a critical focus of advocacy for parity, Mental Health America does not support enactment of legislation that limits parity protection to individuals who have specified diagnoses⁷ and urges major federal, state, and employer funding to address the opioid crisis and ongoing deficits in substance use disorder care.

In the early 2000s, enlightened business leaders in some industries and communities voluntarily provided parity protection for their workforces. But voluntary measures proved an insufficient answer to the widespread discrimination facing most insured Americans. Thus, **Mental Health**

America and other mental health advocates forged a coalition with business to support improved insurance-parity legislation, which finally culminated in passage of the Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”).⁸

Those opposing the 2008 legislation asserted that it would add to the cost of health care. But as the National Business Group on Health observed in its employer’s guide to behavioral health services, a number of parity studies have found that equalizing specialty behavioral health and general medical benefits will either not increase total healthcare expenses at all or will increase them by only a very modest amount relative to employers’ total healthcare premium.⁹ The real cost lies in not treating behavioral health disorders. As the National Business Group noted, the indirect costs associated with mental illness and substance-use disorders – excess turnover, lost productivity, absenteeism and disability – commonly meet or exceed the direct treatment costs, and were estimated to be as high as \$105 billion annually in the United States in 2010.

Although there is no more recent compilation of American data, **a comprehensive 2016 international survey¹⁰ found that mental and substance use disorders constituted 10.4% of the global burden of disease and were the leading cause of years lived with disability among all disease groups.** These consequences were found not to be limited to patients and their social environment—they affect the entire social fabric, particularly through economic costs. The study found that: “improved epidemiological and economic methods and models together with more complete epidemiological data during the past twenty years now allow the accumulation of comprehensive and increasingly reliable data that give us a good idea about the magnitude of the economic impact of mental disorders. **Mental disorders therefore account for more economic costs than [all] chronic somatic diseases such as cancer or diabetes.**”

Against this background, the current debate concerns the definition of parity under the MHPAEA and its implementing regulation, legislation and enforcement by the states, the uncertain role of the federal government as the executive branch seeks to repeal, limit, or overturn the Affordable Care Act,¹¹ with important impacts on parity, the ongoing litigation that will define the enforcement of parity, and changes to the general medical, surgical, mental health and substance use treatment landscape that may result in additional coverage at parity with medical/surgical benefits.¹² This position statement addresses these issues in approximately that order.

What is the Definition of Parity?

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APPLICABILITY OF THE MHPAEA ERISA-GOVERNED PLAN PARITY IS HARDER TO ENFORCE

THE TEXT OF THE MHPAEA

The text of the MHPAEA, HR 1424 (2008), defines parity as:

- “The **financial requirements** applicable to mental health or substance use disorder benefits **are no more restrictive than the “predominant” financial requirements applied to “substantially all”** medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits;” and
- The **treatment limitations** applicable to mental health or substance use disorder benefits **are no more restrictive than the “predominant” treatment limitations applied to “substantially all”** medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.”

THE MHPAEA REGULATION

The MHPAEA Regulation passed by the U.S. Departments of Health and Human Services (“HHS”) and Labor (“DOL”) (“regulation”)¹³ defines the quoted terms.¹⁴ However, **the treatment limitations text was altered substantially**. Under the regulation:

- “A group health plan (or health insurance coverage) **may not impose a non-quantitative treatment limitation [hereafter, “NQTL”, defined broadly in the regulation – see below]** with respect to mental health or substance use disorder benefits in any classification **unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to mental health or substance use disorder [hereafter “MH/SUD”] benefits in the classification are comparable to, and are 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.**” (emphasis added)¹⁵
- The six regulatory treatment “classifications” are very broad: inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, emergency department, and prescription drugs.¹⁶

- **Quantitative treatment imitations and related financial requirements** are straightforward. For e.g.:
 - Number of days of authorized inpatient or residential care;
 - Copayment amounts;
 - Coinsurance amounts;
 - Out-of-network coverage amounts;
 - Ratio of size of networks to persons in need of services, by specialty;
 - Travel distances;
 - Waiting times for providers and beds;

These obvious distinctions were easily discovered and remedied. Gone are restrictive numerical impositions like outpatient visit limits, inpatient day limits, high coinsurance rates, and paltry annual and lifetime dollar limits.

- **Non-quantitative Treatment Limitations (NQTLs)** can be much more difficult to define and compare. These managed care practices are often designed and applied to mental health and substance use disorder treatment in ways that are far more stringent than the application of these same practices to general medical care. The regulation contains an illustrative, non-exhaustive list of NQTLs, which includes:
 - Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for concurrent review);
 - Formulary design for prescription drugs;
 - Network tier design;
 - Standards for provider admission to participate in a network, including reimbursement rates;
 - Plan methods for determining usual, customary, and reasonable charges;

- Fail-first policies and step therapy protocols;
 - Exclusions based on failure to complete a course of treatment; and
 - Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage;
 - **For example:** An inflexible fail-first requirement, that a person receiving treatment must show that outpatient services are not meeting the person’s needs before meriting transfer to an inpatient or residential facility, violates parity, since it doesn’t match the inpatient-to-outpatient track of surgical rehabilitation and other medical treatments such as stroke or overdose. However, trying community-based treatment first for mental health patients has therapeutic as well as financial benefits and may be medically sound and in the best interest of a particular person receiving treatment. Thus, without justification, a strict fail-first requirement would violate parity, but for justifiable medical reasons, referral to a lower level of care would not. A well-considered medical opinion, grounded in an evidence-based and published standard, should trump the insurance company’s blanket policy or the insurance company’s internal decision-making process.
- The regulation does not define the critical term “comparable.” The Webster’s definition is:
 - (1) **Capable of or suitable for comparison.** The situations are not at all *comparable*.
 - (2) **Similar**, like fabrics of *comparable* quality. The two houses are *comparable* in size. Synonyms listed by Webster’s include alike, analogous, corresponding, like, parallel, and resembling. **In the absence of regulatory guidance, both definitions can and should be applied to the required comparison of medical/surgical and MH/SUD NQTLs. Thus, an MH/SUD NQTL cannot be applied if it cannot be compared and found substantially similar to some medical/surgical treatment NQTL.**

THE CROSS-WALK ISSUE

- **The final regulation commentary was quite restrictive in counselling against the comparison of particular medical/surgical and MH/SUD treatments:** “[Some] commenters suggested that specific mental health or substance use disorder benefits be cross-walked or paired with specific medical/surgical benefits (e.g., physical rehabilitation with substance use disorder rehabilitation) for purposes of the parity analysis . . . Cross-walking or pairing specific mental health or substance use disorder benefits with specific medical/surgical benefits is a static approach that the Departments do not believe is

feasible, given the difficulty in determining ‘equivalency’ between specific medical/surgical benefits and specific mental health and substance use disorder benefits and because of the differences in the types of benefits that may be offered by any particular plan.”¹⁷

PARITY ANALYSIS TOOLS

- **To the contrary, the ClearHealth Quality Institute (“CHQI”) analysis¹⁸ openly embraces cross-walking analysis.** As reflected in the CHQI Parity Standards, the current thinking is to crosswalk using three buckets: 1) MH; 2) SUD; and 3) medical/surgical. CHQI recommends that Buckets 1 and 2 be compared to bucket 3, classification by classification. Unfortunately, health plans have not been properly running this comparability analysis. **CHQI has recently developed an Online Parity Tool which provides a proactive and effective solution.**¹⁹
- **The regulation’s adoption of the “comparability” test for NQTLs invites just such a comparison,** and the case law supports it. For example in the leading Ninth Circuit decision in the *Harlick* case (decided under the California parity law), the Court compared inpatient/in-network medical/surgical treatment for life-threatening conditions in general to inpatient/in-network care for MH/SUD conditions like severe eating disorders that can be life-threatening. Such conditions require inpatient care just as a life-threatening medical/surgical condition would require inpatient care. The only difference is that the care may be in a residential treatment center rather than a hospital or a skilled nursing facility. **See discussion of the *Harlick* case, below under “Litigation.”**
- **Several additional tools exist that can help promote parity compliance** including the [U.S. DOL Self-Compliance Tool](#), and the [CMS Parity Compliance Toolkit for Medicaid/CHIAP](#). CHQI is beta testing the only [MH/SUD Parity Accreditation Program](#) in the marketplace.
- In addition, to avoid defaulting to multiple court decisions in individual cases and resulting lack of uniformity in MHPAEA application, HHS has published a steady stream of FAQs.
- **MHA particularly recommends the illustrative approach of The Kennedy Forum, the Amerian Psychiatric Association, and the Parity Implemetation Coalition (of which MHA is a member), which have developed the KF/APA/PIC six steps,**²⁰ that give an extensive list of NQTLs, evidentiary standards, and comparative analyses to consider. Because of their importance in compatting NQTLs that inhibit access to MH/SUD care and treatment, the Six Steps titles and the two most important analyses are excerpted in this

endnote.²¹ The endnote stresses the role of nationwide evidence-based treatment standards in parity analysis.

- **Of course, courts will continue to backfill gaps**, as will be further elaborated in the discussion of the recently-decided and still pending *Wit* case under “Litigation,” below, and in Appendix I. The *Wit* case expanded upon the ClearHealth standard and tool by introducing a comparison based on comparability of adherence to professional quality standards. **The *Wit* decision is exciting, in that it requires adherence to national, evidence-based guidelines in making coverage decisions.** It is important to note that the *Wit* case, while mentioning the MHPAEA twice, and suggesting a broadening of the concept of “comparability,” was not grounded in the MHPAEA.

SUMMARY

To summarize, by translating the regulation to an individual seeking (for e.g.) inpatient/in-network care for an MH/SUD condition, any NQTL which the insurer may raise as a treatment limitation, as written and in operation, and any “processes, strategies, evidentiary standards, or other factors used” in applying such NQTL to such MH/SUD benefit to him/her (1) must be “comparable to” the “processes, strategies, evidentiary standards, and other factors used” in applying the NQTL to a person seeking inpatient/in-network care for a medical/surgical condition and (2) “may not be applied more stringently” than the “processes, strategies, evidentiary standards, or other factors used” in applying the NQTL to a person seeking inpatient/in-network care for a medical/surgical condition. The advocacy challenge is to define those terms to an individual case, and it is the principal purpose of this position statement to explain the advances that parity advocates have achieved in doing so.

PROGRESS IN DEFINING AND COMBATTING INAPPROPRIATE NQTLS

Non-quantitative limitations vary substantially by carrier and over time and are often unwritten or difficult to determine, as applied. Carriers have a compelling business incentive to avoid developing robust medical necessity criteria and to avoid publicizing the weak criteria that they have been using. However, **progress is being made, particularly in the development of the ClearHealth Quality Institute standards and tool and the KF/APA/PIC Six Steps criteria, described above.** As implementation of the MHPAEA and the ACA proceed, ParityTrack’s analysis of state enforcement through legislation, consent decrees, and over 50 individual appeals has kept a comprehensive data base that can be used to fight insurer limitations on coverage of MH/SUD conditions.²² A growing number of states are doing **parity market conduct exams**, though the methodology that they use is not consistent from one state to the next. The NAIC is

developing a model parity market conduct exam that should make such exams more uniform, though early drafts have been heavily criticized.

