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Implementing Parity: Investing in Behavioral Health – Part 2

by Steve Melek

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

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The Department of Labor, Health and Human Services, and the Treasury released interim final rules (IFR) under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 (MHPAEA) in February 2010. These regulations specify what it means to provide behavioral health benefits that are in parity with medical and surgical benefits, and establish a requirement for group health plans and group health insurance issuers to be compliant with parity for plan years beginning on or after July 1, 2010. Understanding compliance with MHPAEA is of great importance to all interested parties, including health insurance companies, health plans, employers, providers, and consumers of behavioral health care. Part 1 of this article was published in the May 2010 issue of *Health Watch* and addressed details of implementation. Here in Part 2, I address the new enforcement safe harbor, how the regulations could impact the business of behavioral health care and the impending decisions for payors, employers, providers, and insureds.

Enforcement Safe Harbor Issued

On July 1, 2010 the sponsoring agencies of MHPAEA "determined that they will establish an enforcement safe harbor under which the agencies will not take enforcement action against a plan or issuer that divides its benefits furnished on an outpatient basis into two sub-classifications for purposes of applying the financial requirement and treatment limitation rules under MHPAEA: (1) office visits, and (2) all other outpatient items and services." (Department of Labor, 7/1/2010). All other aspects of the IFR remain unchanged.

The first step in applying the MHPAEA requirement is to determine whether a financial requirement or quantitative treatment limitation applies to *substantially all* medical/surgical benefits in a classification. For many plan sponsors and insurers of hybrid plans, whose plans use a mix of copays and coinsurance depending on the type of service, this safe harbor change is great news and a welcomed surprise. This change will likely result in an increase in *substantially all* pass rates for financial requirements in the outpatient classifications. Before the safe harbor was issued, many plans were failing the *substantially all* test and were therefore going to have to offer free mental health and substance use disorder benefits in the outpatient class, which did not seem like a sensible result. For example, let's say a plan design has 50 percent of services for which a $20 copay is applied, and 50 percent for which 20 percent coinsurance is applied for outpatient medical/surgical benefits, and is charging a $20 copay for outpatient mental health and substance abuse services. In this case, neither the $20 copay nor the 20 percent coinsurance exist

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for *substantially all* services, which is defined as at least two-thirds of service costs by MHPA 1996 regulation. Therefore, since no single cost sharing type exists which is for *substantially all* services, the result was that plans could not charge any member cost sharing for the mental health and substance abuse services in the outpatient class. However, after the issuance of the safe harbor, the copay and coinsurance services may be tested separately. When tested separately, 100 percent of the copay services have a $20 copay applied, and therefore *substantially all* services have a $20 copay, therefore, the plan could continue to charge a $20 copay for the outpatient class (office visit sub-class) of mental health and substance abuse services, as opposed to $0 as per the IFR prior to this safe harbor.

While this change does shed light on the intent of the IFR in this one area, it does bring back the episodic copay issue in an even more important way. Can ancillary medical/surgical services that are provided during an office visit be included as subject to copays for the purposes of testing (to achieve two-thirds or *substantially all*)? And how far can you stretch with this mapping? The more services that are linked to copays, the easier it will be to pass the *substantially all* tests in both sub-classes for hybrid plans.

Looking Below the Surface

Part 1 of this article addressed some of the key provisions of the IFR, especially as it relates to quantitative restrictions and compliance. After assisting multiple plans with MHPAEA compliance testing under the IFR, the items listed below have surfaced as key additional items to consider when testing for MHPAEA compliance.

Non-quantitative Treatment Limitations

One of the most unexpected new requirements in the regulations is the inclusion of non-quantitative treatment limitations (i.e., a limit not expressed numerically that otherwise limits the scope or duration of benefits). These non-quantitative limitations could include, but are not limited to

- medical management standards
- prescription drug formulary designs
- standards for provider admission to participate in a network
- determination of usual, customary, and reasonable amounts
- requirements for using lower-cost therapies before a plan will cover more expensive therapies
- conditional benefits based on completion of a course of treatment

Under the IFR, any process or standard a plan uses to apply non-quantitative treatment limitations to mental health/substance use disorder benefits *must be comparable to, and applied no more stringently than,* those used for medical/surgical benefits.

