Session 86L, Mental Health Parity

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Introductions

Kristi Bohn, Minnesota Department of Commerce
Jan Graeber, Texas Department of Insurance
Katie Mathews, Milliman (Denver)
Steve Melek, Milliman (Denver)
Mental Health Parity 101
The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (and interim final rules) requires:

Insurers that offer mental health and substance use disorder benefits cannot make financial requirements and treatment limitations on these benefits more restrictive than medical or surgical benefits.
MHPAEA Overview

Parity requires group health plans and health insurance issuers to be no more restrictive regarding mental health/substance use disorder vs. medical/surgical in documents and in operation.
MHPAEA Overview

Parity only applies to health plans that provide MH/SUD benefits.

Parity originally applied to employer plans with 51 or more workers.

• Due to the Affordable Care Act, parity also applies to individual and small group health plans

• In 2014: Mental health and substance use disorder became required essential health benefits for individual and small group
Exemptions from MHPAEA:
• Medicare retiree plans
• Opt-out provision: Self-funded non-Federal governmental plans
• Rarely used increased cost exemption
MHPAEA Overview

Financial Requirements *(e.g. copays, deductibles)*

Quantitative Treatment Limitations *(QTLs, e.g. number of office visits, treatments, days of coverage)*

Nonquantitative Treatment Limitations *(NQTLs)*
Nonquantitative Treatment Limitations (NQTLs)

- Prior authorization
- Concurrent Review
- Retrospective Review
- Outlier Review
- Coding edits
- Medical necessity criteria
- OON coverage standards
- Geographic Restrictions
- Experimental/Investigational Determinations
- Exclusions for Court-Ordered Treatment or Involuntary Holds

- Fail first (step therapy)
- Failure to Complete
- Provider reimbursement
- UCR determination
- Provider credentialing
- Certification requirements
- Unlicensed provider/staff requirements
- Provider-type exclusions
- Formulary/PDL Design
- Network Access
Financial Requirements & Quantitative Treatment Limitations

Final Rules Nov 2013 required complex testing
6 classifications (8 optional if outpatient split)
• inpatient in-network
• inpatient out-of-network
• outpatient (includes professional) in-network
• outpatient (includes professional) out-of-network
• emergency room
• prescription drugs

Test if more restrictive than the predominant financial requirement or QTL of that type applied to substantially all medical/surgical benefits in the same classification
Financial Requirements & QTLs

Amendment to 26 CFR Chapter 1: 54.9812-1 (c)(3)(i)

(3) Financial requirements and quantitative treatment limitations—
(i) Determining “substantially all” and “predominant”—

(A) Substantially all.
For purposes of this paragraph (c), a type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification.

(B) Predominant—
(1) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under paragraph (c)(3)(i)(A) of this section, the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.
Financial Requirements & QTLs

Emergency Services Testing Example

Example:

<table>
<thead>
<tr>
<th>Service</th>
<th>Co-Pay</th>
<th>% of Allowed Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility</td>
<td>$150</td>
<td>55%</td>
</tr>
<tr>
<td>Physician Fees</td>
<td>20% coins</td>
<td>30%</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$100</td>
<td>13%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$50</td>
<td>2%</td>
</tr>
</tbody>
</table>

“Substantially all” type above is co-pay (70% > 2/3)
“Predominant level” is $150 co-pay (50% mark when ranked)

So, a $150 is the most that can be charged for any of the MH SUD emergency category of services, by design. The 20% coinsurance for the MH SUD physician fees is possibly problematic.
Another Example:
A plan has a $500 deductible that is applied to most services, but charges a $150 co-pay for emergency room facility charges.

Only 60 percent of med-surgical (non-MH SUD) emergency care benefits are subject to the deductible because the plan does not apply the deductible, but rather applies a $150 co-pay.

“Substantially all” type not met for the deductible on the emergency room category (60% < 2/3). So, a deductible of $500 to emergency care for MH/SUD cannot be part of the plan, by design.
Mental Health Parity
Texas’ Experience
HB 10, 85th Regular Legislative Session

• Closely aligned Texas parity requirements with the federal Mental Health Parity and Addiction Equity Act.
• Texas law is effective for plans issued or renewed on or after January 1, 2018
• Gave TDI authority to enforce compliance with parity standards for all fully insured health plans.
HB 10, 85th Regular Legislative Session

• TDI must provide a liaison to a new HHSC ombudsman for behavioral health access to care
• TDI must participate on a mental health condition and substance use disorder parity work group (facilitated by HHSC) to develop a strategic plan and metrics for compliance
• TDI and HHSC must collect data related to the rate at which benefits are subject to prior authorization, denial, and internal and external appeals, and report results by 9/1/18
Roles of Divisions within TDI