APPLICABILITY OF THE MHPAEA

The MHPAEA does not apply to Medicare or to the VA or to the Medicaid Fee-For-Service program, However, coverage of some plans is achieved only by the ACA or by regulation or executive order, and non-grandfathered ERISA-governed plans are subject to a separate part of the MHPAEA, governed by the Department of Labor, and by regulations consistent with the regulation, issued by the DOL The following chart is illustrative of the regulatory maze [amend and use URL when complete]:

MH/SUD Parity Coverage Requirements Kennedy Forum Internal Draft 4/21/19 Note: Still Confirming Findings		
Insurance Coverage Type?	Applies?	Notes
Commercial Insurance (State Regulated)		
Commercial Large Group Policies: (e.g., plans with more than 50 insured employees)	Yes	Pursuant to MHPAEA, Affordable Care Act, and applicable state law
Commercial Small Group Policies: Non-Grandfathered (e.g., less than 51 employees)	Yes	Technically MHPAEA does not apply directly to small group health plans, although its requirements are applied indirectly to non-grandfathered small group plans in connection with the Affordable Care Act's essential health benefit (EHB) requirements.
Commercial Small Group Policies: Grandfathered (e.g., less than 51 employees)	No	See comment above
Commercial Individual/Nongroup Policies: Non-Grandfathered	Yes	Non-grandfathered plans are plans that came into existence after the March 23, 2010 passage of the Affordable Care Act.
Commercial Individual/Nongroup Policies: Grandfathered	No	See comment above
Self-Funded Health Plans (U.S. DOL Regulated)		
Employer Self-Funded	Yes	Group health plans that pay for coverage directly, without purchasing health insurance from an issuer, are called self-funded group health plans.
Union/Taft Hartley Plans	Most cases	Most multiemployer defined benefit plans are governed by a joint board of trustees (Trustees) with equal representation from labor and management that is responsible for the operation and administration of the plan. The Trustees often hire a third party administrator (TPA) to carry out the functions of the plan. As a result, both the Trustees and the TPA share fiduciary responsibility under the Employee Retirement Income Security Act of 1974 (ERISA) and the Mental Health Parity and Addiction Equity Act of 2008 (Federal Parity Law).
Medicare (CMS Regulated)		
Medicare FFS	No	
Medicare Advantage	No	

Medicare Special Needs	Yes	
Medicaid (CMS and State Regulated)		
Medicaid managed care plans	Yes	MHPAEA is incorporated by legislative reference into Medicaid, but only for certain forms of Medicaid coverage such as Medicaid managed care.
Children's Health Insurance Program plans	Yes	Same as above for CHIP.
Medicaid Alternative Benefit plans (Medicaid expansion)	Yes	MHPAEA also applies to Medicaid benchmark (a.k.a. alternative benefit plans) that will be offered by states that opt to extend Medicaid coverage to the low-income childless adult population as authorized by the PPACA
Other		
Plans offered through the health insurance exchanges	Yes	Pursuant to the Affordable Care Act
Federal Employees Health Benefits Plans (FEHBP)	Yes	While the MHPAEA statute does not apply to Federal Employees Health Benefits Program (FEHBP), the Office of Personnel Management has issued carrier letters directing such plans to comply with MHPAEA.
TRICARE/DOD plans	Yes	Fall 2016 DOD modifies the TRICARE regulations to reduce administrative barriers to access to MH/SUD coverage for TRICARE beneficiaries
Veterans Administration	No	
Student Health Plans	Maybe	The federal parity laws does not apply to student health plans for students operated by colleges or university. However, other student health plans might be covered. (need to check)
State or Local Employee Plan	Maybe	State law would need to require coverage
Church plans	Maybe	Because of their ERISA exemption, church plans are not affected by the MHPAEA's ERISA requirements. However, to the extent that an ERISA-exempt church purchases a product through a state health insurance exchange, or a state-regulated group insurance product governed by the PHS Act, the product would be subject to parity requirements, unless the church is otherwise exempt under state law.

ERISA-GOVERNED PLANS

ERISA-GOVERNED PLAN PARITY IS HARDER TO ENFORCE. **ERISA-governed plans are reviewed under a deferential “arbitrary and capricious” standard that makes it more difficult to enforce the MHPAEA.**²³ All other MHPAEA-covered plans are subject to the usual civil law “preponderance of the evidence” standard. **No federal plans, ERISA-governed plans or union plans are subject to state parity laws or regulation.**

Regulation

SCOPE OF SERVICE

FOCUS ON NQTLs

MHA CONCERN: REFORM OF MH/SUD TREATMENT

MHA CONCERN: REFORM IMPLEMENTATION OF MEDICAL NECESSITY CRITERIA

MHA CONCERN: AVOIDING EXPANSION OF CARE IN MORE RESTRICTIVE SETTING

SCOPE OF SERVICE

- The regulation clarified that enumeration of benefit classifications in the MHPAEA does not exclude coverage of intermediate levels of care (e.g., intensive outpatient treatment, partial hospitalization, and residential treatment). The regulation concedes that the six enumerated benefit types are broad categories, and within those categories, sub-categories and the intermediate services required must be covered in a comprehensive manner at parity with medical/surgical benefits. The remainder of this section of this position statement addresses additional regulatory refinements in the analysis of NQTLs.
- The regulation **rejected** the proposed exemption that plans could apply more stringent limits to MH/SUD treatment if a "**recognized clinically appropriate standard of care**" justified the difference.
- The regulation clarified that **unreasonably restricting geographic location, facility type, or provider specialty are limitations in scope of service and constitute an NQTL**, subject to parity.
- The regulation clarified that **provider reimbursement rates are NQTLs**, subject to parity. Plans can take into account various factors - service type, geographic market, supply of providers, licensure, etc. - when determining reimbursement, but the determining factors must be equivalent for medical/surgical and mental health and substance use services.
- Under the regulation, **multiple provider network tiers are permitted**, but tiered networks may not impose greater restrictions for mental health and substance use than for medical/surgical treatment.
- Similarly, under the regulation, **multi-tiered prescription drug programs are allowable** but must be equivalent for mental health and substance use medications and medical/surgical medications.
- **Deductibles:** Under the regulation, MH/SUD benefits and medical/surgical benefits have combined deductibles and combined financial restrictions and quantitative treatment limitations.
- **MH/SUD Treatment as a Non-Specialty:** Under the regulation, MH/SUD benefits are not a specialty, and are administered in parity with the medical/surgical non-specialty benefits offered by an insurance plan.
- **The ACA Mandates That Essential Medical Services Include Rehabilitation.** Evidence-based care for “severe and persistent mental illnesses” may require prolonged “treatment that consists of pharmacotherapy, supportive counseling and often rehabilitation services.”²⁴ The same is true of substance use disorder services.

- **Residential Care for Eating Disorders:** Studies thus far support the affordability of parity, and business support was and is premised on them.²⁵ But to the extent that parity drives residential treatment rather than outpatient, community-based care, parity may entail an unanticipated cost. The first court tests of parity laws have come in cases challenging denial of coverage for expensive residential care, and this line of cases risks the consensus that has carried the parity movement forward, as well as the 30-year old movement toward reducing in-patient care.

FOCUS ON NQTLS

A 2017 Milliman report demonstrated that despite the implementation of the MHPAEA, reimbursement rates for mental health and substance use disorder treatment providers, through private insurance plans, remain far lower than reimbursement rates for other medical providers, relative to Medicare rates.²⁶ The focus of the report was on the NQTLs that continue to impede access to treatment.²⁷ To the same effect, in 2013, HHS issued a report authored by Eric Goplerud of the University of Chicago, entitled “Consistency of Large Employer and Group Health Plan Benefits with Requirements of The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008,”²⁸ critiquing the early implementation of the ACA and the MHPAEA. The report found that most insurers had brought their plans into compliance with the quantitative and financial parity requirements of the MHPAEA and the regulation. However, the report pointed to continuing inequities in NQTLs. In fact, while settlements have often focused on quantitative treatment limitations and financial disparities, the reported litigation has dealt mainly with NQTL compliance. See “Litigation,” below.

MHA CONCERN: REFORM OF MH/SUD TREATMENT.

Drugs have become the dominant treatment for MH/SUD conditions, despite improvements in more specialized care that may better meet the needs of MH/SUD patients. Access to specialty mental healthcare services is constrained due to benefit design with substantial NQTLs -- higher co-pays, visit limits, and management of utilization. These additional financial limitations are not applied to psychotropic drug benefits or to many behavioral health interventions delivered in the general healthcare setting. This has created a perverse incentive for patients to (1) access mental healthcare from general healthcare providers (where there are no visit limitations and co-pays are significantly lower) and to (2) rely on psychotropic medication as an exclusive method of treatment. Thus, enforcement of NQTL parity is essential to reform of the MH/SUD system of care.

MHA CONCERN: AVOIDING EXPANSION OF CARE IN MORE RESTRICTIVE SETTINGS.

MHA and its affiliates and the MH/SUD advocacy community will need to monitor the regulatory implementation of the MHPAEA and the Affordable Care Act to ensure that expansion of MH/SUD coverage is used to promote access to evidence-based practices that are administered in the least restrictive settings (e.g., crisis services, ACT (assertive community treatment), supportive housing, home-based services, primary care, etc.). Litigation should be monitored as well, and amicus participation should be considered to avoid the unintended consequence of expanding hospital, residential, and traditional in-office services at the expense of less well-documented, more recovery-oriented services in the community. MHA, its affiliates, and other advocates should monitor the implementation and growth of MH/SUD services due to MHPAEA and the ACA to ensure that people in recovery have benefits that allow them to access clinically appropriate treatment in their communities in the least restrictive clinically appropriate settings. See discussion of the *Harlick* case under “Litigation,” below.

MHA CONCERN: REFORM IMPLEMENTATION OF MEDICAL NECESSITY CRITERIA.

The MHPAEA and the regulation require plans to release medical necessity criteria for MH/SUD treatment and mandate that if coverage of a service has been denied, the plan must release the reason for the denial. However, medical necessity criteria for both MH/SUD benefits and medical/surgical benefits remain vague and in some cases are still treated as guidelines and as proprietary information. Thus, it is difficult to determine if medical necessity criteria are being applied more stringently for MH/SUD treatment. **A 2015 NAMI poll showed that people seeking mental health treatment are twice as likely to be denied mental health care (29 percent) based on “medical necessity” than other medical care (14 percent).**²⁹³⁰

The regulation partially addresses this issue by requiring plans to provide documentation regarding processes, strategies, evidentiary standards, and any other factors used to determine medical necessity for both medical/surgical and MH/SUD benefits. But MHA continues to be concerned with the ability of people in treatment to obtain truly comparable medical necessity criteria for medical/surgical and MH/SUD benefits and to be able to understand their application in order to determine if an NQTL was imposed “more stringently” for MH/SUD than for “comparable” medical/surgical treatments. MHA National, MHA affiliates, and other stakeholders should watch this issue carefully, educate people seeking treatment about their rights to disclosure of medical necessity criteria and their application, and monitor and report plan practices.

Parity analysis depend on comparing medical necessity decisions.³¹ However, what is medically necessary for MH/SUD health care is often less cut and dried than what is medically necessary for general medical/surgical health care. Part of the problem is diagnostic uncertainty and the

difficulty of treating mental illnesses as MH/SUD symptoms shift. Multiple psychiatric diagnoses and other co-existing conditions complicate the determination of medical necessity in treating MH/SUD conditions. Recovery paths vary so much that only clinical observation can be used to guide treatment decisions. Ultimately, behavioral health clinicians should be accorded more respect by insurers, and reviewers should communicate with the treating clinician to reach a well-considered decision. See reviewers discussion, below.

Without clear standards, it is difficult to determine medical necessity on an individual level. Current general standards, such as AACAP (The American Academy of Child and Adolescent Psychiatry), ASAM (The American Society for Addiction Medicine) or CASII (The Child and Adolescent Service Intensity Instrument), have not met this need because they are complex, and carrier standards are often more lax and more vague, compromising access and consistency. To the extent that behavioral health standards are separate and distinct from general medical standards, as is usually the case, comparison is difficult.

