KANSAS MENTAL HEALTH COALITION

An Organization Dedicated to Improving the Lives of Kansans with Mental Illnesses

House Insurance and Pensions Committee Informational Hearing - February 8, 2021

What is Mental Health Parity?

For too long, many Americans paid for insurance coverage that did not recognize that mental health and substance use disorders are every bit as important as physical health, and that going without effective treatment can be debilitating and even life threatening. (U.S. Dept. of Health and Human Services, *"Parity Implementation",* https://www.hhs.gov/about/agencies/advisory-committees/mental-health-parity/task-force/resources/index.html)

A timeline of federal action on mental health parity is attached to this document, for our purposes, three actions are most pertinent:

1996 - the Federal Mental Health Parity Act was enacted requiring comparable annual and lifetime dollar limits on mental health and medical coverage in large group health plans including employer-sponsored group health plans.

2008 - Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) is signed into law - applying to large group health plans including employer-sponsored plans, effective for most plans starting in 2010. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

2010 - The Affordable Care Act (ACA) enacted and extends parity protections to individual health insurance policies and Medicaid expansions to low-income childless adults.

Kansas Mental Health Parity Act

K.S.A. 40-2,105a was initially passed in 2001 and updated in 2009 and 2018.

K.S.A. 40-2,105a establishes: Any group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization that provides medical, surgical or hospital expense coverage shall include coverage for diagnosis and treatment of mental illnesses and alcoholism, drug abuse or other substance use disorders.

And: Such coverage shall be subject to the same deductibles, copayments, coinsurance, out-of-pocket expenses, treatment limitations and other limitations as apply to other covered services.

And: The coverage shall include treatment for in-patient care and out-patient care for mental illness, alcoholism, drug abuse or substance use disorders.

The provisions of this section shall not apply to any small employer group policy, as defined under K.S.A. 40-2209.

See the full statute https://www.ksrevisor.org/statutes/chapters/ch40/040_002_0105a.html

Federal CMS Guidance Regarding Mental Health Parity Requirements in CHIP, Medicaid and Group Insurance

The Federal Centers for Medicare & Medicaid Services (CMS) issued a State Health Official letter on November 4, 2009 regarding the mental health parity requirements under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The letter provides general guidance on implementation of section 502 of CHIPRA, Public Law 111-3, which imposes mental health and substance use disorder parity requirements on all Children's Health Insurance Program (CHIP) State plans under title XXI of the Social Security Act (the Act). This letter also provides preliminary guidance to the extent that mental health and substance use disorder parity requirements apply to State Medicaid programs under title XIX of the Act.

In summary the letter addresses specific requirements in the measure as follows:

1. Qualifying financial requirements and treatment limitations applied to mental health or substance use disorder benefits may be no more restrictive than those applied to medical surgical benefits.
2. No separate qualifying criteria may be applied to mental health or substance use disorder benefits.
3. When out-of-network coverage is available for medical surgical benefits, it must also be available for mental health or substance use disorder benefits.

Mental Health Parity is the Law – Why do we keep hearing about it?

If Parity is now the law of the land – both federally and at the state level – why do we continue to hear about problems?

One of the many important promises of both the Affordable Care Act and the Mental Health Parity and Addiction Equity Act is to ensure that health plans and insurers offer mental health and substance use disorder benefits that are comparable to their coverage for general medical and surgical care.

BUT, parity is only meaningful if health plans are implementing it well, consumers and providers understand how it works, and there is appropriate oversight. (U.S. Dept. of Health and Human Services, *"Parity Implementation",* https://www.hhs.gov/about/agencies/advisory-committees/mental-health-parity/task-force/resources/index.html)

Kansas law also has a gap for policies that are not required to provide parity, including small employer fully insured plans.

Are Health Plans Implementing Parity Well?

A study by the Office of the Assistant Secretary for Planning and Evaluation in 2013 indicated that overall, MHPAEA had improved coverage of behavioral health treatment. Employers and health plans made substantial changes to comply with the Mental Health Parity and Addiction Equity Act and the Interim Final Rule. By 2011, most ERISA-governed group health plans and health insurance offered in connection with group health plans removed most financial requirements that did not

meet MHPAEA standards. Nearly all eliminated the use of separate deductibles for MH/SUD treatment and medical/surgical treatment. The number of plans that apply unequal inpatient day limits, outpatient visit limits or other QTLs for MH/SUD dropped substantially.

While traditional barriers on mental health and substance use disorder treatment have been reduced or eliminated because of the Federal Parity Law, barriers characterized as insurer non-quantitative treatment limitations have kept patients from realizing the true intent of the Federal Parity Law.

Such limits include:

- differences in how health plans enact utilization management and define medical necessity,
- separate deductibles and co-pays for mental and medical healthcare,
- limited behavioral healthcare services offered within their provider networks,
- limited behavioral health provider networks,
- and lower reimbursement or additional audits and scrutiny for behavioral healthcare providers.