• Regulatory Policy Division
• Compliance Division
• Financial Regulation
• Legal and Enforcement
House Bill 10 Data Collection

• Assess Compliance with NQTLs

• Coordinated Effort with TDI and HHSC

• Reporting Forms

• Current Status
Mental Health Parity
Minnesota’s Experience
Nonquantitative Treatment Limitations (NQTLs)

- Prior authorization
- Concurrent Review
- Retrospective Review
- Outlier Review
- Coding edits
- Medical necessity criteria
  - OON coverage standards
  - Geographic Restrictions
  - Experimental/Investigational Determinations
- Exclusions for Court-Ordered Treatment or Involuntary Holds
- Fail first (step therapy)
- Failure to Complete
- Provider reimbursement
- UCR determination
- Provider credentialing
- Certification requirements
- Unlicensed provider/staff requirements
- Provider-type exclusions
- Formulary/PDL Design
- Network Access
Mental Health Parity 101
Mental Health Parity 101
Mental Health Parity and Addiction Equity Act

MHPAEA = \[ \text{Quantitative Treatment Limitations (QTLs)} + \text{Non-Quantitative Treatment Limitations (NQTLs)} \]
Quantitative Treatment Limits

• “...the financial requirements (quantitative treatment limits) that apply to mental health and substance use disorder benefits are no more restrictive than the predominant financial requirements (quantitative treatment limits) applied to substantially all medical and surgical benefits ...”

• Examined QTLs in the form of benefit richness, PMPM claim costs, utilization, and resulting trends to assess MHPAEA’s impact on these metrics.
Impact of Mental Health Parity Analysis Methodology

- Data Sources: Truven MarketScan Databases (2008 – 2013)
- 32 million lives across the U.S.
- Plan Type – Separately by HMO and PPO
- Service Category – Inpatient, Outpatient, Professional, Rx
- Normalized for changes in demographics and geographics between years
BENEFIT RICHNESS
Poll: How do you think benefit richness for behavioral health services may have changed between 2008 (when MHPAEA was first passed) and 2013 (after final rules became effective) as compared to non-behavioral health services?
How do you think benefit richness for behavioral health services may have changed between 2008 (when MHPAEA was first passed) and 2013 (after final rules became effective) as compared to non-behavioral health services?
Benefit Richness BH vs. Non-BH

Change in Total Benefit Richness 2008-2013
Benefit Richness  BH vs. Non-BH

Change in Total Benefit Richness 2008-2013
Paid-to-Allowed Ratios - Non-BH services

*PPO plans*

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
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<tbody>
<tr>
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<td>0.91</td>
<td>0.91</td>
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<td>PROFESSIONAL</td>
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<tr>
<td>RX</td>
<td>0.77</td>
<td>0.78</td>
<td>0.79</td>
<td>0.79</td>
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<tr>
<td>TOTAL</td>
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<td>0.83</td>
<td>0.83</td>
<td>0.82</td>
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</table>
# Paid-to-Allowed Ratios – BH services

*PPO plans*

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<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
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<tbody>
<tr>
<td>INPATIENT</td>
<td>0.83</td>
<td>0.85</td>
<td>0.87</td>
<td>0.87</td>
<td>0.86</td>
<td>0.87</td>
</tr>
<tr>
<td>OUTPATIENT</td>
<td>0.82</td>
<td>0.82</td>
<td>0.85</td>
<td>0.86</td>
<td>0.86</td>
<td>0.87</td>
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<tr>
<td>PROFESSIONAL</td>
<td>0.65</td>
<td>0.65</td>
<td>0.67</td>
<td>0.68</td>
<td>0.67</td>
<td>0.69</td>
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<tr>
<td>RX</td>
<td>0.79</td>
<td>0.78</td>
<td>0.78</td>
<td>0.78</td>
<td>0.78</td>
<td>0.80</td>
</tr>
<tr>
<td>TOTAL</td>
<td>0.76</td>
<td>0.76</td>
<td>0.77</td>
<td>0.77</td>
<td>0.77</td>
<td>0.79</td>
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</table>
## Paid-to-Allowed Ratios – MH vs. SUD services