The *Wit* Court (see discussion under “Litigation” and in Appendix I below) acknowledged that accreditation by organizations such as URAC and NCQA (independent non-governmental healthcare quality validators) does not entail substantive review of medical necessity criteria developed by insurers. Therefore, such accreditation does not guarantee use of medical necessity criteria that are evidence-based and consistent with generally accepted standards for behavioral healthcare or with the terms of insurance policies or parity laws. Current accreditation standards for utilization management functions are outdated and fail to verify the fidelity (including comprehensiveness) of internally and/or externally-developed review criteria. **It is time to move to the next level which are the criteria developed by AACAP, ASAM, CASII, and other specialty groups that are truly evidence-based.**

At a minimum, for any denial, insurance companies should be required to clearly cite the SPECIFIC criteria used to evaluate medical necessity in that case and detail how the individual person’s situation does not meet the cited test. If the standard is set by the carrier, its evidence-based origin must be disclosed and discussed. The regulation seeks but fails to do so because it does not require specific citation to the medical necessity standard at issue.³²

Litigation

[HARLICK V. BLUE SHIELD OF CALIFORNIA](#)

[REA V. BLUE SHIELD OF CALIFORNIA](#)

[JOSEPH F. V. SINCLAIR SERVICES COMPANY](#)

[PARITYTRACK LITIGATION INVENTORY](#)

[WIT AND ALEXANDER V. UNITED BEHAVIORAL HEALTH](#)

HARLICK V. BLUE SHIELD OF CALIFORNIA

- **The leading case of *Harlick v. Blue Shield of California*³³ required reimbursement for residential care for anorexia under California’s state mental health parity statute, holding that: “...we conclude that the [California] Mental Health Parity Act mandates that a plan within the scope of the Act provide all ‘medically necessary treatment’ for ‘severe mental illnesses,’ and that Harlick’s residential care ... was medically necessary.”** CNN summarized the decision in detail.³⁴ The decision is controversial because it cross-walks between particular behavioral and general health treatments.
 - The *Harlick* Court ruled that: “Some medically necessary treatments for severe mental illness have no analog in treatments for physical illnesses. For example, it makes no sense in a case such as Harlick’s to pay for 100 days in a skilled nursing facility, which the Court found to meet the medical necessity test — but which cannot effectively treat her anorexia nervosa — and not to pay for time in a residential treatment facility that specializes in treating eating disorders.”³⁵
 - The *Harlick* case illustrates the principle that **when closely analogous treatments exist, it is discriminatory and a clear violation of parity not to treat them analogously.** The statistical nightmare required to prove that MH/SUD NQTLs are not comparable to or more stringent than the vast universe of general medical/surgical treatment NQTLs quickly yields to the common-sense appeal of comparing treatment approved for analogous chronic and incurable general health conditions (like diabetes any many cancers and neurological conditions) with the ongoing treatment access required to avert disaster for people with MH/SUD disorders.
 - This discussion must be qualified by the aversion of many advocates to using residential care for MH/SUD conditions. Many fear that the MHPAEA can be used to return MH/SUD treatment to the era of the asylums. Reporting on the decision, the New York Times concluded that “The insurers consider residential treatments not only costly — sometimes reaching more than \$1,000 a day — but unproven and more akin to education than to medicine. Even some doctors who treat eating disorders concede there are few studies proving that residential care is effective, although they believe it has value.”³⁶
 - In response, Dr Anne E. Becker, president of the Academy of Eating Disorders and director of the eating disorders program at Massachusetts General Hospital, said that despite a paucity of studies, “There’s no question that residential treatment is life-saving for some patients.” MHA believes that a strong clinical justification is needed

before using an institutional setting for MH/SUD treatment but concedes that for people who need such treatment, residential care in the least restrictive clinically appropriate setting is entirely appropriate. Thus, it is mandated under the MHPAEA.

- Some insurers argue that there is no treatment for physical illnesses that is equivalent to residential treatment for mental illnesses, and therefore residential treatment does not have to be covered under parity laws. Ms. Harlick argued that residential treatment centers for eating disorders were equivalent to skilled nursing facilities, which Blue Shield did cover, and the Court found that in such circumstances it would violate the California Mental Health Parity Act to discriminate against eating disorders while providing coverage for medical/surgical conditions requiring skilled nursing facilities. The same analysis should prevail under the MHPAEA.
- Note that the Departments issuing the regulation (HHS and DOL) only found the cross-walking analysis not to be “feasible” in SOME cases, which it clearly is when no “comparable” treatment exists. They did not find it to be “inappropriate” or “inconsistent with the purpose of the MHPAEA.” So it will be important to demonstrate the appropriateness and feasibility of the cross-walking approach when it is persuasive, and defer to the regulation’s more nuanced approach when it is not.
- **Because it is much more comprehensible, more persuasive, and more easily “sold” to courts and the public, advocates will want to use cross-walking analysis whenever possible in arguing for parity for NQTLs.**

REA V. BLUE SHIELD OF CALIFORNIA

- **In *Rea v. Blue Shield of California*,**³⁷ the California Second Court of Appeals followed the principles of the *Havlick* case, ruling that the California Mental Health Parity Act “requires treatment of mental illnesses sufficient to reach the same quality of care afforded physical illness.” Finding that parity does not require identical matching of services between physical health services and mental health care, the Court of Appeals ruled that the Act “requires treatment of mental illnesses sufficient to reach the same quality of care afforded physical illnesses.” **The Court thus decided that the insurance company could not deny coverage for residential treatment for eating disorders, “even where the health plan does not provide coverage” for such treatment.**

JOSEPH F. V. SINCLAIR SERVICES COMPANY

- In the 2016 case of *Joseph F. v. Sinclair Services Company*,³⁸ the United States District Court for the District of Utah, following the *Harlick* and *Rea* cases, **extended the *Harlick* ruling to apply to the MHPAEA**. The court found that mental health residential treatment benefits were the equivalent of skilled nursing care benefits on the medical benefits side; as a result, the two had to be provided in parity with each other. Since this, like the *Rea* case, the *Joseph F.* case expanded the benefits under the plan, it is significant that the case extended the California precedents to the interpretation of the MHPAEA. Thus plan scope arguments may not be effective to limit coverage mandated by the MHPAEA.

PARITYTRACK LITIGATION INVENTORY

- ParityTrack has compiled an ongoing inventory of over 50 decided cases, which is an invaluable resource, since many are not reported.³⁹ Eating disorders and residential care are the most frequent cases in the inventory, but more complex issues will be decided as the case law proceeds.

WIT AND ALEXANDER V. UNITED BEHAVIORAL HEALTH

- An exciting nationwide-class action captioned *Wit and Alexander v. United Behavioral Health*⁴⁰ has been certified in the Northern District of California. The complaint was filed by Zuckerman Spaeder partners D. Brian Hufford, Jason Cowart, and Carlos Angulo, along with co-counsel Meiram Bendat from Psych-Appeal, Inc. The central claim is a challenge to United’s over-emphasis on responding to acute symptoms to the exclusion of chronic and persistent conditions. The suit alleges that United develops and applies medical necessity criteria that are “not comparable with” and “more stringent than” the generally accepted standards of care for outpatient, intensive outpatient, and residential treatment for mental illness and substance use disorders because they require the presence of acute symptoms, allowing United to deny coverage for treatment needed for individuals who are experiencing chronic and persistent mental illnesses and chronic substance use disorders.
 - **The Court** (Magistrate sitting as District Court Judge by agreement of the parties) **found that United’s Guidelines focused more on “acute” care and failed to address chronic, and co-occurring disorders requiring greater treatment intensity and/or duration:** “[I]n every version of the Guidelines in the class period, and at every level of care that is at issue in this case, there is an excessive emphasis on addressing acute symptoms and stabilizing crises while ignoring the effective treatment of members’ underlying conditions.” **Although not an official part of the Court’s holding, which was that United failed in its fiduciary duty under ERISA, United’s medical management practice created a parity violation by not covering “chronic”**

MH/SUD conditions while it did so for medical/surgical. In addition, the Court was particularly troubled by United’s lack of coverage criteria specific to children and adolescents. The remedy issues have not yet been reached. After they are, the appeal will be to the Ninth Circuit.

- It must be stressed that the *Wit* case did not adjudicate any legal claims associated directly with the MHPAEA. Instead, the Plaintiffs asserted that they were improperly denied benefits for MH/SUD treatment because United’s Guidelines do not comply with the standard of care for chronic conditions in that (1) they are “**more restrictive**” **than generally accepted standards of care** for both residential treatment and intensive outpatient treatment and (2) are “**infected**” **by financial incentives meant to restrict access to care**.
- At the heart of the case were United’s failure to use national evidence-based guidelines developed by nonprofit, clinical specialty organizations such as the American Society of Addiction Medicine (ASAM). Thus, Plaintiffs were harmed by being denied their right to fair adjudication of their claims for coverage based on Guidelines that were developed solely for United’s financial benefit. Based on the Court’s findings, the Guidelines were found to violate ERISA. By extension, the Guidelines could have been stricken under both the California Parity Act and the MHPAEA.⁴¹
- **Eight Generally Accepted Standards of Care** The *Wit* Court found the following to be the generally accepted standards for behavioral healthcare from which United’s Guidelines deviated:
 - *More than Symptom-Based* (Section 71). It is a generally accepted standard of care that effective treatment requires treatment of the individual’s underlying condition and is not limited to alleviation of the individual’s current symptoms.
 - *Co-Occurring Conditions* (Section 72). It is a generally accepted standard of care that effective treatment requires treatment of co-occurring behavioral health disorders and/or medical conditions in a coordinated manner that considers the interactions of the disorders and conditions and their implications for determining the appropriate level of care.
 - *Safe and Effective Threshold Requirements* (Section 73). It is a generally accepted standard of care that patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective – the fact that a lower level of care is less restrictive or intensive does not justify selecting that level if it is also expected to be less effective. Placement in a less restrictive environment is appropriate only if it is likely to be safe and *just as* effective as treatment at a higher level of care in addressing a patient’s overall condition, including underlying and co-occurring conditions.
 - *Erring on the Side of Caution* (Section 74). It is a generally accepted standard of care that when there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care.

- *Maintaining Function or Preventing Deterioration* (Section 75). It is a generally accepted standard of care that effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration.
- *No Default Time Limits* (Section 76). It is a generally accepted standard of care that the appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment.
- *Factoring in the Needs of Young Patients* (Sections 77-78). It is a generally accepted standard of care that the unique needs of children and adolescents must be considered when making level of care decisions involving their treatment for mental health or substance use disorders.
- *The Need for a Multidimensional Assessment* (Sections 79-81). It is a generally accepted standard of care that the determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made based on a multidimensional assessment that considers a wide variety of information about the patient.
- **Expectations of Improvement** (Section 86). In addition to the standard of care analysis, the Court pointed out a significant NQTL that United applies to MH/SUD treatment -- the likelihood is of recovery or long-term disability. This cost/benefit calculation is rarely applied to coverage determinations for medical/surgical treatment. Indeed, it would be unethical to ration such care for non-experimental medical/surgical treatments on that basis. Thus, the Court condemned United's "...requirement contained in all challenged versions of the Guidelines that in order to obtain coverage upon admission, there must be a reasonable expectation that the services will improve the member's 'presenting problems' within a reasonable period of time." Clearly this raises the potential of an implied parity violation because it is highly doubtful that UBH or any other health insurer applies the same requirement to most medical/surgical conditions when making coverage determinations.
- A more detailed analysis of the *Wit* case is attached as APPENDIX I to this position statement.

