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House Select Committee On Mental Health Hearing

June 2, 2016

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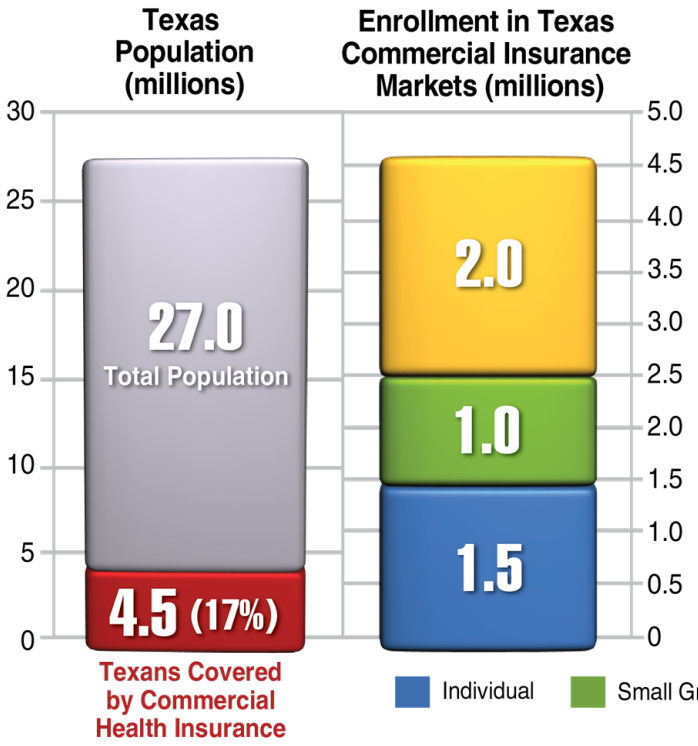
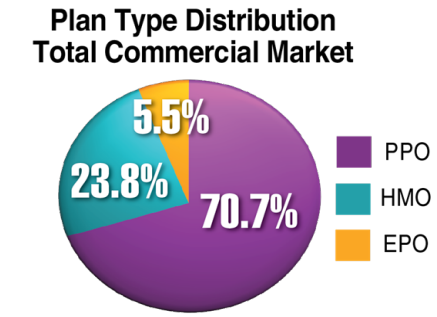
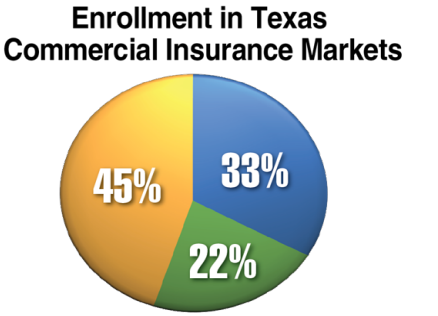
2015 Commercial Health Insurance Market in Texas

- Regulated by TDI
- Mainly Employer- Sponsored
- PPO
  - Most Purchased
  - Higher Premiums
  - Out-of-Network Benefits
  - Referrals not Required
- HMO
  - No Out-of-Network Benefits (Except ER & When Network Provider not Available)
  - May Include PCP Referrals
- EPO
  - No Out-of-Network Benefits (Except ER & When Network Provider not Available)
  - No PCP Referral Requirement







Source: TAHP Enrollment Survey 2015, Miliman Dec. 2015 & TAHP Addendum to 2015 Enrollment Survey, Milliman, April 2016

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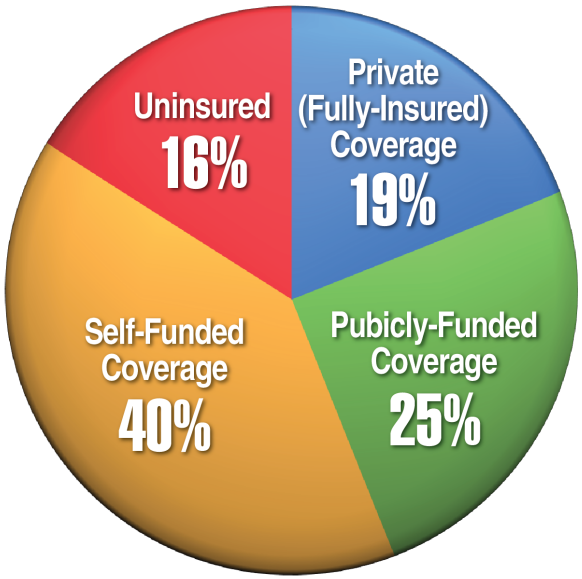
2014 Self-Funded Coverage

