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Mental health parity: History and overview

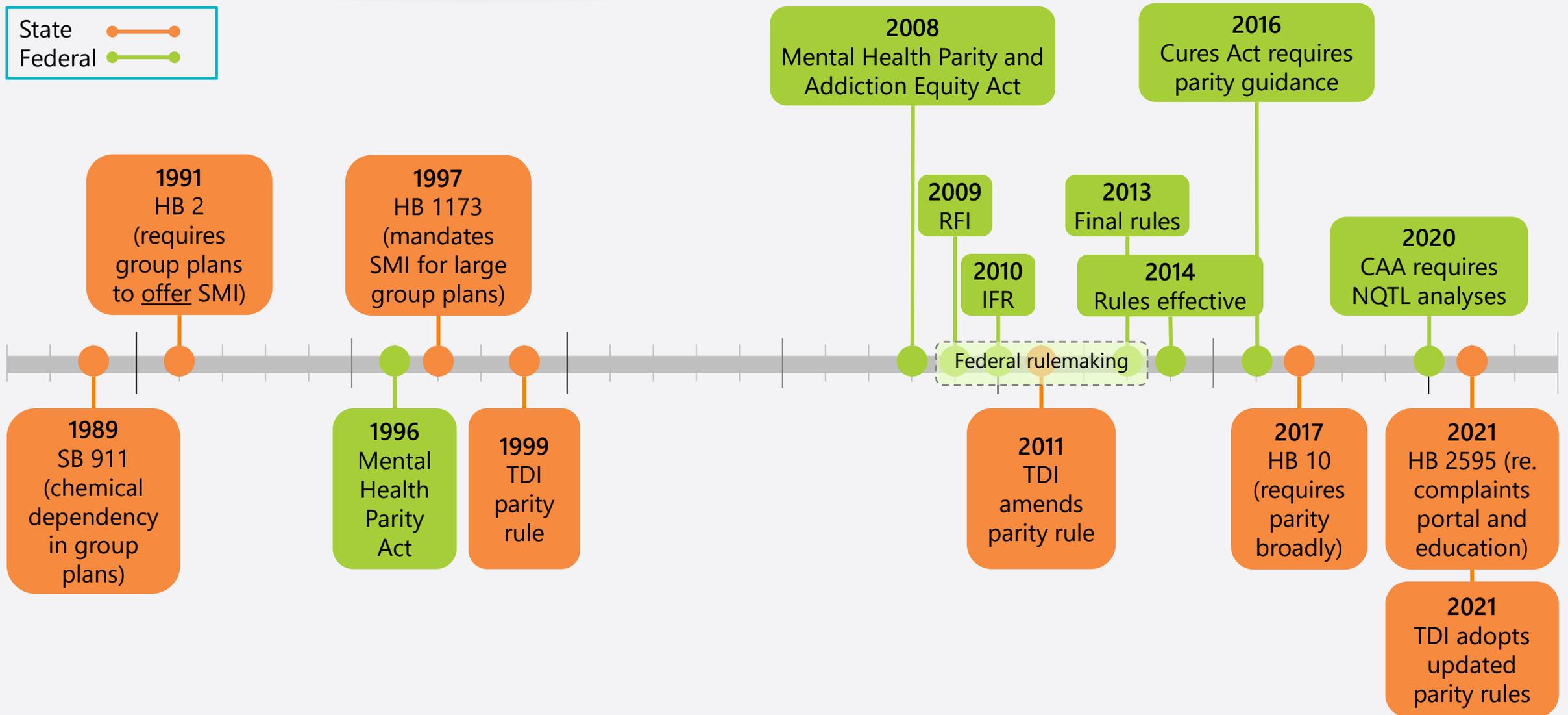
May 26, 2022

# TDI | Agenda

- Parity law evolution
- Federal parity law and rules
- Texas parity law - House Bill (HB) 10, 2017 and HB 2595, 2021
- TDI parity rules adopted in 2021
  - Texas vs. federal
  - Data collection
  - Quantitative parity assessment
  - Non-quantitative parity assessment