The IFR is quite specific about the testing procedure for MHPAEA compliance with the quantitative financial requirements and treatment limitations; it is less specific about what is required to be compliant as it relates to non-quantitative treatment limitations. However, under the IFR, compliance failure in this area is just as severe as compliance failure on benefit design. One area of uncertainty is how the *substantially all* test applies to non-quantitative treatment limitations. The IFR uses the *must be comparable to, and applied no more stringently than* terminology in comparing mental health and substance use disorder and medical/surgical benefits processes, strategies, evidentiary standards, and other factors in comparing non-quantitative treatment limitations after addressing the quantitative limits via the *substantially all* and *predominant* tests. One could interpret this to mean that such non-quantitative limits

1. must apply to substantially all medical/surgical benefits,
2. must be the predominant treatment limitation across medical/surgical benefits, and
3. must be applied no more restrictively than the comparable medical/surgical limitation.

For many health plans, a comparison of the non-quantitative treatment limitations of behavioral health benefits to those of medical/surgical benefits has likely never been done because prior parity legislation did not require it. Under the MHPAEA IFR, such comparisons must be done and health

plans should be actively analyzing these items and be prepared to defend the processes they use to manage behavioral health benefits.

Cover One, *Cover All*

The MHPAEA IFR requires that health plans and self-funded employers who provide benefits for a mental health or substance use disorder in one classification (in-network inpatient, in-network outpatient, out-of-network inpatient, out-of-network outpatient, emergency services, or prescription drugs) must provide benefits for that condition in all classifications in which it provides medical/surgical benefits.

This requirement could be especially important to employers whose response to the parity requirements is to remove the coverage for some or all mental health and substance use disorders. Suppose an individual goes to their primary care physician, who prescribes an anti-depressant for treatment. Anti-depressants are included in the drug formulary, but outpatient mental health visits are not a covered benefit. By including anti-depressants on the drug formulary for the treatment of depression, the employer has violated MHPAEA—if an employer wants to cover prescription drugs used to treat behavioral conditions, it must also provide behavioral benefits in the other classifications where medical/surgical benefits are offered.

Another item that recurs in plans is a specific provision related to the coverage of tobacco cessation products and services. Keep in mind that if a tobacco cessation benefit (to cover nicotine addiction, a substance use disorder) is provided in any of the classifications for which medical/surgical benefits are provided, it must be covered in all of them. In addition, rules limiting the duration of use of tobacco cessation benefits must be removed if comparable limitations for medical/surgical services or drugs do not exist and pass the *substantially all* and *predominant* tests.

Determining the Dollar Amounts Expected to be Paid

Some confusion has arisen about whether paid claims or allowed claims are appropriate for parity testing. The IFR description suggests that using plan payments prior to member responsibility is appropriate. However, the IFR does include the phrase *expected to be paid under the plan.* Many actuaries involved in MHPAEA compliance testing believe that the use of allowed dollars makes more sense when testing the quantitative financial requirements.

In an extreme case, consider the situation where the copay equals the cost of the service. In this situation, using paid dollars would result in zero paid dollars for that benefit and therefore costs associated with the coverage for that benefit would be excluded from the testing altogether. The IFR includes language that permits the use of any reasonable method to determine the dollar amounts, and using allowed dollars is a reasonable approach.

Episodic Copays

Office visits to a provider could result in numerous services being delivered, such as the office visit itself, an x-ray, and some lab work. In this situation, which medical services should be treated as being subject to the copay? If the answer is all of them, then how does the copay get split between the services? Because office visits and related costs typically represent a non-trivial amount of costs for a plan, understanding how to implement the quantitative financial requirement testing for these episodic copays is important. How to perform the substantially all and predominant testing for this type of copay is unclear in the IFR and further guidance is needed on this subject.