Source: Texas Department of Insurance, U.S. Census Bureau, ERS, TRS, FEHBP

Coverage Overview—2014 Texas Populations Estimates



Source: Texas Department of Insurance and U.S. Census Bureau

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Ensuring Access to Quality Behavioral Health Care

- **Health plans and behavioral health organizations support and are committed to the protections established by the Mental Health Parity and Addiction Equity Act**
- **Health plans meet network adequacy and benefit requirements under federal and state laws**
- **In addition to parity, health plans have demonstrated strong leadership in pioneering innovative programs to meet the health care needs of patients with mental health and substance use disorders, often through partnerships with behavioral health care organizations**
  - **Amerigroup:** In Tarrant County, Amerigroup has partnered with a local non-profit to provide supportive housing for individuals experiencing homelessness. This project has helped individuals remain stable after discharge and prevent repeat hospitalizations.
  - **Cigna:** Cigna recently announced it is pursuing an evidence-based approach to substance abuse treatment and opioid addiction. It aims to cut its customers' prescriptions for opioid treatments by 25% over the next three years.
  - **Cigna:** Cigna Health Spring implemented an intensive behavioral health intervention that reduces the overall costs for the top 5% most expensive members by 40%. This program serves members with schizophrenia, bipolar disorder, substance abuse disorder, and personality disorder. Its motto is, "Do whatever it takes to allow the member to live as independently as possible".
  - **Driscoll Health Plan:** 20 counties served by Driscoll Health Plan in South Texas have no child and adolescent psychiatrists. Driscoll developed an initiative to better serve their members including education for PCPs in behavioral health concerns in children and convened a joint project with UTMB and Behavioral Health Services of Nueces County to implement the Tele-Psych Clinic.
  - **United Healthcare:** United partnered with local homeless coalitions in Houston and Austin to track down the health plan's members who don't have a stable place to live. This allows United to work with those members to find subsidized housing and help coordinate their health care. The goal is to ensure that high-risk members will make fewer expensive visits to the emergency room if they have a safe place to live. Working with ECHO (Austin homeless coalition) and the Houston Homeless Coalition, the United Pilot Program includes engagement in housing needs assessment, assignment of a housing case manager, immediate enrollment with a PCP, and a dedicated service coordinator.

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Mental Health and Substance Abuse Coverage

- **The Mental Health Parity Act (1996) and the Mental Health and Addiction Equity Act (2008) do not mandate coverage, only require that when such benefits are offered through an employer, they be offered at full parity**
  - Only applied to large employer plans (51+)
  - Does not mandate coverage
- **Texas Mental Health Mandate**
  - Applies to large employer groups
  - Must provide SMI - At least 45 inpatient days & 60 outpatient visits
  - Requires financial limitations be the same for medical care
- **The Affordable Care Act**
  - Expanded the federal parity requirements to:
    - qualified health plans
    - plans offered through the small employer and individual market
  - Mandated mental health and substance abuse services through the essential health benefits package (mandate only applies to individual and small groups that are not grandfathered)
  - Created guaranteed issue regardless of preexisting coverage – everyone can purchase coverage
  - Ended all lifetime and yearly dollar limits
  - Free preventive care with no cost-sharing: Includes screening adults for depression

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Mental Health and Substance Abuse Coverage