Implementation

Given the paucity of case law, it is essential to look at state settlements of parity cases and state implementing legislation to be able to understand the major improvements that have been mandated to achieve real parity. APPENDIX II gives a representative sample of the most important advances made by the states in defining and implementing parity. This includes the comprehensive 2019 Colorado Bill (awaiting the Governor's signature),⁴² the Connecticut experience with the Healthcare Advocate model adopted by Colorado in 2018, and the five New York settlements that direct parity compliance for New York carriers. But the Appendix is incomplete. In particular,

more and more states are adopting statutes to compel use of nationwide, evidence-based standards of care such as those discussed in this position statement, or enforcing them through regulatory processes. For a comprehensive analysis of state actions to legislate and regulate and to pursue consent decrees and settlements as health insurers come into compliance with the MHPAEA, see the current ParityTrack state-by-state summary,⁴³ from which the Appendix is derived. The ParityTrack state-by-state compilation of parity enforcement initiatives is an invaluable resource for affiliates and other advocates to use in formulating and advocating for state parity legislation and regulation.

The Twenty-First Century Cures Act

The Twenty-First Century Cures Act, HR 6 (12/13/16), the only Congressional action since the MHPAEA and the ACA, requires, as part of a mandated Two-Year Plan, analysis of: examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered MH/SUD benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment. Note the cross-walk inherent in this comparison.

Reviewer Advice

The Kennedy Forum is drafting a white paper looking at the different types of review guidelines (e.g., internal, commercial agencies like MCG/InterQual (formerly Milliman), and specialty provider groups like ASAM). The white paper will be cited in future versions of this position statement. In preparing this position statement, five reviewers were interviewed to get an admittedly non-representative sample of how the process works. All of the interviewees practice in Colorado, where carriers may permit more deviance from internal Guidelines than other states, which is not typical in larger states. The interviewed reviewers consider the medical necessity guidelines NOT to be binding, consider their role to be rendering a second opinion on the diagnosis and the prescribed treatment, and believe that they would give the same review decision in the same factual situation to different carriers with different guidelines. Thus, at least for those reviews that are *de facto de novo* (allowing reviewer discretion), the review decision is best understood as an independent diagnosis and treatment plan, based on the facts in the chart and the reviewer's professional judgment, generally without talking to the patient or the treating clinician.

One reviewer of this position statement estimated that she is twice as likely to authorize residential care if she is able to consult fully with the treating clinician. There are three reasons for this:

- Greater grasp of the facts that led to the treatment being recommended,

- Greater understanding of the treating clinician’s reasoning process, and
- Greater deference to the treating clinician after a relationship of trust is established.

Another reviewer advocated in-person consultation with the prescribing clinician because:

- She gave several examples of cases in which she was able to understand and support the doctor’s plan from a phone conversation despite lack of documentation in the chart.
- She also gave an example of a case in which the treating doctor had not considered an alternate to the treatment which had been denied, but readily agreed that the alternative that the reviewer suggested was preferable to the service which had been disallowed.
- She said that a phone conversation also saves her time in getting to a clear understanding of what she should write as the basis for an affirmation or reversal.
- **Thus, a transparent dialogue between the treating and the reviewing clinician should be required for all coverage disputes**, to maximize the potential for a mediated solution prior to an adversary procedure, such as arbitration or litigation.

Call to Action

- MHA continues to support the principles of MHPAEA and the ACA and the implementation of the regulation at the federal level and also suggests vigorous enforcement of real parity at both the federal and the state level, through its affiliate network and through the development of consumer advocacy organizations such as established by Connecticut and several other states.
- **MHA advocates that Congress:**
 - **Appropriate funds to allow for randomized compliance audits, rather than just responding to complaints**
 - **Subject Medicare to parity**
 - **Eliminate Medicare’s arbitrary 190-day lifetime limit on inpatient psychiatric hospital care—a restriction that does not exist for any other inpatient Medicare service.**
 - **Authorize the DOL to collect civil monetary penalties for parity violations**
 - **Subject non-ERISA plans to the same disclosure requirements as ERISA plans**
 - **Eliminate the HIPAA provision allowing self-insured state and local governments to opt out of parity requirements**
 - **Subject ERISA and fee-for-service Medicaid plans to the same standard of proof as any other health insurance plan.**

- **For additional federal legislative priorities, see the Kennedy Forum's https://chpwpuploads.s3.amazonaws.com/www.thekennedyforum.org/uploads/2017/06/The_New_Frontier_CongressGuide.pdf**
- **MHA advocates that Congress examine parity in CMS payments** to Medicare Advantage plans, Medicaid Managed Care Organizations, Accountable Care Organizations, and other alternative payment models. The payment formula for these programs are based on historic payment data, which are not parity compliant. By paying based on parity non-compliant data, CMS propagates historic discrimination and advances systemic disincentives to address mental health and substance use. CMS should adjust payment formulae based on what expected payments would be for the population if parity were effectively implemented.
- MHA advocates that CMS use the available quality measures as a secondary indicators of parity implementation, determining whether health care systems are performing worse in treating MH/SUD than in medical and surgical care, and determining whether disparities in performance relate to possible parity violations.
- MHA is concerned about potential expansion of residential services using parity as a lever, and continues to support community-based care and cost containment. All advocates should ensure that individual cases be decided based on particularized findings of medical necessity.
- HHS and DOL, MHA, its affiliates, and other advocates should monitor the enforcement of parity cases and settlements to determine if a systemic problem of over-institutionalization is developing that should to be addressed with further guidance or plan enforcement.
- MHA, its affiliates, and other advocates should also monitor the compliance of plans and educate consumers and providers with regard to scope of service, NQTLs, and medical necessity criteria to ensure proper implementation of the MHPAEA.
- **More transparency must be provided in the deliberation, drafting and publication of MHPAEA decisions. At a minimum, as stated in the position statement, MHA believes that it is essential that health plans disclose the clinical and/or coverage criteria used in the decision** and clearly explain the specific steps required to file an appeal.
- Regulators should strictly enforce the MHPAEA's requirement that denial letters include a detailed explanation of why the patient does not meet the plan's clinical criteria, a description of the evidence reviewed by the plan, and why the evidence submitted by the patient or their provider was deemed insufficient.
- **Transparent medical necessity decisions require:**

- **Complete transparency of medical necessity criteria, ideally on the internet;**
 - **Support by peer-reviewed scientific studies and recognized clinical standards;**
 - **Specific citations and explanations showing that the criteria are not met in case of any denial of coverage;**
 - **Plans that fully explain the “processes, strategies, evidentiary standards, or other factors” they use to both design and apply the medical necessity criteria both as written and in operation.**
- In some instances, ordering or attending providers are not allowed to file an appeal on behalf of their patients. This is counterintuitive and inefficient as the provider is often in the best position to understand the denial decision and then explain why the service or treatment is still recommended or why the care was already delivered. All limitations on the filing of appeals should be abolished.
 - A national and consistent standard should be implemented to make the appeals process more effective. At present, many different appeal pathways exist. These pathways vary based on how the health plan is regulated, the type of coverage provided, the type of plan sponsor, the jurisdiction, the type of denial (e.g., based upon a medical necessity or benefit determination), the timing of the denial (e.g., prospective, concurrent and retrospective), the urgency of the care being requested (i.e. standard care versus urgent care), and where the patient is in the appeals process. **The goal should be to establish one national appeals standard that promotes transparency, fairness and due process to all parties involved.** A unified system can be promoted through new model legislation, accreditation standards and Requests for Proposal (RFP) requirements.
 - Currently, people appealing an adverse coverage decision, or their authorized representatives, must specifically request an external review of their claim. In most cases, the external review appeal only can be pursued after the person first successfully completes an appeal through the health insurer in accordance with the health plan. In some instances, the aggrieved party may not even know that she or he has the right to appeal to an external party. One simple way to address this confusion is to automatically refer the appeal to an independent review organization after the internal appeal is completed or, better yet, make the internal and external appeals concurrent.
 - **All Stakeholders Should File More Appeals, and MHA affiliates should help whenever possible. While working to lower the number of denials issued on claims, stakeholders should simultaneously work to ensure that every questionable denial is subjected to the appeals process so that enrollees receive the care to which they are entitled.**
 - **The creation of a transparent dialogue between the treating and the reviewing physician should be required for all coverage disputes,** to maximize the potential for a mediated solution prior to an adversary procedure, such as arbitration or litigation.
 - Since the regulation assigns to states the initial/primary obligation to enforce the federal parity laws and because some states have stronger parity laws than the federal law, affiliates

and other advocates should focus their efforts on advocating that state insurance departments and other state actors vigorously enforce both state and federal parity, and that they are adequately funded to do so.

- Specifically, and in accordance with MHA Position Statement 32,⁴⁴ affiliates should advocate strongly to minimize the use of “fail-first” or “step therapy” policies to restrict needed access to medications. A fail-first policy can only mitigate serious potential harms only if it:
 - Takes into account the history of the illness and past treatments
 - Exempts anyone who is already being successfully treated with another treatment, even if insurance coverage has changed;
 - Provides a quick and easily accessible mechanism through which a clinician can establish a clinical basis for using another treatment without trying and failing with a cheaper one; and
 - Establishes policies, standards and practices which minimize the nature and duration of any failure.
 - Takes into account the financial realities of the clinician and the person in treatment.
- States should ban all health insurer limits on coverage of long term residential, in-patient and intensive outpatient care except for limits based on an individual determination of medical necessity.
- By statute, effective in 2015, Massachusetts has required mandatory coverage of inpatient and residential treatment for substance use conditions. Health insurance carriers are prohibited from requiring prior authorization for most SUD services. Facilities are required to notify the patient’s health insurer and provide an initial treatment plan to the insurer within 48 hours of accepting the patient. Health insurers may begin to conduct utilization review on day 7 of the stay. Affiliates and other advocates should advocate for similar legislation in every state.
- Arbitrary de facto 30-day limits on residential MH/SUD treatment cannot be justified. A medical necessity determination that assesses treatment progress is the only acceptable way of limiting coverage. Affiliates and other advocates should be vigilant in insisting on individual determinations of coverage and on transparency in the decision-making process.
- States should ban inflexible outpatient visit limits and preauthorization requirements. The acute danger of psychosis and suicide, for which the general medical/surgical parity comparison would be catastrophic risk, require that any cost containment process not impede immediate access to evidence-based “urgent care.”
- States should enforce current deadlines that limit access to urgent care and should require concurrent appeals and an after-hours grievance system
 - A functioning after-hours grievance system is essential

- California continues to require a 24-hour-a-day urgent grievance system and has sanctioned companies for failing to provide these services.
 - The ACA regulations were amended in 2011 to change a 24-hour turnaround deadline to 72 hours, but emphasize that turnaround must be “as soon as possible.”
 - Although the ACA regulations require an expedited appeal for “urgent care,” concurrent review would better accomplish the purpose, especially for residential and inpatient services, where the review appears to be futile in about 70-80 % of the cases.
- Affiliates should analyze differential reimbursement rates for behavioral health and medical and surgical office visits and per diem charges and urge equal reimbursement. Reimbursement rates are directly addressed by the MHPAEA regulation, and low reimbursement for behavioral health services is a critical factor in the documented difficulty that people in need of treatment experience in getting access to effective behavioral health treatment.

Effective Period

The Mental Health America Board of Directors approved this policy on June 13, 2019. It is reviewed as required by the Mental Health America Public Policy Committee.

Expiration: December 31, 2024

¹ *Mental Health: A Report of the Surgeon General* (1999) at 23.

² “Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited,” United States General Accounting Office, May 2000, at 21.

³ *Id.* at 13-14.