# TDI | Timeline

State   
Federal 



# TDI | Federal law structure

Like other federal health care laws, the parity act is repeated in three separate codes and involves three agencies:

- Fully insured plans and non-federal governmental plans are governed by the federal Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) under the Public Health Service Act (PHSA), [42 USC §300gg-26](#); rules in [45 CFR §146.136](#).
  - The PHSA authorizes the states to enforce the law on fully insured plans.
  - CMS will take responsibility for enforcement if the state does not.
- Self-funded employer plans are governed by Department of Labor under the Labor Code (ERISA), [29 USC §1185a](#); rules in [29 CFR §2590.712](#).
- The Department of Treasury and Internal Revenue Service enforce the Internal Revenue Code, [26 USC §9812](#); rules in [26 CFR §54.9812-1](#).

# TDI | Mental Health Parity Act of 1996

## The Mental Health Parity Act of 1996:

- Required large group health plans that already provided benefits in both mental health (MH) and medical/surgical (M/S) to comply with parity laws.
- Only extended parity to:
  - Aggregate lifetime limits
  - Annual limits
- The Act did not:
  - Require plans to provide MH benefits.
  - Extend to coverage of substance use disorder (SUD).

# **TDI** | Federal parity act, 2008

## **The Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008:**

- Effective for plan years starting October 3, 2009.
- Extended parity to substance use disorder benefits.
- Parity includes financial requirements, treatment limitations.
- Limits on mental health/substance use disorder (MH/SUD) may not be more restrictive.
- Issuers must disclose medical necessity criteria to enrollees and providers upon request.

## **The Affordable Care Act of 2010:**

- Expanded parity requirements to individual market plans.
- Established essential health benefits (EHB) that included mental health and substance use disorder benefits, creating a new coverage mandate for non-grandfathered individual and small group plans.
- EHB rules extend parity requirements to non-grandfathered individual and small group plans

# **TDI** | 21st Century Cures Act, 2016

**Amended 42 USC 300gg-26(a) to add (6) and (7), requiring federal regulators to:**

- Publish compliance guidance for health plans (updated every two years), including illustrative examples of findings of compliance and noncompliance, detailed guidance concerning non-quantitative treatment limitations (NQTLs), and recommendations to advance compliance.
- Provide guidance to health plans on disclosure requirements and to consumers and providers on how to obtain plan information.

# TDI | Consolidated Appropriations Act, 2021

Division BB, Title II – Transparency, Section 203 amended 42 USC 300gg-26(a) to add (8), requiring:

- Health plans to perform and document comparative analyses of the design and application of NQTLs, available to state and federal regulators upon request.
  - Effective as of February 10, 2021.
  - Tri-agency guidance contained in [FAQ #45](#).
- Federal regulators to review at least 20 analyses each year.
- Federal regulators to publish annual reports summarizing the comparative analyses reviewed and compliance findings.

# TDI | Federal parity rules

## 45 CFR §146.136:

- Defines six classifications of benefits for testing parity.
- Parity test: may not be more restrictive than the predominant limit that applies to substantially all medical/surgical benefits.
- If MH/SUD is covered, benefits must be provided in the same classifications where medical/surgical benefits are provided.
- Aggregate requirements (deductible, out-of-pocket limit) must combine medical/surgical and MH/SUD benefits.

# TDI | Federal parity rules

- Address parity for financial requirements and treatment limitations
- Specified that “treatment limitations” include:
  - Quantitative treatment limitations (QTLs) are **expressed numerically** (such as 50 outpatient visits per year).
  - Non-quantitative treatment limitations (NQTLs) **limit the scope or duration** of benefits for treatment under a plan or coverage.

# TDI | House Bill 10 (2017)

- Established ombudsman for behavioral health.
- Established MH/SUD parity workgroup charged (abolished September 1, 2021, after completing a [strategic plan](#) for improving parity).
- Added general parity requirements to Insurance Code ([Chapter 1355, Subchapter F](#)) and required TDI to adopt rules and enforce parity compliance.
- Directed TDI and HHSC to collect and compare data related to the application of utilization review to MH/SUD benefits and [report](#) the results of the study.