- **End Result: All new commercial plans offered on or after January 1, 2014, in the individual, small employer, and large employer markets are required to:**
  - Provide mental health and substance abuse coverage (EHB Mandate and Texas Mandate)
  - Ensure parity of coverage
  - Offer and sell this coverage to anyone regardless of a pre-existing condition
  - Have no annual or life time limits
  - Provide preventive care at no cost with no cost-sharing: Including screening adults for depression
- **Grandfathered Plans: "You can keep your coverage" – Any grandfathered or transitional plans (grandmothered) are exempt from:**
  - The mental health and substance abuse mandate in the essential health benefits package (small group and individual)
  - Parity: Small group (2-50 employees)
- **All commercial plans in Texas must meet TDI's network adequacy standards, which include distance and wait times for behavioral health providers**
- **Increased access to coverage: 20% increase in the commercial market (Increased from 3.6 to 4.5 million from 2013 to 2015), 115% increase in individual market**

Grandfathered Plan: Plan existed prior to March 10, 2010 **Transitional Plan (Grandmother Plan):** Sold between March 23, 2010 and January 1, 2014. Must be ACA compliant by December 31, 2017

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Mental Health & Substance Abuse: Coverage & Parity

Type of Coverage	Mandate for Mental Health and Substance Abuse Disorders	Mental Health and Substance Abuse Parity (Only Applies if the Plan is Providing Coverage)
Individual • ACA Marketplace • Outside of the Marketplace • Grandfathered/Grandmother	ACA EHB Mandate • Yes - EHB • Yes - EHB • Not required to follow EHB	Yes (if not GF/transitional) – EHB • Yes (through EHB) • Yes (through EHB) • Yes
Small Employer • Grandfathered/Grandmother • ACA Marketplace (SHOP) • Outside of the Marketplace	ACA EHB Mandate • Not required to follow EHB • Yes - EHB • Yes - EHB	Yes (if not GF/transitional) - EHB • No (2 - 50 employees), Yes 51+ • Yes (through EHB) • Yes (through EHB)
Large Employer (51+)	State Mandate for SMI - No EHB	Yes – State mandate for SMI
Self Funded • Large Group • Small Group	No State SMI Mandate Not required to follow EHB Not required to follow EHB	Yes (51+) Yes (51+) No (2-50 employees)

Grandfathered Plan: Plan existed prior to March 10, 2010 **Transitional Plan (Grandmother Plan):** Sold between March 23, 2010 and January 1, 2014. Must be ACA compliant by December 31, 2017

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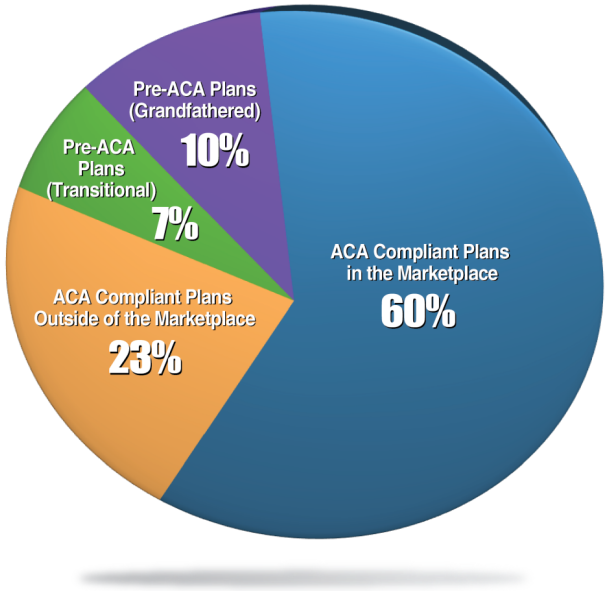
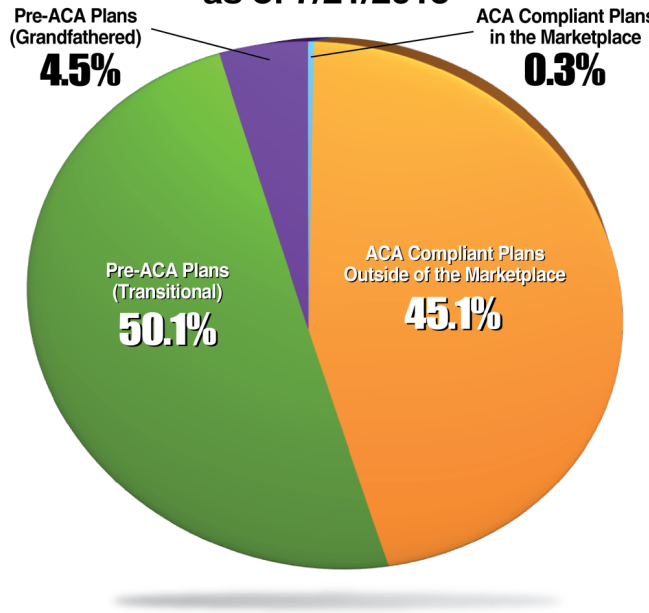
ACA Compliant Plans: Distribution