⁴ Remarks by the President on Mental Health, April 29, 2002; Hackett, J.T., CEO of Ocean Energy Inc., testimony before the Subcommittee on Health of the Energy and Commerce Committee, House of Representatives, July 23, 2002.

⁵ “An Employer’s Guide to Behavioral Health Services,” National Business Group on Health, 2005, <https://www.businessgrouphealth.org/pub/?id=f3139c4c-2354-d714-512d-355c09ddcbc4> at 68.

⁶ The Employer Retirement Income Security Act of 1974 (ERISA) allows employers to offer uniform national health benefits by preempting states from regulating employer-sponsored benefit plans. Thus, while states can regulate health insurers, they are unable to regulate employee benefit plans established by employers.

⁷ A law that requires health plans to provide parity only for those with a severe mental illness or those with a “biologically-based mental illness,” for example, implicitly conveys the message that it is acceptable to discriminate against those with other mental and substance use disorders, and suggests that such disorders do not merit the law’s protection. Such limited parity protection discourages early intervention and leaves children at particular risk, since the few illnesses covered under such laws seldom can be diagnosed until late adolescence or early adulthood. Mental Health America does, nevertheless, recognize that enactment and

implementation of such laws have enabled advocates in some states to build on an incremental gain and later win passage of comprehensive legislation.

⁸ Public Law 110-343, https://www.cms.gov/ccio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html

⁹ An Employer’s Guide to Behavioral Health Services,” National Business Group on Health, <https://www.businessgrouphealth.org/pub/?id=f3139c4c-2354-d714-512d-355c09ddcbc4>

¹⁰ Trautman, S., Rehm, J, & Wittchen, H-U, “The Economic Costs of Mental Disorders: Do Our Societies React Appropriately to the Burden of Mental Disorders?” *EMBO Rep.* 2016 Sep; 17(9): 1245–1249. Published online 2016 Aug 4. doi: [10.15252/embr.201642951](https://doi.org/10.15252/embr.201642951) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC507565/>

¹¹ The regulation must be read *in pari materia* (with equal force) with the MHPAEA and the requirements of the 2010 Affordable Care Act (“ACA”) and its implementing regulations.

¹² Stacey A. Tovino, “All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law,” 49 *Harv. J. on Legis.* 1, 42 (2012), at 40-42 (“[M]any health insurance plans that were previously exempt from [providing mental health benefits at parity] are now are prohibited from offering inferior mental health insurance benefits.”).

¹³ 26 CFR 54.9812-1(c)(4)(ii); 29 CFR 2590.712(c)(4)(ii); 45 CFR 146.136(c)(4)(ii); and 147.160.

¹⁴ All insurance plans administered after July 1, 2014 must comply with the Final Regulation implementing the MHPAEA and the comparable regulation applying the MHPAEA to self-insured employers under ERISA (collectively, the “regulation”).¹⁴ The regulation must be read *in pari materia* (with equal force) with the MHPAEA and the requirements of the 2010 Affordable Care Act (“ACA”) and its implementing regulations.¹⁴ The MHPAEA originally applied to group health plans and group health insurance coverage, was amended by the Affordable Care Act (ACA) to also apply to individual health insurance coverage. The HHS has jurisdiction over public sector group health plans (referred to as “non-federal governmental plans”), while the Departments of Labor and the Treasury have jurisdiction over private group health plans. Significantly, it is the ACA that mandates MH/SUD coverage as an “essential benefit.” The MHPAEA merely requires that, to the extent provided, MH/SUD coverage must be provided at parity with medical/surgical coverage. This would become a salient issue if the APA were to be overturned, repealed or amended.

¹⁵ <https://www.federalregister.gov/d/2013-27086/p-426>
<https://www.federalregister.gov/documents/2013/11/13/2013-27086/final-rules-under-the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act#p-426>

¹⁶ *Id.*

¹⁷ <https://www.federalregister.gov/d/2013-27086/p-426>
<https://www.federalregister.gov/documents/2013/11/13/2013-27086/final-rules-under-the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act#p-426> § B. Clarifications—Parity Requirements 1. CLASSIFICATION OF BENEFITS

¹⁸ <https://www.chqi.com/programs-and-services/parity-accreditation/>

¹⁹ *Id.*

²⁰ <https://www.paritytrack.org/resources/model-resources/six-step-parity-compliance-guide/>

²¹ **Examples of factors for medical management and utilization**

Examples of factors for provider network adequacy

Examples of sources for provider network adequacy factors

Examples of factors for provider reimbursement

Examples of sources for provider reimbursement factors

- **Examples of evidentiary standards**, their sources, and other evidence considered include:
 - Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
 - Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.

-
- **Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.**
 - Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay.
 - Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode.
 - More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record
 - Review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care)
 - Two published RCTs required to establish a treatment or service is not experimental or investigational.
 - Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
 - State regulatory standards for health plan network adequacy.
 - Health plan accreditation standards for quality assurance.
 - **Examples of comparative analyses include:**
 - Results from analyses of the health plan’s paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
 - Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) of parity compliance.
 - **Comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written.**
 - A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had “high cost variability” (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
 - **A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.**
 - **Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.**
 - Internal review to determine that the issuer or health plan’s panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such **experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.**
 - Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.
 - Identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency.
 - **Illustrative Analyses are provided, applying the Six Steps analytical framework (emphasis added)**

²² <https://www.paritytrack.org/>

²³ Comment, “The Arbitrary and Capricious Standard under ERISA: Its Origins and Application,” 23 Duq. L. Rev. 1033 (1984-1985).

²⁴ Federal Register, Vol. 75, No. 21 Feb. 2, 2010, at 5422.

²⁵ <http://www.nytimes.com/roomfordebate/2011/10/14/should-insurers-pay-for-eating-disorders/parity-wont-break-the-bank?scp=3&sq=mental%20health%20parity&st=cse>.

²⁶ <http://www.milliman.com/NOTLDisparityAnalysis/>

²⁷ The introduction says it all: “As state and federal regulators increase their focus on the enforcement of mental health and addiction parity laws, non-quantitative treatment limitations have emerged as a key trouble area for some health plans. This report provides a quantitative approach to investigating non-quantitative treatment limitations. It focuses on two quantitative analyses: (1) out-of-network utilization rates for inpatient and outpatient facility services as well as professional office visits and (2) reimbursement rates for office visits for in-network healthcare providers. The report includes appendices that provide detailed results for each state, including sample sizes, for 2013 to 2015.”

²⁸ <https://docplayer.net/13429733-U-s-department-of-health-and-human-services-assistant-secretary-for-planning-and-evaluation-office-of-disability-aging-and-long-term-care-policy.html>

²⁹ National Alliance on Mental Illness, *A Long Road Ahead* (2015), <http://www.nami.org/parityreport>

³⁰ Under the ACA, new individual and small group plans in and outside of mandated health insurance exchanges are required to offer MH/SUD coverage at parity. Self-insured employer plans and large group plans can exclude such benefits, but, thus far, that has not happened, probably because large employers, most of which supported passage of the MHPAEA, recognize the business benefits of getting care to deal with workplace risks and problems.

³¹ A denial of care based on medical necessity is processed through a UM Appeal, and an adverse benefit determination based on scope of coverage is often processed through a grievance procedure.

³² This type of disclosure requirement has been on the books in most states for 25 years through their respective UM statutes, and regulators are not enforcing the law. If they can’t enforce this requirement, how can we expect regulators to enforce the disclosure requirements for a comparability analysis which is much more complicated?

³³ 686 F.3d 699 (9th Cir. 2012), <https://caselaw.findlaw.com/us-9th-circuit/1602377.html>

³⁴ <https://www.cnn.com/2019/03/06/health/unitedhealthcare-ruling-mental-health-treatment/index.html>

³⁵ 686 F.3d at 716

³⁶ <http://www.nytimes.com/2011/10/14/business/ruling-offers-hope-to-eating-disorder-sufferers.html>.

³⁷ 226 Cal.App.4th 1209, 172 Cal.Rptr.3d 823 (2014),

https://scholar.google.com/scholar_case?case=10077160895261409935&hl=en&as_sdt=6&as_vis=1&oi=scholar

³⁸ __ F. Supp. 3d __, 2016 WL 309787 (D. Utah Jan. 25, 2016), https://ecf.utd.uscourts.gov/cgi-bin/show_public_doc?214cv0505-37

³⁹ <https://www.paritytrack.org/resources/legal-cases/>

⁴⁰ 2014 WL _____, <https://www.leagle.com/decision/infdco20170817612>

⁴¹ See CNN summary at <https://www.cnn.com/2019/03/06/health/unitedhealthcare-ruling-mental-health-treatment/index.html> “In a scathing decision, a federal judge blasted a subsidiary of the nation’s largest insurance company for focusing on the ‘bottom line as much or more’ than patients’ health, saying the insurer illegally denied treatment to thousands of people. The judge also slammed the company’s medical directors for being ‘deceptive’ under oath.”

⁴² file:///C:/Users/jinder/Downloads/2019a_1269_rer.pdf

⁴³ <https://www.paritytrack.org/mhpaea-10th-anniversary/>

⁴⁴ <http://www.mentalhealthamerica.net/positions/access-medications>

WIT V. UNITED BEHAVIORAL HEALTH SUMMARY

As analyzed by the national law firm of Dickinson Wright,⁴⁴ in a summary authored by Russell Kolsrud and Erica Erman, the *Wit* case represents a potential broadening of the MHPAEA standards. Significantly, the decision does not use the statistical analysis mandated by the MHPAEA and the regulation, and focusses instead on the failure of UBH to implement acknowledged behavioral health standards of care. This summary is included because the *Wit* decision is 27 pages long, but the full text can be found at endnote 40.

This analysis is included with the permission of the authors.

“The plaintiffs in *Wit* asserted two claims against UBH: (1) breach of fiduciary duty (the ‘Breach of Fiduciary Duty Claim’), and (2) arbitrary and capricious denial of benefits (the ‘Denial of Benefits Claim’) based on a facial challenge to UBH’s Level of Care Guidelines and Coverage Determination Guidelines (collectively, ‘Guidelines’). Both claims arose under ERISA. Plaintiffs argued that these Guidelines did not comport with generally accepted behavioral health standards of care and thus, wrongfully denied coverage to many patients, including both adults and children.

According to Plaintiffs, UBH breached the duties it owed as an ERISA fiduciary to the class members by (1) developing guidelines for making coverage determinations that are far more restrictive than those that are generally accepted even though Plaintiffs’ health insurance plans provide for coverage of treatment that is consistent with generally accepted standards of care; and (2) prioritizing cost savings over members’ interests. As to the second claim, Plaintiffs allege that the Denial of Benefits Claim is based on the theory that UBH improperly adjudicated and denied Plaintiffs’ request for coverage by using its overly restrictive Guidelines to deny benefits.

The court agreed, and found that **the Guidelines were fundamentally flawed by being “tainted” via significant involvement by the Financial Department in their development and the Guidelines’ unwavering and inflexible language.**

The court explained that the preponderance of the evidence showed that the only reason UBH declined to adopt criteria following the generally accepted standards of care, despite a clear consensus among UBH’s addiction specialists that those generally accepted standards of care criteria were preferable to UBH’s own Guidelines, was that its Finance Department wouldn’t sign off on the change. ‘The Court finds that the financial incentives...have, in fact, infected the Guideline development process.’ ‘In other words, UBH’s Finance Department had veto power with respect to the Guidelines and used it to prohibit even a change in the Guidelines that all of its clinicians had recommended.’

Regarding the Guidelines' inflexibility to follow generally accepted standards of care, although every class member's health benefit plan includes, as one condition of coverage, a requirement that the requested treatment must be consistent with generally accepted standards of care, the court found that there was no evidence in the record that the much more restrictive words in the Guidelines could be ignored when they are in conflict with generally accepted standards of care.