The impact of such limits on access to mental healthcare has been significant. Behavioral health patients are four times more likely to go out of network to get care, which raises the cost for such services, according to a 2017 report by actuarial firm Milliman. The report found out-of-network providers provided 32% of behavioral outpatient care in 2015 compared to 6% of medical/surgical care in the same setting. Perhaps the greatest complaints come from the criteria used for utilization review.

Do Consumers and Providers Understand How It Works?

Policyholders are rarely skilled at reading the fine print, navigating appeals processes and deadlines, or knowing where to turn for help. This condition is often much worse when facing their own behavioral health crisis or that of their children. Providers must engage billing staff and dedicate extensive time to navigating the claims processes of health plans, and often there is a behavioral health entity contracted by the health plan to administer prior authorizations, utilization review and payment processes.

Last year, the House Insurance Committee heard testimony from grieving families and frustrated providers about the barriers and inequities that Kansans encounter with their insurance coverage or lack of coverage for behavioral health treatment.

Some commonly cited issues include:

- The patient finally agrees to go to treatment – only to find that there are no beds available or their health plan will not pay for the treatments that are available.
- Providers must fight repeatedly whether or not the patient is at risk of suicide or relapse, regardless of the screening conducted by a mental health professional and rather than being able to apply effective practices that assure better outcomes.
- Patients in crisis are rejected due to a lack of prior attempts at lower levels of care. In the most tragic cases, these individuals take desperate measures that threaten their own lives or even result in death in a terrible attempt to receive treatment.

- Poor reimbursement rates and excessive administrative burdens lead behavioral health providers to refuse participation in insurance plan networks. Out of network services require more out of pocket expense for the patient or may not be allowed at all.

The 2019 Milliman Research Report, Addiction and Mental Health v. Physical Health: Widening Disparities in Network Use and Provider Reimbursement concludes that mental health and substance use disorders are still treated inequitably in America and the realization of parity has yet to be achieved. The report found that in most states, people received behavioral health treatment from out-of-network providers far more often than they received medical and surgical treatment from out of network providers. (Melek, Steve; Davenport, Stoddard; Gary, TJ; "Addiction and Mental Health v. Physical Health", Mental Health Treatment and Research Institute, LLC; November 2019)

Is There Appropriate Oversight?

Regulation is a complex issue where federal rules and state rules apply to different types of health plans and the intersection of federal and state laws applies two layers of oversight with somewhat undefined roles. Meanwhile, dissatisfaction across the country with individuals' access to true parity has led to several recent actions.

The National Association of Insurance Commissioners established a working group to assist states as they navigate jurisdictional challenges. A unique challenge for states has been the intersection of state regulation of insurance and enforcing a federal law - because the Federal government envisioned payment parity between physical and behavioral health coverage. However, unlike self-funded insurance plans that are subject to federal and not state oversight, the federal government didn't enact federal enforcement or make it clear that states were responsible for the plans impacted by the MHPAEA.

The NAIC Working Group is made up of state regulators who work closely with federal regulators at the Department of Labor and the Department of Health and Human Services – federal agencies that carry the regulations for MHPAEA. One of the primary objectives this group is working toward is developing a template for providers, payors and regulators to be on the same page across the states. It is an ongoing process and will continue to be a patchwork of solutions across the country as state based regulation continues to be independent but must establish some uniformity in order to enforce the federal law across state lines.

America's Health Insurance Plans (AHIP) has been consistent in calling for more clarification in the law, particularly as it relates to the use of non-quantitative treatment limitations, saying the guidance around them has been ambiguous and that it has created complexities.

SAMHSA issued guidance based on best practices from the states as follows:
Parity compliance is most successful when all elements of enforcement—communication with carriers, standardized forms, checklists and templates, network adequacy assessments and market conduct exams, and collaboration with other agencies—are implemented together.

All of the interviewed states cited many efforts that contributed to their work to ensure parity compliance. Most states stressed the importance of conducting market conduct exams. These exams were universally viewed as the most important way of broadly

increasing compliance, especially when they included on-the-ground examination of processes and procedures through direct follow-up with carriers that usually were not immediately evident from the information initially collected. However, states also noted that actual improvements in access require explicit attention to adequacy of provider availability. States emphasized that evaluating network adequacy and addressing workforce issues are critical components of improving behavioral health care delivery within the context of parity implementation. Finally, successful implementation of all of these strategies requires collaboration with multiple other agencies and stakeholder groups.

(Substance Abuse and Mental Health Services Administration. Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States. HHS Publication No. SMA-16-4983, Rockville, MD: Substance Abuse and Mental Health Services Administration; 2016.)