Individual Market: Distribution of Enrollment as of 7/21/2015



Source: Texas Association of Health Plans: Enrollment Survey 2015, Milliman Dec. 2015

Small Group Market: Distribution of Enrollment as of 7/21/2015



Source: Texas Association of Health Plans: Enrollment Survey 2015, Milliman Dec. 2015

Grandfathered Plan: Plan existed prior to March 10, 2010 **Transitional Plan (Grandmother Plan):** Sold between March 23, 2010 and January 1, 2014. Must be ACA compliant by December 31, 2017

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Parity Regulation

- **Dual regulatory approach**
- **TDI regulates group health policy forms for parity based on the Texas mental health and substance abuse mandate and the 2011 TDI Parity Rules (quantitative parity)**
- **Federal regulators review individual and small group policies for compliance with essential health benefits**
  - Since Texas is one of five states that has opted out of ACA enforcement, federal agencies regulate the additional parity and mandate requirement related to mental health and substance abuse in the Affordable Care Act
- **Federal regulators enforce parity based on the 2014 final federal rules issued by Department of Treasury, Labor, and Health and Human Services for parity (quantitative and non-quantitative limits)**

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Federal Parity Rules

- **Plans may not impose any financial requirements or treatment limitations that only apply to mental health and substance use disorder**
- **If out-of-network coverage is a benefit, it must also apply to mental health and substance use disorders**
- **Must use the same type of of process and standards to determine medical necessity and prior authorizations (standards and reason for denial must be disclosed)**
- **Creates classifications of benefits under which parity rules apply - Benefits must be provided in all classifications**
  - Inpatient, in-network and out-of-network
  - Outpatient, in-network and out-of-network
  - Emergency Care
  - Prescription Drugs
- **The "substantially all/predominate" test outlined in statute must be applied separately to six classifications of benefits.**
  - Plans are prohibited from imposing a financial requirement or treatment limit that is more restrictive than the "predominant" financial requirement or treatment limit restriction that applies to "substantially all" medical/surgical benefits in the same classification
    - "Predominate" was defined as "more than half" and "Substantially all" was defined as "two-thirds"
- **The Regulation distinguishes between quantitative and nonquantitative treatment limitations**

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Federal Parity Rules

- **Quantitative treatment limitations apply to deductibles, copays, coinsurance, out-of-pocket maximums, number of treatments, visits, or days of coverage.**
- **Nonquantitative treatment are not expressed numerically but otherwise limit the scope or duration of benefits for treatment; they include but are not limited to medical management, step therapy and pre-authorization.**
- **Nonquantitative treatment limitations include:**
  - Medical management standards limiting benefits based on medical necessity, experimental/investigative status
  - Formulary design
  - For plans with multiple network tiers, network tier design
  - Standards for provider admission to participate in a network, including reimbursement rates
  - Plan methods for determining usual, customary, and reasonable charges
  - Step therapy protocols or fail-first policies
  - Exclusions based on failure to complete a course of treatment
  - Restrictions based on geographic location, facility type, provider
  - specialty, and other criteria that limit the scope or duration of benefits for covered services
- **Any nonquantitative treatment limits applied to mental health or substance use disorder benefits in a classification must be comparable to, and applied no more stringently than, the limitations applied with respect to medical/surgical benefits in each classification**