# TDI | House Bill 2595 (2021)

- Established October as Mental Health Condition and Substance Use Disorder Parity Awareness month.
- Established requirements for TDI's complaint portal and directed TDI to develop best practices for parity complaints.
- Required TDI to develop educational materials and parity law training sessions for MH/SUD parity.
- Required TDI, in collaboration with the HHSC Ombudsman for Behavioral Health, to develop a report on parity complaints and related parity issues.

# TDI | HB 10 study findings

With the caveat that data on its own does not prove a parity violation exists, the study identified disparities that may warrant further investigation, including:

- Higher utilization of out-of-network care.
- Higher claim denial rates.
- Denials of prior authorization for care for children.
- Higher rates of concurrent review.
- Higher rates of step therapy for prescription drugs.

# **TDI** | HB 10 parity provisions

- Applies to major medical coverage that covers mental health or substance use disorder.
- Defines quantitative and non-quantitative requirements.
- Requires plans to provide benefits under the same terms and prohibits imposing a limit that is generally more restrictive.
- Directs TDI to adopt rules and enforce compliance.
- Requires plans to define conditions consistent with generally recognized standards.

# TDI | TDI rules implementing HB 10

## 28 Texas Administrative Code (TAC) Chapter 21, Subchapter P

- Division 1 includes parity requirements that generally align with federal rules in 45 CFR §146.136.
- Division 2 requires issuers to submit data annually that allows TDI to monitor parity compliance and identify warning signs.
- Division 3 requires issuers to conduct parity compliance analyses for QTLs and NQTLs and share upon request.
- Division 4 addresses autism spectrum disorder and replaces rules in Chapter 21, Subchapter JJ.

# **TDI** | Rule implementation dates

## **Division 1 – General provisions and parity requirements**

Effective September 7, 2021

## **Division 2 – Plan information and data collection**

Due July 1 of each year (2020 data was due January 15)

## **Division 3 – Compliance analysis for MH/SUD parity**

- QTL analyses effective March 6, 2022.
- NQTL analyses phased in, beginning June 1, 2022.
- Analyses must be available on request but are not required to be submitted annually.

## **Division 4 – Autism spectrum disorder**

Effective September 7, 2021.

# **TDI** | Texas vs. federal applicability

- The federal parity law includes exemptions:
  - Grandfathered or self-funded small employer plans.
  - Short-term limited duration and excepted benefit plans.
  - Increased cost exemption (45 CFR §146.136(g), unused).
  - Opt out for non-federal governmental self-funded plans.
  - Medicare, MedSupp, FFS Medicaid, and TriCare.
- The Texas law exempts only excepted benefit plans, as stated in Texas Insurance Code (TIC) §1355.253 and TIC §1425.001.
- Additionally, Multiple Employer Welfare Arrangements (MEWAs) are subject to HB 10 and TDI's rules.

# TDI | Classifications

- Parity is assessed by comparing benefits and limits for M/S conditions to MH/SUD conditions across 6 classifications (and subclassifications, if the issuer chooses).
  - Inpatient, in-network; inpatient, out-of-network.
  - Outpatient in-network; outpatient, out-of-network.
    - Optional subclassification for office visits vs. all other.
  - Emergency care.
  - Prescription drugs.
- Pharmacy or network tiers may also be subclassified.

# TDI | Classification and categorization

- All plan benefits must be assigned a classification for analysis.
- All plan benefits must also be categorized as either MS or MH/SUD based on the diagnosis being treated.
- Services that are sometimes used to treat MS and other times used to treat MH/SUD must be included in both categories.
- Classifications and categorizations must be used consistently for QTL and NQTL analyses.
- Under [28 TAC §21.2436\(f\) and \(g\)](#), issuers must explain within the QTL template the methodology for categorization and classification.

