# Mental Health & Addiction Parity

**Position:** Kansans living with mental health and substance use conditions experience barriers in accessing care based on violations of state and federal parity statutes and regulations by their insurance carriers. Enforcement of parity violations is lacking at the state level. The Kansas Insurance Department (KID) over the last 15 years has maintained that policyholders must file complaints with KID in order to document denials of service which represent a parity violation. It is unrealistic for individuals dealing with serious mental health and substance use conditions to deal with complaint and appeal procedures. When reimbursement for services is denied, treatment may be discontinued, and patients then have the financial burden of paying out of pocket.

The Coalition is seeking informational hearings on parity enforcement from Insurance Committees at the beginning of the 2022 legislative session, a commitment to establish an Interim Committee to review the findings of the Targeted Market Conduct Examination (scheduled for completion by KID in July 2022) and to make recommendations for necessary statutory changes in 2023.

**The Problem:** State and Federal laws require equal treatment of behavioral health conditions in comparison to primary care. Enforcement of parity statutes is lacking and complaints to the Kansas Insurance Department are needed to make the case for closer scrutiny by regulators and legislators. Insurers have failed to adopt appropriate standards of care based on established nonprofit professional criteria standards. Insurers often apply different standards for behavioral health than what is generally accepted, requiring the courts to intervene such as in the decision in *Wit v. United Behavioral Health*.

Selected examples of potential parity violations by insurance carriers include these types of restrictions. Click here for a more complete listing and description of potential parity violations.

1. There is a higher incidence of retrospective reviews and recoupment of payments from mental health providers compared to primary care providers.
2. Out-of-state treatment options are seldom or never authorized even when there are no appropriate treatment options available locally.
3. There is an inadequate network of behavioral health providers.
4. Continued payment for out-patient therapy is denied because progress has not been "proven."
5. Payment is refused for therapy relating to a co-occurring mental illness while a member is receiving in patient treatment for substance use disorder.
6. Payment is refused for higher cost therapies despite evidence supporting the need for more intensive treatment.
7. Payment is excluded for certain types of therapy without any medical necessity analysis, but authorization for is refused for partial hospitalization or intensive outpatient therapy.
8. Payments to out-of-network providers is less than for in-network providers.

**Why this matters:** Restrictions on behavioral health treatments which are not applied to other chronic medical conditions unnecessarily limit access to treatment, resulting in poor outcomes for individuals affected by these conditions, shifting costs to more costly treatment venues and to the justice system.

**The bottom line**: Legislative oversight is critically important to ensure that regulation of insurance company practices is not unfairly limiting Kansans' access to medically necessary treatment.

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## The rest of the story about Parity Enforcement:

The Coalition endorses these Guiding Principles for Medical Necessity, which includes the following eight standards for effective treatment established by the court in the *Wit* case.

1. **Underlying Conditions**: Requires treatment of the individual's underlying condition and is not limited to alleviating the individual's current symptoms.
2. **Co-occurring disorders**: 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.
3. **Safety and Effectiveness:** 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.
4. **Errs on the side of caution:** 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.
5. **Prioritizes Maintaining functioning and preventing deterioration:** Effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration.
6. **Individual duration of treatment:** 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.
7. **Special considerations for children/adolescents:** 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.
8. **Multidimensional assessment**: 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.



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