House Select Committee On Mental Health Hearing
June 2, 2016

Texas Department of Insurance

2016

Issues in Regulating Mental Health Parity in Insurance Coverage

Health insurance regulation

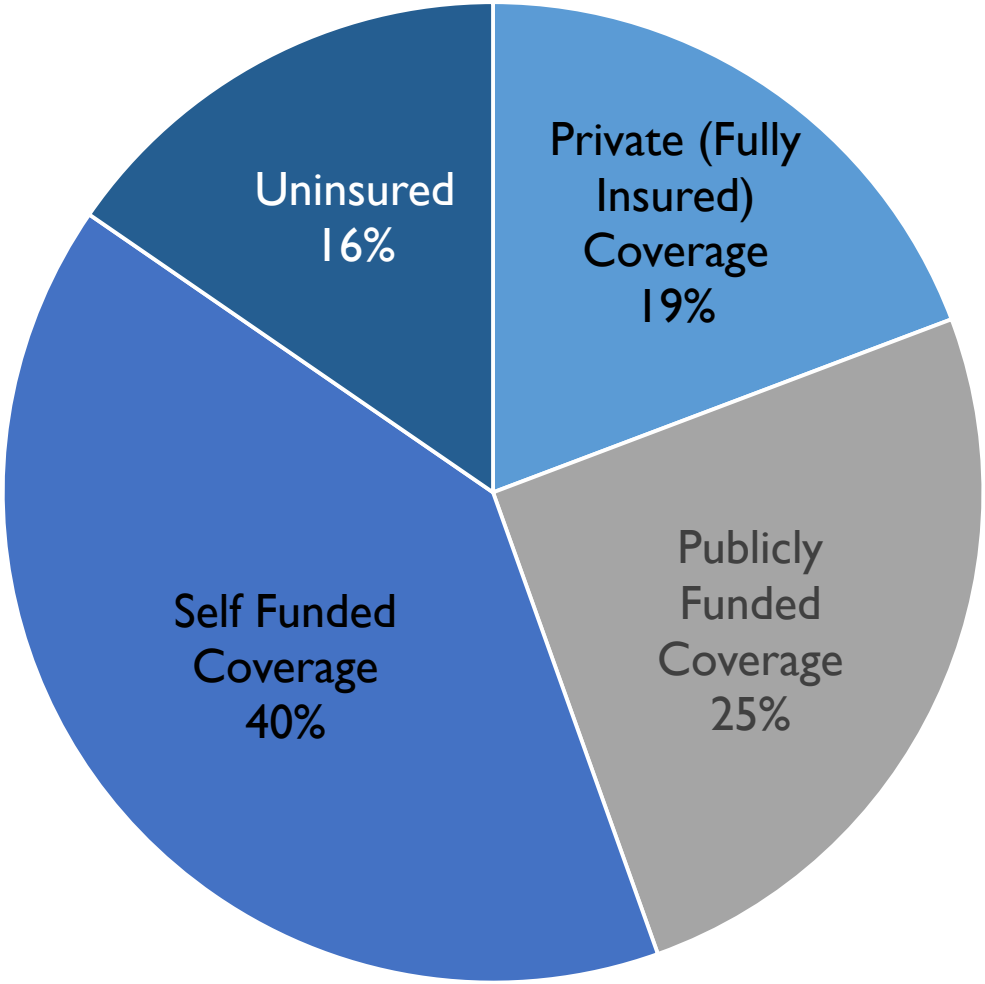
Parity regulations

- History
- State and Federal Requirements
- Compliance

Network adequacy

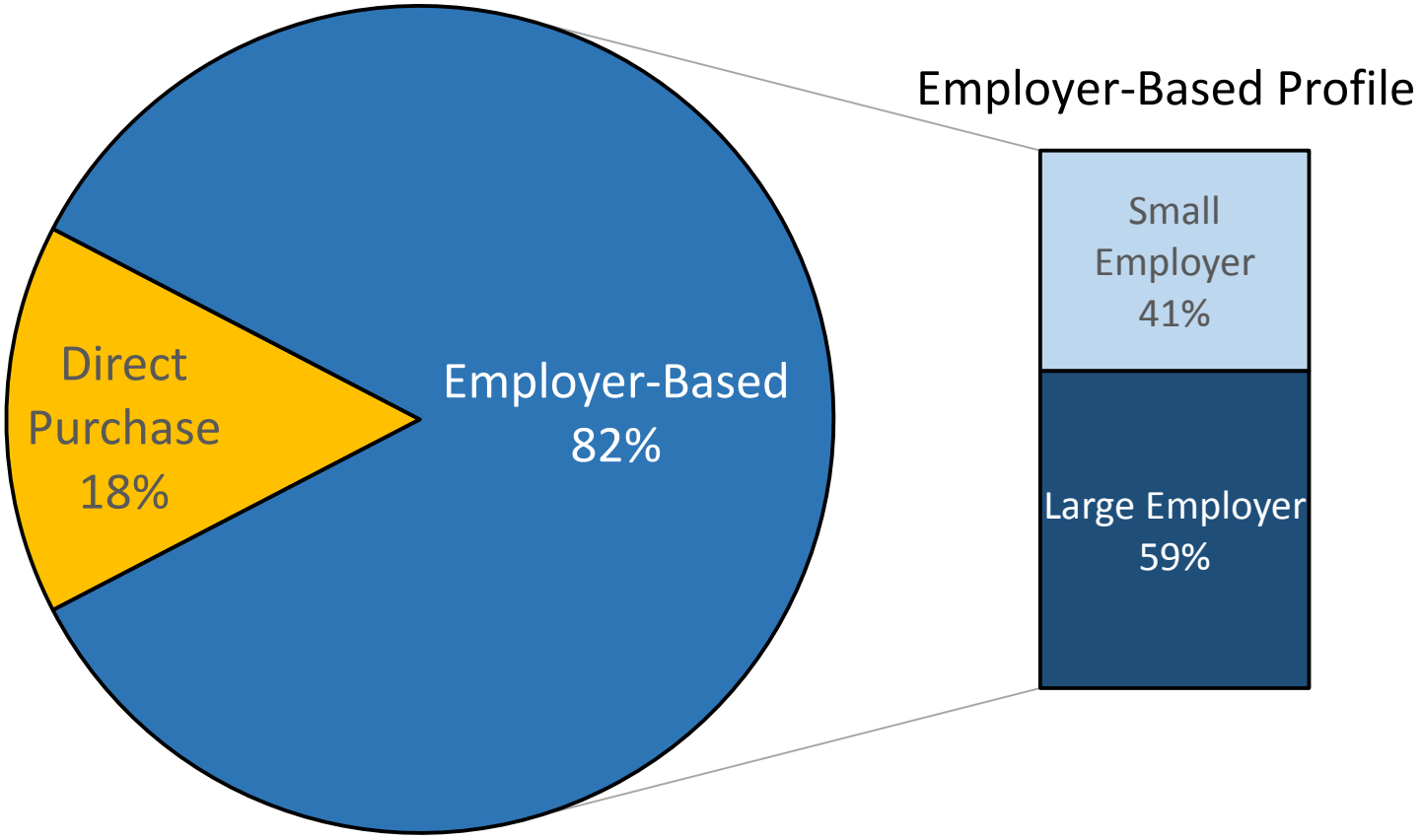
Medical necessity

Coverage Overview – 2014 Texas Populations Estimates



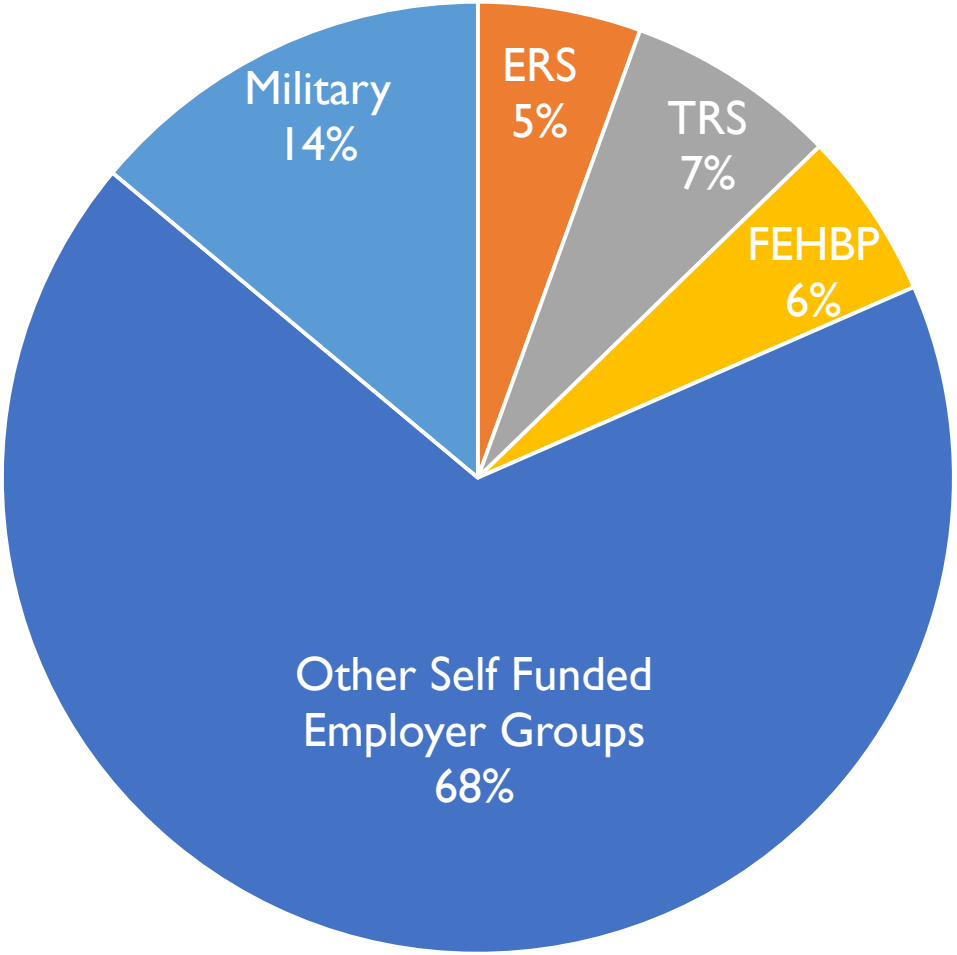
Source: US Census Bureau

Fully Insured Sources of Coverage in 2014



Source: US Census Bureau and TDI

2014 Self-Funded Coverage



Source: US Census Bureau, ERS, TRS, and FEHBP

Types of Coverage: Fully Insured Major Medical Plans