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Medicaid Parity Rules

- Final rule published on March 30, 2016 by CMS
- Rule is effective 18 months from publication: September 29th, 2017
- States have flexibility in defining how they cover and deliver Medicaid MH/SUD services, which are largely optional benefits
- Final rule aims to ensure that beneficiaries enrolled in MCOs have access to a set of benefits that meets parity
- MCOs must inform the state of changes required to bring the MCO contracts into compliance with parity
- In Medicaid, parity also applies to long-term care services (CMS plans to provide additional information to states regarding the application of parity to long-term care services)
- State must conduct oversight

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Medicaid Parity Rules

- **Quantitative limits - Not as big of a factor, as there are no co-pays or deductibles, or lifetime or annual limits in Medicaid**
  - Does apply to financial requirements or treatment limitations - Cannot be more restrictive than the "predominant" financial requirement or treatment limitation of that type that is applied to "substantially all" medical/surgical benefits
  - Must be applied on a classification by classification basis
  - Four classifications: inpatient, outpatient, emergency care, and prescription drugs
- **Nonquantitative Treatment Limitations**
  - Examples: Prior authorizations, geographic limitations, medical management standards, prescription drug formulary design, standards for provider admission to participate in a network, conditioning benefits on completion of a course of treatment
- **May not be imposed in a classification unless the "factors" are comparable and "applied no more stringently"**
  - "Factors" include process, strategies, evidentiary standards, or other considerations used in determining limitations
  - "Applied no more stringently" – requires that any process, strategies, evidentiary standards, or other considerations that are comparable on their face be applied in the same manner
  - CMS "Points of Clarifications" - factors depend on the nature of the limit and the benefit - There may not be a single factor or set of factors that can be practically applied the same, so they can be comparable (apples to oranges problem)
- **Reimbursement Rates – May use a wide array of factors for determining provider rates**
  - Service type, geographic market, demand for services, supply of providers, provider practice size, Medicare rates, training, experience, and licensure
  - Factors must be comparable – However, different reimbursement rates and results do not mean the methodology failed to meet parity

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Key Considerations: Mental Health and Substance Abuse Treatment

- **Lack of coverage options for low-income adults**
  - A substantial number of Texans with a mental health or substance use disorder do not qualify for Medicaid and have incomes that are too low to qualify for financial assistance to purchase individual health insurance (<100 of FPL)
  - Coverage gap – Cannot afford coverage
  - Expand coverage options: Mental Health Medicaid Expansion
- **Provider shortages**
- **Lack of coordination and integration of MH/SUD services with medical services**
  - Research shows that lack of coordination between providers is one obstacle for patients seeking mental health services
  - Health plans are uniquely positioned to coordinate care across the fragmented delivery system and ensure patients receive the right treatment and support to manage mental and behavioral health issues
  - Health plans see a patient's entire interaction with the health care system
  - Health plans have information on whether the patient is filling his/her prescription or getting care in another setting. This information is critical to diagnosing patients correctly and helping to ensure they are getting the best care possible
- **Mental health and substance abuse coverage only goes so far and usually does not include:**
  - Housing assistance
  - Vocational training and support
  - Crisis intervention
  - Peer support services

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Medical Necessity (Prior Authorization) Reviews

- Utilization Review (UR): review of the medical necessity and appropriateness or experimental or investigational nature of health care services. It does not include a review in response to an elective request for clarification of coverage.
- TX Ins. Code requires UR screening criteria to be evidence-based, scientifically valid and compatible with established principles of health care.
- Adverse determinations (denials) may only be determined by an appropriate physician or other licensed health care provider.
- Before issuing an adverse determination (denial), health plan or UR agent must provide a reasonably opportunity for the treating provider to discuss the plan of treatment for the enrollee and clinical basis for the denial with a physician ("peer-to-peer" discussion).
- For life-threatening conditions, the notification of adverse determination must include notice of the independent review process and an IRO request form.
- A health plan or UR agent may not compensate employees or agents based on volume of adverse determinations, reductions of or limitations on lengths of stay, benefits, services, or charges.
- Health plans and UR agents may not require the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes; can require only a summary of an enrollee's mental health medical record.