The Wit v. United Behavioral Health decision

In the class-action lawsuit *Wit v. United Behavioral Health* (UBH), a federal court in California ruled in February 2019 that UBH, the largest managed behavioral health care company in the U.S., used defective, internally-developed criteria inconsistent with generally accepted standards of care to deny coverage to over 50,000 members, half of whom were children/adolescents.

The court's remedies decision, issued on November 3, 2020, requires UBH to reprocess the more than 60,000 denied claims, using court-approved criteria of generally accepted standards of care. The federal court issued a 10-year injunction against UBH, requiring it to exclusively use the following medical necessity criteria:

- The ASAM Criteria developed by the American Society of Addiction Medicine
- Level of Care Utilization System (LOCUS) developed by the American Association of Community Psychiatrists
- Child and Adolescent Service Intensity Instrument (CASII) and Early Childhood Service Intensity Instrument (ECSII) developed by the American Academy of Child and Adolescent Psychiatry

These criteria reflect the eight generally accepted standards of care described by the *Wit* court:

> 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 systems.
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> 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.
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> 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.
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> 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.

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.

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.

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.

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.

States Are Moving Forward

- New York included a provision in its 2019-2020 budget implementation bill stipulating that all mental health criteria must be reviewed and approved by the state. Subsequently, the New York Office of Mental Health (OMH) put out draft "Guiding Principles for Acceptable Clinical Review Criteria."
- California recently enacted Senate Bill 855, which requires California health plans to use medical necessity criteria that follows generally accepted standards of care.
- Connecticut, Illinois, and Rhode Island require that when reviewing substance use disorder claims for medical necessity, insurers must apply criteria consistent with American Society of Addiction Medicine (ASAM) standards.
- Oklahoma passed SB 1718 require companies that offer health coverage and are regulated by the state insurance department to follow federal laws on parity in the health care industry. Plans must report annually to the insurance commissioner the process by which they determine the criteria for mental health benefits and the criteria for medical and surgical benefits to be made public by June of each year.

Parity is Important and Needs Attention

As policymakers, you are likely to hear from your constituents as the ongoing struggle between equitable coverage, access to care and insurance restrictions and cost containment continues.

This informational overview is not a recommendation for a particular piece of legislation but there is a need to improve access to behavioral health care for the individuals and families that need it. For Kansans who have health insurance, perhaps the Wit Decision is a good model. The Kansas Insurance Department has been working with the NAIC to improve their processes and identify where their authority begins and ends for enforcing federal parity rules. Perhaps the Kansas Legislature will have a role in assisting the Department as those efforts progress.

Legislatures are expected to continue to update state Parity Laws or implement options such as:

- Mandates for coverage of specific conditions, payment for specific treatments.
- Limiting the use of cost containment tools such as prior authorization and step therapy.
- Empowering state regulatory agencies to apply meaningful oversight and market conduct exams to assure that the current statutes are being implemented.
- Require health plans to use accepted standards of care and medical necessity criteria.

The Kansas Mental Health Coalition reconvened a Parity Committee in April 2019 because of the growing frustration expressed by our members and the action related to parity across the country. The Committee is working to gather data about barriers to parity in Kansas and educate Kansas policyholders, providers and policymakers. We stand ready to work with you, the Kansas Insurance Department, representatives of the insurance industry and policyholders to consider options to improve the implementation of parity in our state. This is expected to be an ongoing commitment.

Untreated mental health and substance use disorders contribute to historic rates of suicides and overdoses, in addition to homelessness and violent encounters with the criminal justice system. As the nation struggles to cope amid a myriad of challenges in 2020 and 2021—the COVID-19 pandemic, racial injustices, political divisiveness, and more—better access to mental health and addiction treatment is critical. The Kansas Legislature has shown great foresight in the past four years to address the growing need, commissioning two reports from the Mental Health Task Force and now the Special Committee on Mental Health Modernization and Reform.

In the broad spectrum of modernizing our mental health system, assuring the effective implementation of mental health parity is absolutely important. Individuals and families who pay for health insurance must be able to expect that their health care coverage will be there when they need it – for physical health and for mental health.

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Timeline of Federal Parity Policies attached
https://www.hhs.gov/about/agencies/advisory-committees/mental-health-parity/task-force/resources/index.html

The Kansas Mental Health Coalition is dedicated to improving the lives of Kansans living with Mental Illnesses and Severe Emotional Disorders. We are consumer and family advocates, provider associations, direct services providers, non-profit and for profit entities and others who share a common mission. At monthly roundtable meetings, participants develop a consensus agenda for legislative advocacy efforts each year. This format enables many groups, that would otherwise be unable to participate in the policy making process, to have a voice in public policy matters that directly affect the lives of their constituencies. The opportunity for dialogue and the development of consensus makes all of us stronger and more effective in achieving our mission.