# TDI | M/S or MH/SUD categorization

- **Mental health benefits:** Benefits with respect to services for mental health conditions.
- **Substance use disorder benefits:** Benefits with respect to services for substance use disorders:
  - As defined under the terms of the plan.
  - In accordance with applicable Federal and State law.
  - Consistent with generally recognized independent standards of current medical practice [e.g., DSM, ICD].
- **Medical or surgical benefits:** Does not include mental health or substance use disorder benefits.

# **TDI** | Parity fundamentals

If a plan provides MH/SUD benefits in any classification, they must be provided in every classification in which M/S Benefits are provided.

## **Danny P. v. Catholic Health Initiatives (June 6, 2018)**

- Room and board costs covered for an inpatient stay for M/S in a skilled nursing facility, but denied for a residential mental health treatment facility.
- 9th Circuit Court of Appeals found this to be an improper treatment limitation.

# TDI | Quantitative parity analysis

Financial requirements and quantitative treatment limitations (QTLs) applied to MH/SUD must meet a two-part test, applied by comparing MH/SUD and M/S benefits within a classification:

1. A **type** of QTL may be applied to MH/SUD benefits only if it applies to **substantially all** the M/S benefits.
2. The **level** of a QTL that is permitted for a MH/SUD benefit must be no more restrictive than the **predominant level** applied to M/S benefits.

# TDI | Expected payment amounts

- To determine the expected payment amounts for M/S benefits needed to conduct the QTL analysis, an issuer must use a “reasonable method,” as defined by [28 TAC §21.2406\(31\)](#).
  - If sufficient data is available, the projection should be based on claims data for the plan design.
  - If the data is not sufficient, the issuer must use appropriate and sufficient data (such as data from other similarly structured plans with similar demographics).
- The issuer must explain the methodology used to determine the expected payment amounts within the QTL template, as required under [28 TAC §21.2435](#).

# TDI | Quantitative parity – type of limit

- A **type** of QTL includes:
  - A financial requirement (e.g., deductible, coinsurance, copay); or
  - A quantitative limit (e.g., visit, day, quantity, episodic limits).
- **Substantially all** means at least two thirds of medical benefits, calculated based on the percent of the expected claims dollars in the classification that would be paid for the medical benefits subject to a given type of financial requirement or quantitative limit.

# TDI | Substantially all

- To determine if a type of QTL is permitted for MH/SUD, analyze the **QTLs applied to M/S benefits**.
- Proportion is calculated by looking at all expected claims dollars for M/S within a classification.
  - What % of expected claims are subject to the type of QTL?
  - If  $\geq 2/3$ , proceed to predominant analysis.
  - If  $< 2/3$ , the type of QTL may not be applied to any MH/SUD benefit.

# TDI | Quantitative parity – level of limit

- A **level** of QTL means the magnitude of the limit:
  - A deductible of \$500 vs. \$2,500, a coinsurance of 20% vs. 30%.
  - A limit of 25 visits, 31 pills, or 3 episodes.
- **Predominant** means the level of a QTL that applies to more than 50 percent of medical benefits, calculated based on the percent of expected claims dollars for medical benefits within the classification that are subject to the type of financial requirement or quantitative limit.

# TDI | Predominant

- To determine if a level of QTL is permitted for MH/SUD, analyze the QTLs applied to M/S benefits.
- Proportion is calculated by looking at all expected claim dollars for M/S within a classification that are subject to a permitted type of QTL.
  - Expected claim dollars include all allowed amounts.
  - What % of claims dollars are subject to a level of QTL?
  - The level that applies to  $\geq 50\%$  of expected claims is the most restrictive level of QTL permitted for MH/SUD benefits within the classification.