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Appeals of Adverse Determinations (Prior Authorization Denials)

- The enrollee, a person acting on behalf of the enrollee, or the treating provider may appeal a health plan's or UR agent's adverse determination.
- For a life-threatening condition, the enrollee is entitled to an immediate appeal to an IRO and is not required to comply with the health plan's or UR agent's procedures for appeal.
- Appeal decisions must be made by a physician who has not previously reviewed the case.
- Appeals must be resolved "as soon as practical," but in no case later than 30 calendar days after receipt of the appeal.
- Expedited appeals are available for denials of emergency care, care for life-threatening conditions, continued hospitalization stays and concurrent review of prescription drugs or intravenous infusions (i.e., for which the enrollee is receiving benefits).
- Expedited appeals must include a review by a health care provider who has not previously reviewed the case and who is of the same or a similar specialty and must be completed based on the immediacy of the condition, procedure, or treatment, but no later than one working day from receipt of all necessary information.
- If an appeal is denied, the treating provider may (within 10 days of the denial) request a "specialty review" of the denial by a health care provider in the same or similar specialty. The specialty review must be completed within 15 working days of receipt of the request.

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Independent Review Process

- Any party who receives an adverse determination involving a life-threatening condition or concurrent review of prescription drugs or intravenous infusions, or whose appeal of an adverse determination is denied, may seek review of that determination or denial by an Independent Review Organization (IRO) assigned by TDI.
- The health plan or URA must notify TDI within one working day of receiving a request for an independent review. Within one working day of receipt of a complete request, TDI will randomly assign an IRO to conduct an independent review and notify all parties.
- The health plan and URA must comply with the IRO's determination with respect to the medical necessity or appropriateness, or the experimental or investigational nature, of the health care items and services for an enrollee.
- The health plan or URA must pay the costs for an independent review.
- IRO's timeframes so you may want to add that: The IRO has 20 days from the date TDI assigned the case or 3 days for life-threatening conditions.

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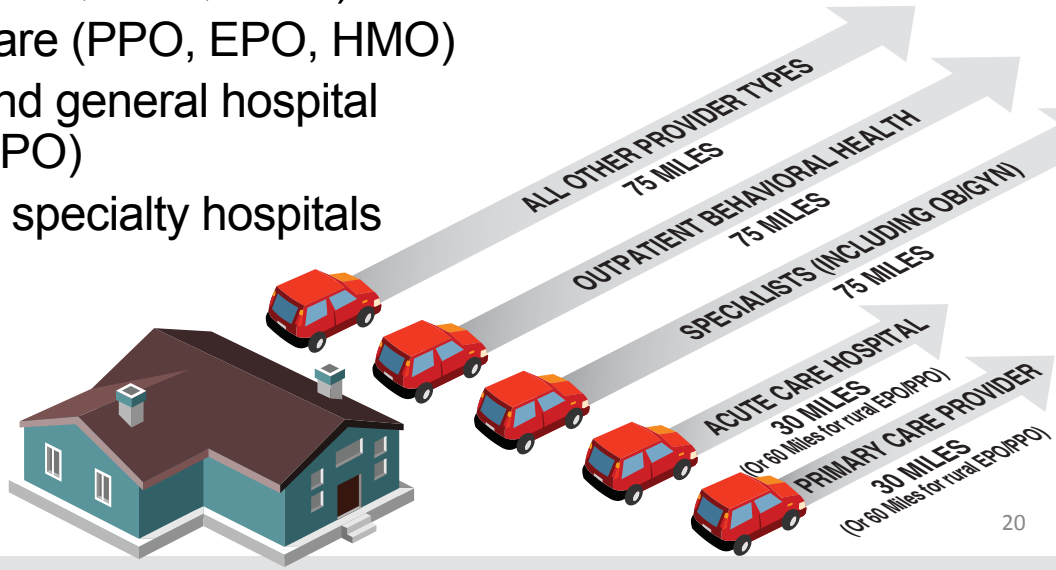
CMS Enforcement of the ACA