Year	**Event**
1961	President Kennedy directs the Civil Service Commission (now known as the Office of Personnel Management) to implement parity (by 1975 this was scaled back)
1970s through present day	Parity laws enacted in many states - mostly for small group health plans; some for individual policies; many states establish minimum benefit level requirements for mental health and substance use disorders - employer-sponsored group health plans are generally exempt
1992	The first federal parity legislation is introduced in Congress by Senators Pete Domenici and John Danforth (S.2696)
1996	The Mental Health Parity Act enacted requiring comparable annual and lifetime dollar limits on mental health and medical coverage in large group health plans including employer-sponsored group health plans
1999	President Clinton directs the Office of Personnel Management to implement parity in the Federal Employee Health Benefit Plan (FEHBP)
2003	President Bush's New Freedom Commission on Mental Health includes a recommendation regarding parity in the Commission's Final Report
2008	Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) is signed into law - applying to large group health plans including employer-sponsored plans, effective for most plans starting in 2010 Medicare Improvements for Patients and Providers Act enacted including a provision to phase out statutory provision requiring a higher co-pay for outpatient mental health services
2009	Children's Health Insurance Program Reauthorization Act enacted requiring parity in CHIP plans CMS releases State Health Official letter to provide additional guidance regarding MHPAEA's application to CHIP.
2010	The Affordable Care Act (ACA) enacted and extends parity protections to individual health insurance policies and Medicaid expansions to low-income childless adults
2010	Interim final rules issued to implement MHPAEA effective for most policies and plans in 2011
2013	Final rules are issued to implement MHPAEA - effective for most policies and plans in 2015 Final rules on Essential Health Benefits are issued, implementing mental health and substance use disorder as a category of EHB and extending MHPAEA final rule parity requirements to small group insurance and individual insurance plans starting in 2015 Final rules on Alternative Benefit Plans are issues providing further guidance regarding MHPAEA's application to Essential Health Benefits in this Medicaid program. Medicaid State Health Officials letter published providing guidance on the application of MHPAEA requirements to Medicaid managed care organizations, Medicaid Alternative Benefit Plans, and the Children's Health Insurance Program

2016	TRICARE issues a proposed rule that levels cost sharing between medical-surgical and behavioral health care and eliminates treatment limits for mental health and substance use disorder care
2016	Final regulations issued on parity in Medicaid managed care organizations, Medicaid Alternative Benefit Plans, and the Children's Health Insurance Program

K.S.A. 40-2,105a. Kansas mental health parity act; insurance coverage for services rendered in the treatment of mental illnesses, alcoholism, drug abuse or substance use disorders; limitations. (a) (1) Any group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization that provides medical, surgical or hospital expense coverage shall include coverage for diagnosis and treatment of mental illnesses and alcoholism, drug abuse or other substance use disorders. Reimbursement or indemnity shall be provided for treatment in a medical care facility licensed under the provisions of K.S.A. 65-429, and amendments thereto, treatment facilities licensed under K.S.A. 65-4605, and amendments thereto, a community mental health center or clinic licensed under the provisions of K.S.A. 2020 Supp. 39-2001 et seq., and amendments thereto, a psychiatric hospital licensed under the provisions of K.S.A. 2020 Supp. 39-2001 et seq., and amendments thereto, or by a physician or psychologist licensed to practice under the laws of the state of Kansas. Such coverage shall be subject to the same deductibles, copayments, coinsurance, out-of-pocket expenses, treatment limitations and other limitations as apply to other covered services.

(2) The coverage shall include treatment for in-patient care and out-patient care for mental illness, alcoholism, drug abuse or substance use disorders.

(b) For the purposes of this section, "mental illness, alcoholism, drug abuse or substance use" means any disorder as such terms are defined in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association.

(c) The provisions of this section shall be applicable to health maintenance organizations organized under article 32 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

(d) The provisions of this section shall not apply to any small employer group policy, as defined under K.S.A. 40-2209, and amendments thereto, providing medical, surgical or hospital expense coverage or to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation.

(e) The provisions of this section shall be applicable to the Kansas state employees health care benefits program and municipal funded pools.

(f) The provisions of this section shall not apply to any policy or certificate that provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 40-2227, and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, any coverage issued as a supplement to liability insurance, workers compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

(g) Treatment limitations include limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment.

(h) There shall be no coverage under the provisions of this section for any assessment against any person required by a diversion agreement or by order of a court to attend an alcohol and drug safety action program certified pursuant to K.S.A. 8-1008, and amendments thereto, or for evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody or child visitation proceedings.

(i) Utilization review for mental illness shall be consistent with provisions in K.S.A. 40-22a01 through 40-22a12, and amendments thereto.

History: L. 2001, ch. 178, § 1; L. 2009, ch. 136, § 8; L. 2018, ch. 71, § 13; July 1.