# TDI | QTL analysis example

- **Substantially all:** Deductible and copay (no coinsurance)
- **Predominant deductible:** \$1,000
- **Predominant copay:** \$35 copay (45/85 = 53%)\*

Outpatient office visits, in-network, M/S benefits:

Service	Deductible	Coinsurance	Copay	Expected claims
Preventive	NA	NA	NA	15%
PCP	\$1,000	NA	\$25	25%
Specialist	\$1,000	20%	\$35	45%
Urgent care	NA	NA	\$50	15%
Substantially all	Yes (70%)	No (45%)	Yes (85%)	Threshold: 66.7%
Predominant	\$1,000 (100%)	NA	35% (53%)	Threshold: 50%*

## 28 TAC §§ 21.2431 - 21.2437

- Analyze each plan design for QTL compliance using either TDI's QTL template or an alternative tool that produces the same level of specificity and uses the same methodology.
- Analyses may be combined for multiple plans with the same plan design as defined in [28 TAC §21.2406\(25\)](#).
- QTL analyses must be completed for all existing plans, before marketing a new plan, and within 30 days of making a material change to a QTL or NQTL.
- Analyses must be provided to TDI upon request; TDI may inquire during form review, complaints, exams, etc.

# TDI | Non-quantitative treatment limits

- NQTLs are standards other than explicit numeric limits that act to limit the scope or duration of benefits, for example:
  - Prior authorization and medical necessity standards.
  - Step therapy protocols or fail-first policies.
  - Standards for provider admission into network, including contracting practices and reimbursement rates.
  - Formulary design.
- Limits for MH/SUD must be **comparable to** and **applied no more stringently** than M/S limits.

# TDI | Non-quantitative parity

- The **processes, strategies, evidentiary standards, or other factors** used to apply an NQTL must be comparable to and applied no more stringently to behavioral health benefits than to medical benefits in a given classification:
  - as written; and
  - in operation.
- Outcomes are not determinative of compliance, but disparities are a warning sign of potential operational parity noncompliance.

# TDI | Non-quantitative parity

- For each NQTL in each classification, compare the behavioral benefits and medical benefits to which the NQTL applies.
- How is the NQTL designed?
  - What factors are considered? What sources or evidentiary standards are used to define the applicable factors? What is the threshold or methodology?
- How is the NQTL applied?
  - What process is used to design or apply the NQTL? What is the frequency of review? What are the qualifications of the key staff?

# TDI | Non-quantitative parity

- How does the plan ensure NQTLs are comparable and no more stringently applied?
- How much discretion exists in practice?
- Is the same level of detail present for behavioral care and medical care NQTLs?
- How are operations audited for consistency with written procedures?
- What disparities exist in operation?
- What incentives may influence the application of the NQTL?

# **TDI** | NQTL analysis required

## **28 TAC §§ 21.2438 – 21.2441**

- Analyze each plan using either TDI's NQTL template or an alternative issuer tool that follows the required four-step process and produces documentation that provides the same level of specificity.
- A single analysis may be completed for multiple plans that contain an identical set of NQTLs.

# TDI | Four-step analysis

1. Identify all NQTLs applied to each MH/SUD and M/S benefit, provide specific plan terms regarding the NQTL, and describe how the NQTL is implemented.
2. Identify each factor considered in the design and application of the NQTL.
3. Identify the sources (including any processes, strategies, or evidentiary standards) used to define the factors identified in Step 2.
4. Provide a comparative analysis demonstrating NQTL compliance.

# TDI | Deadline for NQTL analyses

- TDI rules provided for a phased-in deadline:
  - **June 1, 2022:** Initial analysis of utilization review-related NQTLs.
  - **June 1, 2023:** Initial analysis of network-adequacy-related NQTLs,
  - **June 1, 2024:** Initial analysis of all remaining NQTLs.
- Under 42 USC 300gg-26(a)(8), as of February 10, 2021, NQTL analyses must be provided to state or federal regulators on request.

- [TDI's parity compliance resources](#)
- [TDI parity info for consumers](#)
- [Texas Health and Human Services Ombudsman for Behavioral Health](#)
- [Texas Medicaid and CHIP parity information](#)
- [Department of Labor Self-Compliance Tool for Mental Health Parity and Addiction Equity Act](#)
- [Department of Labor Parity Resources](#)
- [2022 MHPAEA Report to Congress](#)
- [National Association of Insurance Commissioners MHPAEA Working Group](#)
- [Sample of a Sufficient Non-quantitative Treatment Limitations Comparative Analysis](#)