- If a state informs CMS that it does not have authority to enforce one or more of the provisions of the Affordable Care Act, and the state has not entered into a collaborative arrangement, CMS has the responsibility to directly enforce the relevant provisions in the state with respect to health insurance issuers in the group and individual markets
- To do so, CMS will notify issuers in the state that they must submit policy forms to CMS for review
- After collection and review of policy forms for compliance with the respective market reform provisions, CMS will notify issuers of any concerns
- CMS will also conduct targeted market conduct examinations, as necessary, and respond to consumer inquiries and complaints to ensure compliance with the health insurance market reform standards
- CMS will work cooperatively with the state to address any concerns
- At any time, a state that is willing and able may assume enforcement authority of the Affordable Care Act market reform standards. When that happens, CMS will work with the state to ensure an effective transition

Texas Department of Insurance: Distance Requirements

- **Maximum distance from any point in a health plan's service area:**
  - 30 miles for primary care (PPO, EPO, HMO)
  - 30 miles general hospital care (PPO, EPO, HMO)
  - 60 miles for primary care and general hospital care in rural areas (PPO, EPO)
  - 75 miles for specialists and specialty hospitals (PPO, EPO, HMO)



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Texas Department of Insurance: Wait Times

- **EPO & PPO Wait Times**
  - ER - 24 hours a day, 7 days a week
  - Non - emergency, urgent care - within 24 hours
  - Preventive care - within 2 months for a child and 3 months for adults
  - Appointment for medical condition - within 3 weeks
  - Appointment or behavioral health conditions - within 2 weeks
- **HMO Wait Times**
  - ER Care - 24 hours a day, 7 days a week
  - Preventive health - within 2 months for a child, 3 months for an adult, and 4 months for dental services
  - Routine care - within 3 weeks for medical services, 8 weeks for dental conditions, and 2 weeks for behavioral health conditions
  - Urgent care - within 24 hours for medical, dental, and behavioral health conditions

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HHSC: Medicaid Distance Requirements

CATEGORY	PROVIDER TYPE	GEOGRAPHY	ACCESS REQUIREMENT	PERCENT OF MEMBERS
Medical Providers	PCP*	Statewide	30 miles	90%
	Acute Care Hospital		30 miles	
	Specialists (including OB/GYN)		75 miles	
	Outpatient Behavioral Health	Urban	30 miles	
		Rural	75 miles	
	All Other Provider Types	Statewide	75 miles	
Pharmacy	Non-MRSA**	Urban	2 miles	80%
		Suburban	5 miles	75%
		Rural	15 miles	90%
	MRSA	Urban	2 miles	75%
		Suburban	5 miles	55%
		Rural	15 miles	90%
	24-Hour Pharmacy	Statewide	75 miles	90%
Dental	Main Dentist	Urban	30 miles	95%
		Rural	75 miles	95%
	Specialists	Statewide	75 miles	75%

HHSC may assess up to $1,000 in liquidated damages per quarter, per program, per service area, and per provider type.

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HHSC: Medicaid Wait Times

SERVICE TYPE	WAIT TIME
Emergency services	Upon member presentation at service delivery site
Urgent care	Within 24 hours
Routine primary care	Within 14 days
Initial outpatient behavioral health	Within 14 days
PCP referrals to specialty	No later than 30 days
Pre-natal care	Within 14 days
Pre-natal care for high-risk pregnancy	Within 5 days
Preventive health services—adults	Within 90 days
Preventive health services—children	In accordance with periodicity schedule

HHSC may assess up to $1,000 in liquidated damages per quarter, per program, per service area, and per provider type.