What are the generally accepted standards of care in the field of mental health and substance use disorder treatment and placement, and how do the UBH Guidelines breach these standards?

1. It is a generally accepted standard of care that effective treatment requires treatment of the individual's underlying condition and is not limited to alleviation of the individual's current symptoms. The court elaborated, "While current symptoms are typically related to a patient's chronic condition, it is generally accepted in the behavioral health community that **effective treatment of individuals with mental health or substance use disorders is not limited to the alleviation of the current symptoms. Rather, effective treatment requires treatment of the chronic underlying condition as well.**

Regarding UBH's Guidelines, the Court reasoned, 'Although the Guidelines contain statements of principle that are consistent with generally accepted standards of care, they are **not incorporated** into the specific Guidelines that establish rules for making coverage determinations.'

2. It is a generally accepted standard of care that **effective treatment requires treatment of co-occurring behavioral health disorders and/or medical conditions in a coordinated manner that considers the interactions of the disorders and conditions and their implications for determining the appropriate level of care.**

The court elaborated, 'Co-occurring disorders can interact in a "reciprocal way" that makes each of them 'worse.' **Because co-occurring disorders can aggravate each other, treating any of them effectively requires a comprehensive, coordinated approach to all conditions.**

Regarding UBH's Guidelines, the Court reasoned that the Guidelines deviate from this by focusing on the 'current' condition.

3. It is a generally accepted standard of care that patients should receive treatment for mental health and substance use disorders at the **least intensive and restrictive level of care that is safe and effective.**

The court elaborated, ‘The evidence at trial did not support the conclusion that under generally accepted standards of care, there is a balancing of effectiveness against the restrictiveness or intensity factor; in other words, **the fact that a lower level of care is less restrictive or intensive does not justify selecting that level if it is also expected to be less effective. Placement in a less restrictive environment is appropriate only if it is likely to be safe and just as effective as treatment at a higher level of care in addressing a patient’s overall condition, including underlying and co-occurring conditions.**’

Regarding UBH’s Guidelines, the Court reasoned that the Guidelines do not adhere to these principles. Instead they actively seek to move patients to the least restrictive level of care at which they can be safely treated, even if a lower level of care may be less effective for that patient.

4. It is a generally accepted standard of care that when there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care.

The court elaborated, ‘Research has demonstrated that patients with mental health and substance use disorders who receive treatment at a lower level of care than is clinically appropriate face worse outcomes than those who are treated at the appropriate level of care....On the other hand, there is no research that establishes that placement at a higher level of care than is appropriate results in an increase in adverse outcomes.’

Regarding UBH’s Guidelines, the Court reasoned, “**Not only do the Guidelines in all relevant years contain provisions that improperly instruct clinicians to consider only safety and not effectiveness in deciding whether to move a patient to a lower level of care; they also deviate from generally accepted standards of care by using language that strongly conveys to clinicians that they should err on the side of moving members to lower levels of care even when there is uncertainty about whether such a move is safe.** For example, the 2011 Guidelines use the terms ‘clear and compelling evidence’ that patients should be kept at a higher level rather than a safe, but less effective lower level of treatment.’

5. It is a generally accepted standard of care that effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration.

Regarding UBH's Guidelines, the Court reasoned, 'UBH Guidelines deviate from that standard by requiring a finding that services are expected to cause a patient to 'improve' within a 'reasonable time' and further restricting the concept of 'improvement' to 'reduction or control of the acute symptoms that necessitated treatment in a level of care.'

6. It is a generally accepted standard of care that the appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient; **there is no specific limit on the duration of such treatment.**

The court reasoned that to follow the generally accepted standard of care, there should be attempts to motivate a patient to participate in treatment before treatment at that level of care is discontinued, and sometimes effective treatment will require the patient to move to a higher level of care in the fact of such a lack of motivation.

The court found that '[b]eginning in 2014, UBH's common Discharge Criteria clearly violated the standards set forth above by providing that the 'continued stay criteria are no longer met' when the 'member is unwilling or unable to participate in treatment and involuntary treatment or guardianship is not being pursued.'

However, the Guidelines for 2011, for example, did not make lack of motivation an automatic reason for discontinuation of coverage at a given level of care, and leave room for coverage at a given level of care even where the patient is not actively participating in treatment for an 'initial period of stabilization and/or motivational support.' Thus, the court found 'these requirements are not inconsistent with the generally accepted standards of care discussed above.'

7. **It is a generally accepted standard of care that the unique needs of children and adolescents must be taken into account when making level of care decisions involving their treatment for mental health or substance use disorders.**

The court reasoned that it is necessary to apply a more lenient standard to children and adolescents since they are not fully developed psychologically. 'As a corollary of these more lenient standards, children and adolescents are likely to need longer duration of treatment than adults.'

Regarding UBH's Guidelines, the Court reasoned, **'One of the most troubling aspects of UBH's Guidelines is their failure to address in any meaningful way the different standards that apply to children and adolescents with respect to the treatment of mental health and substance use disorders.** Throughout the Class Period, UBH failed to adopt separate level-of-care criteria tailored to the unique needs of children and

adolescents. Nor do the Guidelines instruct decision-makers to apply the criteria contained in the Guidelines differently when the member is a child or adolescent....Generally accepted standards of care do not require that UBH create an entirely separate set of guidelines to address the needs of children and adolescents. They do, however, require that UBH's Guidelines instruct decision-makers to apply different standards when making coverage decisions involving children and adolescents, where applicable, including relaxing the criteria for admission and continued stay to take into account their stage of development and the slower pace at which children and adolescents generally respond to treatment. UBH has failed to meet this requirement for all relevant years.'

8. It is a generally accepted standard of care that the determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made on the basis of a **multidimensional assessment** that takes into account a wide variety of information about the patient.

On whether UBH Guidelines are consistent with generally accepted standards of care, the court stated: "Having reviewed all of the versions of the Guidelines that Plaintiffs challenge in this case and considered the testimony of the witnesses addressing the meaning of the Guidelines, the Court finds, by a preponderance of the evidence, that in every version of the Guidelines in the class period, and **at every level of care that is at issue in this case, there is an excessive emphasis on addressing acute symptoms and stabilizing crises while ignoring the effective treatment of members' underlying conditions.**"

The court continued, 'These requirements are not consistent with generally accepted standards of care because they are overly focused on treatment of acute symptoms. In particular, under these provisions a member is denied coverage – even if the other criteria are met – if the reason the patient requires the prescribed level of care and 'cannot' be treated in a lower level of care is anything other than 'acute changes in the member's signs and symptoms and/or psychological and environmental factors.' But as discussed above, neither 'acute symptoms' nor 'acute changes' should be a mandatory prerequisite for coverage of outpatient, intensive outpatient or residential treatment.'

Additional highlights from the decision:

- "Mitigating" the impact of the 2008 Parity Act: **The court found that "the record is replete with evidence that UBH's Guidelines were viewed as an important tool for meeting utilization management targets, 'mitigating' the impact of the 2008 Parity Act, and keeping 'benex' (benefit expenses) down."** The Parity Act, simplified,

mandates that behavioral healthcare and physical healthcare be treated equally. Thus, UBH's Guidelines' objective to help UBH minimize their behavioral health costs was illegal.

- Financial self-interest was a 'critical consideration:' As briefly discussed above, the court found that UBH's Financial and Affordability Departments play 'key roles in the Guideline development process.' As the court states, "The Court finds that the financial incentives discussed above have, in fact, infected the Guideline development process. In particular, instead of insulating its Guideline developers from these financial pressures, UBH has placed representatives of its Finance and Affordability Departments in key roles in the Guidelines development process throughout the class period.'

For example, UBH's decision making with respect to coverage of Transcranial Magnetic Stimulation ("TMS"), a treatment for major depressive disorder, was influenced by a commissioned internal study of the 'financial impact' of covering TMS claims where medically necessary and the 'return on investment' if it revised the Guidelines to cover TMS treatment in accordance with national standards. As another example, although the Utilization Management Committee had approved a Guideline broadening coverage of Applied Behavioral Analysis ("ABA"), a treatment for autism spectrum disorder, UBH's CEO overruled the recommendation, cautioning UBH staff, '[w]e need to be more mindful of the business implications of guideline change recommendations.'" (emphasis supplied)

APPENDIX II gives a representative sample of the most important advances made by the states in defining and implementing parity.

COLORADO ENFORCEMENT

In 2018, Colorado replicated the Connecticut initiative, setting up an office to help claimants pursue parity claims. The 2019 bill to reinforce parity was much more ambitious:

A 2019 Bill enacts the "Behavioral Health Care Coverage Modernization Act" to address issues related to coverage of behavioral, mental health, and substance use disorder services under private health insurance and the state medical assistance program (Medicaid).

The Bill

- Specifies that mandatory insurance coverage for behavioral, mental health, and substance use disorders includes coverage for the prevention of, screening for, and treatment of those disorders and must comply with the federal "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008" (MHPAEA)
- **Requires coverage for services for behavioral, mental health, and substance use disorders to continue while a claim for the coverage is under review until the carrier notifies the covered person of the claim determination**
- **Requires carriers to comply with treatment limitation requirements specified in federal regulations and precludes carriers from applying treatment limitations to behavioral, mental health, and substance use disorder services that do not apply to medical and surgical benefits**
- **Requires carriers to provide an adequate network of providers that are able to provide behavioral, mental health, and substance use disorder services and to establish procedures to authorize treatment by nonparticipating providers when a participating provider is not available under network adequacy requirements**
- Modifies the definition of "behavioral, mental health, and substance use disorder" to include diagnostic categories listed in the mental disorders section of the International Statistical Classification of Diseases and Related Health Problems, the Diagnostic and Statistical Manual of Mental Disorders, or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood
- **Updates the required coverage related to alcohol use and behavioral health screenings to reflect the current requirements of that coverage as specified in recommendations of the United States preventive services task force**
- **Requires the commissioner of insurance (commissioner) to disallow a carrier's requested rate increase for failure to demonstrate compliance with the MHPAEA**
- For purposes of denials of requests for reimbursement for behavioral, mental health, or substance use disorder services, requires carriers to include specified information about the protections included in the MHPAEA, how to contact the division of insurance or the office of the ombudsman for behavioral health access to care (office) related to possible violations of the MHPAEA, and **the right to request medical necessity criteria**
- For health benefit plans issued or renewed on or after January 1, 2020, requires carriers that provide coverage for an annual physical examination as a preventive health care

service to also cover an annual mental wellness checkup to the same extent the physical examination is covered

- Requires carriers to submit an annual parity report to the commissioner
- Starting January 1, 2020, **requires carriers that provide prescription drug benefits for the treatment of substance use disorders to provide coverage of any FDA-approved prescription medication for treating substance use disorders without prior authorization or step therapy requirements** and to place all covered substance use disorder prescription medications on the lowest tier of the drug formulary, and precludes those carriers from excluding coverage for those medications and related services solely on the grounds that they were court ordered

With regard to Medicaid, the Bill:

- **Requires the department of health care policy and financing (department) to ensure that Medicaid covers behavioral, mental health, and substance use disorder services to the extent that Medicaid covers a physical illness and complies with the MHPAEA**
- **Requires the statewide system of community behavioral health care in the managed care system to require managed care entities (MCEs) to provide an adequate network of providers of behavioral, mental health, and substance use disorder services and to prohibit MCEs from denying payment for medically necessary and covered treatment for a covered behavioral health disorder diagnosis or a covered substance use disorder on the basis that the covered diagnosis is not primary**
- **Requires the department to make MCE annual network adequacy plans public and to examine complaints from the office regarding compliance with the requirements of the bill or the MHPAEA**
- Requires MCEs to include specified statements regarding the applicability of the MHPAEA to the managed care system in Medicaid and how to contact the office regarding possible violations of the MHPAEA
- **Requires MCEs to submit specified data to the department regarding behavioral health services utilization by groups that experience health disparities, denial rates for behavioral health services requiring prior authorization, and behavioral health provider directories**
- **Requires the department to submit an annual parity report to the specified committees of the general assembly**
- Starting January 1, 2020, requires an MCE that provides prescription drug benefits for the treatment of substance use disorders to **provide coverage of any FDA-approved prescription medication for treating substance use disorders without prior authorization or step therapy requirements** and precludes those MCEs from excluding coverage for those medications and related services solely on the grounds that they were court ordered

NEW YORK ENFORCEMENT

New York has led the way through actively pursuing consent decrees. Based on clear enforcement authority and the enactment of Timothy's Law,⁴⁴ the New York parity legislation, and inaction by the New York Division of Insurance, **the New York Attorney General has**

taken exemplary efforts to enforce both state and federal parity, based on consumer complaints to that office. See New York Attorney General settlement agreements with MVP/ValueOptions,⁴⁴ Cigna,⁴⁴ Emblem/ValueOptions,⁴⁴ ValueOptions/Beacon,⁴⁴ and Excellus.⁴⁴ The most significant parity principles gleaned from these five settlements are **bolded** in this description.