*PPO plans*

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>INPATIENT MENTAL HEALTH</td>
<td>0.84</td>
<td>0.85</td>
<td>0.87</td>
<td>0.87</td>
<td>0.87</td>
<td>0.87</td>
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<tr>
<td>INPATIENT SUBSTANCE USE</td>
<td>0.82</td>
<td>0.85</td>
<td>0.86</td>
<td>0.86</td>
<td>0.85</td>
<td>0.87</td>
</tr>
<tr>
<td>OUTPATIENT MENTAL HEALTH</td>
<td>0.82</td>
<td>0.82</td>
<td>0.85</td>
<td>0.87</td>
<td>0.87</td>
<td>0.88</td>
</tr>
<tr>
<td>OUTPATIENT SUBSTANCE USE</td>
<td>0.82</td>
<td>0.81</td>
<td>0.85</td>
<td>0.85</td>
<td>0.85</td>
<td>0.87</td>
</tr>
</tbody>
</table>
COST AND UTILIZATION TRENDS
Poll: How do you think annualized cost and utilization trends compare between behavioral health and non-behavioral health services for the period 2008-2013?
How do you think annualized cost and utilization trends compare between behavioral health and non-behavioral health services for the period 2008-2013?
## PMPM Claim Cost Trends

*HMO Plans*

<table>
<thead>
<tr>
<th></th>
<th>BEHAVIORAL</th>
<th>NON-BEHAVIORAL</th>
<th>DIFFERENTIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INPATIENT</strong></td>
<td>6.4%</td>
<td>1.0%</td>
<td>5.4%</td>
</tr>
<tr>
<td><strong>OUTPATIENT</strong></td>
<td>18.9%</td>
<td>4.1%</td>
<td>14.8%</td>
</tr>
<tr>
<td>(INCL. ER)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PROFESSIONAL</strong></td>
<td>5.9%</td>
<td>4.4%</td>
<td>1.5%</td>
</tr>
<tr>
<td></td>
<td>Behavioral</td>
<td>Non-Behavioral</td>
<td>Differential</td>
</tr>
<tr>
<td>------------------</td>
<td>------------</td>
<td>----------------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>10.7%</td>
<td>-1.1%</td>
<td>11.8%</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>19.5%</td>
<td>2.0%</td>
<td>17.5%</td>
</tr>
<tr>
<td><strong>Professional</strong></td>
<td>9.4%</td>
<td>3.1%</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

PMPM Claim Cost Trends

*PPO Plans*
Average Annual Utilization Trends (2008-2013)

HMO Plans

- Inpatient
- Outpatient (incl. ER)
- Professional

July 3, 2018
Average Annual Utilization Trends (2008-2013)

*PPO Plans*

- Behavioral
  - Inpatient
  - Outpatient (incl. ER)
  - Professional

- Non-behavioral
Achieving Compliance

• We continue to see offered benefits that don’t meet full compliance.
• It has been shown that untreated behavioral conditions can substantially increase medical expenses for comorbid medical conditions.
• Consistent enforcement is increasing.
Mental Health Parity and Addiction Equity Act

MHPAEA = \[ + \] Quantitative Treatment Limitations (QTLs) + Non-Quantitative Treatment Limitations (NQTLs)
Nonquantitative Treatment Limits

• “...any processes, strategies, evidentiary standards, and other factors used in managing mental health and substance use disorder benefits must be comparable to, and applied no more stringently than, those used in managing the medical/surgical benefits...”

• NQTLs include medical management standards, prescription drug formulary design, network adequacy, provider fee levels, and step therapies, among other processes.

• Potential Disparity Analysis
Network Disparity Analysis Approach

- Data Sources: Milliman Consolidated HCG Databases, Truven MarketScan Databases (2013 – 2015)
- 42 million lives across the U.S.
- Provider Specialty Codes – Behavioral, Medical PCP, Medical Specialty
- Service Category Codes – Facility Services (IP vs. OP), Professional Services - used for Network Adequacy
- Service Codes - Specific E&M codes, other office service codes – used for Provider Payment Levels
HIGHER PROPORTION OF OUT-OF-NETWORK CARE FOR BEHAVIORAL VS. MEDICAL/SURGICAL

![Bar chart showing higher proportion of out-of-network care for behavioral vs. medical/surgical services across different care settings (inpatient facility, outpatient facility, primary care office visits, specialist office visits) for the years 2013, 2014, and 2015.]
HIGHER PROPORTION OF OUT-OF-NETWORK CARE FOR BEHAVIORAL VS. MEDICAL/SURGICAL