Tiered Networks

Some plans use a tiered network approach in their benefit designs where the cost-sharing requirements differ depending upon the tier placement of the provider. The IFR does not separately address how to test this type of plan design. Using the standard approach, a plan would need to separate medical/surgical costs by tier so that cost-sharing requirements within each tier could be applied and accurate *predominant* levels could be determined. If all mental health and substance use disorder benefits are covered at the top tier levels, then testing each tier separately would not be necessary.

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State Mandates for Autism

Some states mandate specific dollar amounts for the treatment of autism and other pervasive developmental disorders (PDDs), commonly including applied behavioral analysis (ABA). Key questions regarding PDDs include how they are classified, how are ABA providers credentialed, and how do medical necessity criteria apply to ABA benefits. Is treatment for these disorders a combination of medical and behavioral benefits? If PDDs are considered behavioral disorders and dollar limits have to be removed in order to comply, will this cause plans to meet the MHPAEA cost exemption threshold which will allow them to opt-out of parity in subsequent (alternate) years? The IFR does not specifically address the treatment of autism and other PDDs.

Scope of Services

The IFR did not address how treatments for behavioral disorders without analogous medical/surgical treatments (partial hospitalization, residential treatment facilities, ABA) should be handled. The federal agencies did receive many comments regarding the continuum of care issue. The comments received covered the entire spectrum. Some requested that the regulations clarify that a plan is not required to provide benefits for any particular treatment or treatment setting if benefits for the treatment or treatment setting are not provided for medical/surgical benefits (such as non-hospital residential treatment, partial hospital services, and ABA). Others requested that beneficiaries should have access to the full scope of medically appropriate services to treat mental disorders and substance use disorders if the plan covers the full scope of medically appropriate services to treat medical/surgical conditions.

A key element in this discussion is the need for medically appropriate services delivered by qualified, licensed and credentialed providers. Because such a wide range in qualifications and credentials exists within the behavioral healthcare field, some plans have historically limited what benefits are covered under the plan.

One solution to this scope of services issue is for health plans to use specific behavioral healthcare guidelines that incorporate the full spectrum of services in order to achieve the quality and efficiency outcomes desired for medically necessary care.

The Response of Self-funded Plan Sponsors

Since the release of the IFR, it appears that many fully insured plans have been actively engaged in parity compliance and making decisions which will bring their plans into compliance. From my observations, self-funded plans which are also affected by MHPAEA and the IFR have been slower to react to the legislation. For a self-funded plan to perform the detailed testing involved, they must have access to the cost data which will likely be provided by the contracted ASO. It is the employer's responsibility to ensure that the plans offered are in compliance with the law. However, as a service to their customers, some ASOs have proactively contacted their customers regarding MHPAEA.

For employers who offer behavioral healthcare coverage through a managed behavioral healthcare organization (MBHO) on a carve-out basis, the employer must communicate any benefit design changes that have to be made as a result of the compliance testing. Some MBHOs are assisting self-funded employers directly by making benefit design change recommendations and determining price impacts as a result.

MHPAEA: Just Another Mandate or an Opportunity?

The MHPAEA could be viewed as yet another federal mandate that requires compliance and increases costs. On the other hand, the MHPAEA could be viewed as a reason to revisit how behavioral health conditions are treated and how services are delivered to arrive at optimal clinical outcomes which could ultimately result in cost reductions. With increased access to behavioral healthcare benefits as a result of parity, payors should be looking for ways to improve the delivery of behavioral healthcare services. Here are some of these considerations.

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

Support of Primary Care. There will be geographic areas where maintaining a sufficient behavioral specialty network to provide the desired access and clinical outcomes will be impossible. Patients will then rely on their primary care providers (PCPs) for behavioral healthcare. Systems of support will need to be developed to help PCPs improve their diagnostic and treatment capabilities of behavioral disorders. This could include increased funding for care management of behavioral illnesses provided through nurse practitioners, increased funding of diagnostic behavioral screening/testing in primary care settings, and increased support for work processes that improve clinical outcomes. There is a huge opportunity for such improvement in primary care settings.

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

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

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