The Emblem/ValueOptions settlement, described above, and the more recent Excellus settlement, provided for **residential treatment for eating and substance use disorders**. The Excellus settlement broadened the requirement to cover all diagnoses, subject to a determination of medical necessity. The Cigna settlement eliminated a numerical limit on **nutritional counselling** for eating disorders. The MVP settlement was more complex and overturned the system of **utilization review** instituted by ValueOptions, MVP's behavioral health contractor, which resulted in more significantly denials and more appeals than MVP experienced for medical and surgical claims. In relevant part, the settlement agreement provided:

- **Comparability of Utilization Review Processes:** MVP and/or any entity that administers benefits on behalf of MVP will not use the Outpatient Outlier Model for utilization review purposes. If MVP and/or any entity that administers benefits on behalf of MVP uses a utilization review tool for behavioral health services that is based on quantity or frequency of outpatient visits, such tool will be developed and updated annually based on clinical evidence and will be approved by a physician who is board certified in general psychiatry, or, in the case of substance abuse services, a physician who is certified in addiction medicine. Any utilization review performed by MVP and/or any entity that administers benefits on behalf of MVP under such tool will be conducted only to the extent that the quantity or frequency of visits is inconsistent with clinical evidence. Where, after applying such tool to the requests or claims of a member, MVP denies coverage for services, the member shall be afforded all internal and external appeal rights.
- **No visit limits:** there will not be any day or visit limits for behavioral health services in any MVP plan, except for family counseling services, which may be capped at 20 visits per year.⁴⁴
- **Utilization Review Process Reforms:** a. Co-Location of Utilization Review Staff: a significant number of MVP's utilization review staff, and staff of any entity that administers behavioral health benefits on behalf of MVP, will be located at the same physical site. For purposes of this Paragraph, "a significant number" means any amount between 40% and 60% of utilization review staff subject to this Paragraph. In the event that a significant number of utilization review staff is not located at the same physical site for any reason, including, but not limited to, change of vendor or loss of staff members due to resignations/terminations/reductions, MVP shall have 180 days within which period to meet the requirements of this Paragraph. MVP supervisors at the site will have access to employees of any entity that administers behavioral health benefits on behalf of MVP.
- **Collection of Information during Utilization Review:** MVP and any entity that administers behavioral health benefits on behalf of MVP will follow a protocol for the

collection of information during Utilization Review, which will include the elements set forth in Exhibit A.

- **Substance Abuse Treatment: The utilization review process for determining medical necessity for inpatient substance abuse rehabilitation treatment should reflect that there are individuals for whom it may be medically necessary to begin inpatient substance abuse rehabilitation treatment without first undergoing outpatient treatment.**
- Substance Abuse Treatment Criteria: For determining medical necessity for substance abuse treatment for Medicaid patients, MVP will adopt criteria that comport with or otherwise follow guidelines set by the New York State Department of Health and/or the New York State Office of Alcoholism and Substance Abuse Services.
- Continued Treatment: When an MVP member transitions from one level of behavioral health treatment to another, for example from inpatient to outpatient care, the review for the second level will be conducted as a concurrent review, because it concerns continued treatment.
- Classification of Denials: Any denials by MVP of coverage for behavioral health services due to lack of clinical information, and/or preauthorization, where the request for preauthorization was submitted by a credentialed provider for the actual date and services provided, will be processed as medical necessity denials.
- Duration of Approvals: **The number of days or visits approved for behavioral health treatment will not be limited to one day or one visit per approval and will be based on the treatment needs of the member**, unless clinically appropriate. (emphasis supplied)

The settlement with ValueOptions/Beacon was even more extensive. The Assurance of Discontinuance, which functions as a settlement agreement, provides for:

- Removing visit limits for almost all MH/SUD services, and removing preauthorization requirements for outpatient behavioral health services;
- Covering services provided by mental health practitioners, such as Mental Health Counselors;
- Ensuring that its provider networks and online provider directory are accurate, and assisting members in transitioning providers where necessary;
- Conducting full and fair reviews for services that require preauthorization, such as inpatient substance use disorder treatment;
- Providing detailed oral and written **explanations for denied claims**, so that members can exercise their appeal rights, and providing up-to-date information about alternative treatment providers;

-
- Classifying claims correctly so that reviews are done expeditiously and members are afforded full appeal rights;
 - Removing the requirement that members “fail” outpatient substance use disorder treatment before qualifying for inpatient rehabilitation treatment;
 - Basing the number of treatment days or visits approved on members’ needs, rather than arbitrary limits;
 - Integrating medical and behavioral health claims review staff, which will facilitate the coordination of members’ care;
 - Continuing coverage of treatment pending the completion of appeals, so that treatment is not interrupted;
 - Reimbursing coverage of treatment for most diagnoses listed in the Diagnostic and Statistical Manual of Mental Disorders (“DSM”), including **gender identity disorders**;
 - Reimbursing members for out-of-network services at the usual, customary and reasonable rate (“UCR”) for the relevant behavioral health service, without applying arbitrarily applying lowered rates for non-M.D. providers (emphasis supplied);

Additional concerns were reflected in the Excellus settlement. The Assurance of Discontinuance provides for:

- Not imposing any preauthorization or concurrent review requirements for routine outpatient behavioral health services (i.e., psychotherapy and medication management);
- Covering **partial hospitalization and intensive outpatient** treatment for MH/SUD conditions;
- **Not requiring** that members demonstrate a **substantial impairment** in their ability to function in a major life activity in order to receive coverage for MH/SUD care;
- Removing the requirement that members “fail” SUD treatment before qualifying for inpatient SUD treatment;
- Conducting full and fair reviews for services that require preauthorization, such as inpatient SUD treatment;⁴⁴
- Posting its MH/SUD medical necessity criteria on a website, to improve the **transparency of the review process**;
- Providing detailed, **accurate oral and written explanations for denied claims**, so that members can exercise their appeal rights;

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- **Employing in-house behavioral health advocates**, who will supply members and providers with assistance and information regarding claims denials, appeals, and in-network treatment facilities and providers in the member's service area;

Only two significant acts have been passed in New York since Timothy's law, [A10164/S07912](#) (2014), requires plans to use **peer-reviewed clinical review criteria** when making medical necessity review decisions for people with substance use disorders. In addition, medical necessity decisions for substance use disorder treatment must now be made by **professionals who specialize in substance use disorder treatment**. The law also allows people with substance use disorders to use an **expedited appeals process and not be denied care during the appeals process**. The law also requires all substance use disorder coverage to comply with the MHPAEA.

2019 legislation (A2904/S4808) prohibits certain insurance policies from requiring prior authorization for initial or renewal prescription for all buprenorphine products, methadone and long acting injectable naltrexone for detoxification or maintenance treatment of substance use disorders.

CONNECTICUT ENFORCEMENT

Connecticut has taken a different approach, creating a new agency rather than relying on the attorney general's consumer protection powers. Several other states have now replicated this model, beginning with Colorado in 2018. The Office of the Healthcare Advocate (OHA) was created in 1999 and began operation in 2001, with one employee. As of 2016, it has 17 employees, including two lawyers. It has jurisdiction over all denials of healthcare and health insurance coverage in the state, and has focused on parity since the first federal parity statute was passed in 2006.

- OHA has broad powers to help consumers deal with insurance issues.⁴⁴
- OHA publishes self-help manuals and checklists to help guide consumers through the appeals process.
- OHA also has caseworkers on call to carry out the appeal process for consumers. Caseworkers independently review the record and adverse determination and then draft the appeal based on the law and pertinent clinical standards.
- OHA does not have statutory authority to bring suit on behalf of consumers, but can instigate multiple appeals and push for coverage.⁴⁴
- The OHA focuses on individual cases rather than broad settlements of parity principles like those established in New York.
- OHA has been politically popular because it has been responsive to consumer and legislator concerns, and has a track record of success and savings (through successful appeals). Its responsiveness allows legislators and state officials to have confidence that legitimate parity problems will be resolved.

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- OHA is proposing regulations that will greatly increase its ability to demonstrate parity violations. These include required **annual reports** of:
 - (A) the annual number and percentage of covered children, young adults and adults, who received covered treatment of a substance use disorder, by level of care provided; (B) the range and median length of a covered treatment provided to covered children, young adults and adults, for a substance use disorder, by level of care provided; (C) the frequency of readmission to the same level of care or an Emergency Department within three and six months, respectively; (D) the per member per month claim expenses for covered children, young adults and adults who received covered treatment of substance use disorders; and (E) (i) the number of in-network health care providers who provide treatment of substance use disorders, by level of care and the percentage of such providers who are accepting new clients under each managed care organization's plan and (ii) the number in each category of in-network providers in each county of the state.
 - the annual number, by licensure type, of in-network health care providers who provide treatment of substance use disorders, co-occurring disorders and mental disorders, who (A) have applied for in-network status, (B) the percentage of those who were accepted for such status, (C) the reasons and percentages of those reasons such applicants were refused in-network status, and the geographic network density of the in-network providers of the same type and (D) the percentages of those providers who no longer participate in the network;
 - the annual number, by level of care provided, of in-network health care facilities that provide treatment of substance use disorders, co-occurring disorders and mental disorders, that (A) have applied for in-network status, (B) the percentage of those that were accepted for such status, (C) the reasons and percentages of those reasons such applicants were refused in-network status, and the geographic network density of the in-network providers of the same type and (D) the percentages of those providers who no longer participate in the network;
 - identifying and explaining factors that may be negatively impacting covered individuals' access to treatment of substance use disorders, including, but not limited to, screening procedures, the supply state-wide of certain categories of health care providers, health care provider capacity limitations and provider reimbursement rates;
 - plans and ongoing or completed activities to address [such] factors;
 - A comparison of claims for the previous plan year of the ten most frequent CPT codes used in both medical/surgical services and behavioral health/substance use services with a range of in-network reimbursement rates, as well as the mean and median value for each code;