<table>
<thead>
<tr>
<th>CARE SETTING AND YEAR</th>
<th>OUT-OF-NETWORK UTILIZATION</th>
<th>HIGHER PROPORTION OF BEHAVIORAL OUT-OF-NETWORK USE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MEDICAL/SURGICAL</td>
<td>BEHAVIORAL</td>
</tr>
<tr>
<td>INPATIENT FACILITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>3.4%</td>
<td>9.6%</td>
</tr>
<tr>
<td>2014</td>
<td>4.0%</td>
<td>11.3%</td>
</tr>
<tr>
<td>2015</td>
<td>4.0%</td>
<td>16.7%</td>
</tr>
<tr>
<td>OUTPATIENT FACILITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>5.3%</td>
<td>15.6%</td>
</tr>
<tr>
<td>2014</td>
<td>5.6%</td>
<td>22.5%</td>
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<tr>
<td>2015</td>
<td>5.5%</td>
<td>31.6%</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>OFFICE VISITS</th>
<th>PRIMARY CARE</th>
<th>SPECIALISTS</th>
<th>BEHAVIORAL</th>
<th>COMPARED TO PRIMARY CARE</th>
<th>COMPARED TO SPECIALISTS</th>
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</thead>
<tbody>
<tr>
<td>2013</td>
<td>3.8%</td>
<td>5.1%</td>
<td>19.0%</td>
<td>5.0X</td>
<td>3.7X</td>
</tr>
<tr>
<td>2014</td>
<td>4.0%</td>
<td>5.1%</td>
<td>16.2%</td>
<td>4.8X</td>
<td>3.7X</td>
</tr>
<tr>
<td>2015</td>
<td>3.7%</td>
<td>5.2%</td>
<td>18.7%</td>
<td>5.1X</td>
<td>3.6X</td>
</tr>
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</table>
HIGHER PROPORTION OF OUT-OF-NETWORK CARE FOR BEHAVIORAL VS. MEDICAL/SURGICAL
Poll: Have you evaluated your own company’s in-network and out-of-network use rates between physical healthcare and behavioral healthcare for a potential issue with MHPAEA NQTL compliance?
Have you evaluated your own company’s in-network and out-of-network use rates between physical healthcare and behavioral healthcare for a potential issue with MHPAEA NQTL compliance?
Poll: Do you think it is necessary to complete a review of your network adequacy between physical healthcare and behavioral healthcare as a part of your parity compliance work?
Do you think it is necessary to complete a review of your network adequacy between physical healthcare and behavioral healthcare as a part of your parity compliance work?
Higher Provider Payments for Medical/Surgical Office Visits Compared to Behavioral Office Visits - % MCR
Higher Provider Payments for Medical/Surgical Office Visits Compared to Behavioral Office Visits
### Higher Provider Payments for Medical/Surgical Office Visits Compared to Behavioral Office Visits

<table>
<thead>
<tr>
<th>CARE SETTING AND CALENDAR YEAR</th>
<th>ALLOWED CHARGES RELATIVE TO MEDICARE</th>
<th>HIGHER PAYMENTS COMPARED TO BEHAVIORAL</th>
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<tbody>
<tr>
<td></td>
<td>PRIMARY CARE</td>
<td>SPECIALISTS</td>
</tr>
<tr>
<td>ALL OFFICE VISITS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>112.1%</td>
<td>110.1%</td>
</tr>
<tr>
<td>2014</td>
<td>114.6%</td>
<td>111.9%</td>
</tr>
<tr>
<td>2015</td>
<td>115.2%</td>
<td>111.3%</td>
</tr>
</tbody>
</table>

**LOW COMPLEXITY E&M (CPT 99213*)**

|                               | PRIMARY CARE | SPECIALISTS | BEHAVIORAL | PRIMARY CARE | SPECIALISTS |
| 2013                          | 112.6%       | 106.0%      | 95.1%      | 18.3%        | 11.4%        |
| 2014                          | 115.1%       | 108.1%      | 97.2%      | 18.4%        | 11.2%        |
| 2015                          | 115.4%       | 109.2%      | 95.7%      | 20.6%        | 14.1%        |

**MODERATE COMPLEXITY E&M (CPT 99214*)**

|                               | PRIMARY CARE | SPECIALISTS | BEHAVIORAL | PRIMARY CARE | SPECIALISTS |
| 2013                          | 110.9%       | 107.8%      | 92.2%      | 20.4%        | 16.9%        |
| 2014                          | 113.3%       | 110.0%      | 94.5%      | 19.9%        | 16.4%        |
| 2015                          | 114.2%       | 112.2%      | 95.2%      | 20.0%        | 17.8%        |
Higher Provider Payments for Medical/Surgical Office Visits Compared to Behavioral Office Visits

Legend
Higher primary care payment levels compared to behavioral office visits
- None
- 0.1% - 10%
- 10% - 20%
- 20% - 30%
- 30% - 40%
- 40% - 69.1%
Poll: Have you evaluated your own company’s provider payment rates between physical healthcare and behavioral healthcare for a potential issue with MHPAEA NQTL compliance?
Have you evaluated your own company’s provider payment rates between physical healthcare and behavioral healthcare for a potential issue with MHPAEA NQTL compliance?
Poll: Do you think it is necessary to complete a review of your provider payment rates between physical healthcare and behavioral healthcare as a part of your parity compliance work?
Do you think it is necessary to complete a review of your provider payment rates between physical healthcare and behavioral healthcare as a part of your parity compliance work?