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- A summary of: (i) the number of independent peer reviewers utilized by the managed care organization, (ii) and the mean and median outcomes of the independent peer reviewer's decision for each of the ten CPT codes.⁴⁴
 - These kinds of reporting requirements are the centerpiece of the legislation proposed by the national coalition ParityTrack.
 - Under the Connecticut External Review Program, covered persons may apply for an expedited external review if they can show that delay may seriously jeopardize the life or health of the covered person or the covered person's ability to regain maximum function.
 - If a consumer's appeal is unsuccessful, consumers may bring independent suit against insurers with the record created by OHA, having a much higher likelihood of success.
 - CASE DATA for FY 2016:
 - Estimated Consumer Savings \$13,413,140
 - 833 Outreach Events
 - 7,397 cases ⁴⁴
 - Still, a lot of work remains to be done. According to the 2015 report card issued by the Connecticut Insurance Department in 2015,⁴⁴ the rate of denials by the state's largest managed care insurers of requests for mental health services rose nearly 70 percent between 2013 and 2014, with an average of about one in 12 requests for prescribed treatment initially rejected. At the same time, the proportion of enrollees in the largest managed care companies who received outpatient or emergency department care for mental health doubled, from an average of 9.4 percent in 2013 to 20.8 percent in 2014. The percentage of members who received inpatient mental health care also doubled, although it remained low, with most companies providing inpatient services for less than .5 percent of all enrollees.
 - Home-based services, including intensive out-patient services to assure that people in treatment stay on their medications, are a major unaddressed area, since there is controversy about the comparability of medical and surgical outpatient treatments like physical therapy, which are usually less intensive.
 - Unofficial data show that office visit reimbursement rates for mental health visits in Connecticut are only 75% of the rate for general medical visits for the same level of service.
 - OHA has been seeking carrier agreement on clinical guidelines to use as a standard of care, but has had difficulty finding a perfect solution. While insurance companies have been open to discussion and collaboration on language, no clear consensus has arisen. The Joint Commission Behavioral Health Guidelines and the Association for Ambulatory

Behavioral Healthcare standards,⁴⁴ as well as ASAM and CASII, have been used as a point of departure.

- Connecticut passed a strict statute mandating publication of medical necessity standards but weakened it in response to carrier complaints that the standards should be treated as proprietary information.⁴⁴
- Connecticut has not publicized broad parity standards like those promulgated in New York and treats individual cases as confidential. The cases are not summarized or digested.
- The PROPOSED Connecticut REGULATIONS drafted by OHA are an even more powerful tool to be considered by the State Division of Insurance. Those include:
 - the annual number and percentage of covered children, young adults and adults, who received covered treatment of a mental health or substance use disorder, by level of care provided; (B) the range and median length of a covered treatment provided to covered children, young adults and adults, by level of care provided; (C) the frequency of readmission to the same level of care or an Emergency Department within three and six months; (D) the per member per month claim expenses for covered children, young adults and adults who received covered treatment of substance use disorders; and (E) (i) the number of in-network health care providers who provide treatment of substance use disorders, by level of care and the percentage of such providers who are accepting new clients under each managed care organization's plan and (ii) the number in each category of in-network providers in each county of the state.
 - the annual number, by licensure type, of in-network health care providers who provide treatment of mental health and substance use disorders and co-occurring disorders, who (A) have applied for in-network status, (B) the percentage of those who were accepted for such status, (C) the reasons and percentages of those reasons such applicants were refused in-network status, (D) the percentage of licensed individuals accepted by license type (E) the geographic network density of the in-network providers of the same type and (F) the percentages of those providers who no longer participate in the network;
 - the annual number, by level of care provided, of in-network health care facilities that provide treatment of mental health and substance use disorder and co-occurring disorders that (A) have applied for in-network status, (B) the percentage of those that were accepted for such status, (C) the reasons and percentages of those reasons such applicants were refused in-network status, and the geographic network density of the in-network providers of the same type and (D) the percentages of those providers who no longer participate in the network;
 - identifying and explaining factors that may be negatively impacting covered individuals' access to treatment of mental health and substance use disorders, including, but not limited to, screening procedures, the supply state-wide of

certain categories of health care providers, health care provider capacity limitations and provider reimbursement rates;

- plans and ongoing or completed activities to address [such] factors;
- A comparison of claims for the previous plan year of the ten most frequent CPT codes used in both medical/surgical services and behavioral health services with a range of in-network reimbursement rates, as well as the mean and median value for each code;
- A summary of: (i) the number of independent peer reviewers utilized by the managed care organization, (ii) and the mean and median outcomes of each independent peer reviewer's decision for each of the ten CPT codes.⁴⁴

CALIFORNIA ENFORCEMENT

California consumers are active in bringing enforcement actions for parity violations, and some of the largest private cases setting precedent, like *Harlick, Daniel F. v. Blue Shield of California*, and *Rea v. Blue Shield of California* have been litigated in California and in the Ninth Circuit. California's Department of Managed Healthcare investigates violations as reported by consumers and has a helpline for consumers to call with questions, although it does not appear to have the same consumer advocacy stance as Connecticut, which obviously has a unique relationship with the insurance industry.

- California provides a help line for consumers to call to help guide consumers through the external appeals process (Independent Medical Review in California's terminology) or lodge a consumer complaint against an insurer.⁴⁴
- California has required a 3-day maximum turnaround for expedited administrative appeals (IMR's) for time-sensitive, urgent health matters when the standard time frame (30 days) could involve an imminent and serious threat to the health of the enrollee.⁴⁴ California also allows for concurrent internal and external appeals proceedings in urgent cases.⁴⁴
 - The DMHC brought an action against Cigna for violating the expedited appeals process by failing to have a **functioning after-hours urgent grievance system** and by failing to provide the DMHC with an **available representative with authority to resolve an urgent grievance and authorize the provision of health care services**.⁴⁴ Cigna was ordered to pay a \$150,000 administrative penalty in the action.⁴⁴
- The DMHC website shows seven enforcement actions for parity and medical necessity, since 2000.⁴⁴
 - Five of those enforcement actions were against Blue Shield. All five actions appear to be related to the same denial of **Applied Behavior Analysis for children**. These actions ended in a settlement agreement.⁴⁴

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- Two actions were against HealthNet for denying **speech therapy**. These actions ended letters of agreement. ⁴⁴
 - It appears that none of these settlement agreements have much precedential value.
 - In its biggest enforcement action to date, in 2013, the [DMHC fined](#) Kaiser Foundation Health Plan \$4,000,000 for many violations, including one related to the parity provisions within the Health and Safety Code. Kaiser failed to provide “accurate and understandable behavioral health education services including information regarding the availability and optimal use of mental health care services available.” Kaiser also provided insureds with inaccurate information about benefits that would make the benefits appear to be noncompliant with parity laws and made recommendations that would lower the utilization of some behavioral health services. In February of 2015, the DMHC [released a follow-up report](#) regarding the steps Kaiser had taken to correct violations of state law identified by the Department in 2013.
 - The fourth of the four violations was directly relevant to parity in that the DMHC found that Kaiser and its providers were informing consumers that certain mental health services were not covered, which was in direct violation of the parity sections of the California Parity Law. In this follow-up report, the Department determined that Kaiser had not adequately corrected this violation. The DMHC found that while Kaiser had corrected this information on its website and in its explanation of benefits documents, its providers were still telling consumers that certain medically necessary services were not covered, like long-term therapy.
 - The DMHC required all plans to complete and file a “Compliance Filing” reflecting their assessment of their MHPAEA compliance no later than 9/18/2014. The DMHC provided insurers with [detailed instructions](#) that required them to [complete worksheets](#) that compare their behavioral health coverage to other medical coverage, and required them to [complete](#) another worksheet comparing their application of non-quantitative treatment limitations for behavioral health coverage and other medical coverage.⁴⁴ The DMHC found that none of the submitted plans complied with the MHPAEA and continues to audit plans in an effort to promote voluntary compliance.
 - On May 6, 2014, the DMHC reminded plans that no prior authorization may be required for admission to emergency inpatient psychiatric services.

OREGON ENFORCEMENT

Oregon announced an extraordinary parity enforcement initiative in 2014 that began defining its state law and federal enforcement priorities. The Department of Consumer and Business Services (DCBS) issued a bulletin that explained to insurance plans what is required of them under the parity section of the state insurance law and the regulations that apply to it, what is required of them under the MHPAEA and its final regulation, and what is required of them relating to parity under the Affordable Care Act. This bulletin specifically expects plans to do the following:

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- Must make coverage decisions for behavioral health services the same way they do for other medical services;
 - Cannot categorically deny all forms of a treatment that might be medically necessary, thereby making state and federal mandates “effectively meaningless;”
 - Review their appeals decisions and independent review organization (IRO) decisions for guidance on how to handle future behavioral health claims;
 - Medical necessity determinations and whether a behavioral health service is considered experimental must be “no more restrictive” than for other medical services;
 - Cannot tell insureds verbally that a service is not covered; must encourage insureds to submit a claim and then the plan can deny the claim in writing;
 - Must use peer-reviewed scientific studies and national or international clinical standards when making medical necessity determinations;
 - Make available to providers and insureds the plan’s medical necessity criteria and instances of how certain denials do not meet these criteria;⁴⁴

The bulletin then goes into great detail about the state law, the MHPAEA and its final regulation, the ACA and its final regulation, and how all of this applies to various plans:

- History of state law and the plans to which it applies (pg. 3);
- Types of plans the different state and federal laws apply to and how (pg. 4);
- Coverage requirements of state law (pg. 4-5);
- Coverage requirements due to the MHPAEA and the ACA (pg. 5-6);
- Explanation of requirements related to quantitative treatment limitations and non-quantitative treatment limitations (pg. 6);
- States that **DCBS will be monitoring external review decisions made by IROs to see if those decisions reveal patterns of possible non-compliance with state and federal law** (pg. 9);

MASSACHUSETTS ENFORCEMENT

- Massachusetts has a state parity law very similar to Colorado’s and covers autism and eating disorders as “biologically-based.”⁴⁴
- By statute, effective in 2015, Massachusetts has required mandatory coverage of inpatient and residential treatment for substance use conditions. Health insurance carriers are prohibited from requiring prior authorization for most SUD services. Facilities are required to notify the patient’s health insurer and provide an initial treatment plan to the

insurer within 48 hours of accepting the patient. Health insurers may begin to conduct utilization review on day 7 of the stay.⁴⁴

- In 2013, the Massachusetts Division of Insurance (DOI) required insurance plans to submit materials showing how they would meet the standards in the Massachusetts Parity Law and the MHPAEA. Plans had to submit their initial certification materials by October 1, 2013. Plans are required to review their practices every year. By July 1st every year, plans have to submit documents to the Division of Insurance and the Office of the Attorney General showing that the plan had done a full review of their practices for compliance with the Massachusetts Parity Law and the MHPAEA.⁴⁴
- The DOI engaged Dixon Hughes Goodman LLP to examine insurance companies' utilization management records for two different groups of patients who had received emergency department treatment and then needed follow-up care. One group was patients who needed behavioral health (BH) treatment and the other group was patients who needed non-behavioral health (NBH) treatment. The purpose of the examination was to see if there were differences in how the insurance companies reviewed and authorized treatment decisions for the BH patients compared to the NBH patients.
- The examination found that BH Patients on average have to wait much longer for follow-up care than NBH patients, although the delays were not necessarily caused by federal or state parity law violations.⁴⁴ Dixon Hughes Goodman did not conclude that parity violations definitely took place, but noted that records were lacking details for many of the patients who had to wait more than 24 hours for follow-up care.
- The report recommended, among other things, that the DOI should create standards for the detail required in insurance company records about follow-up care so that it is easier to see if there are differences in the utilization management process for BH patients versus NBH patients. The report also recommended that the DOI strengthen its MHPAEA certification process to collect more information about any possible differences insurance companies have in their review processes for BH patients compared to NBH patients.⁴⁴