Individual major medical (including consumer choice plans): • Health Maintenance Organization plans (HMO) • Preferred Provider Organization plans (PPO) • Exclusive Provider Organization plans (EPO)
Small and large group major medical (including consumer choice plans)
Small and large employer health group cooperatives
Major medical plans issued by: • Group hospital service corporations • Approved nonprofit health corporations • Stipulated premium companies • Fraternal benefit societies • Reciprocal exchanges
Child only health plans
Professional employer organization plans (PEOs) and multiple employer welfare arrangements (MEWAs)
Group health plans issued by unlicensed carriers outside of Texas but covering Texas residents

Types of Coverage: Self-Funded Group Health Plans

Local governmental employee plans (city and county employees)
State employee plans (ERS)
State university plans (UT, A&M, etc.)
Church employee plans
Local government plans offered to the public
Public school employee plans (TRS)
Private employer plans (ERISA)
Federal employee plans
Military employee plans (Tricare)

Types of Coverage: Public Plans

Medicaid

Children's health insurance program (CHIP)

Medicare

Types of Coverage: Other Plans

Lloyd's plans
Blanket accident and health policies
Short term medical policies
Travel insurance
Accident-only or accidental death and dismemberment insurance
Limited or specified disease policies
Supplemental insurance (Medicare supplement)
Long term care
Disability
Dental or vision insurance
Fixed indemnity policies
Workers' compensation insurance or occupational accident

Mental Health Parity – Complaints by Year

	2013	2014	2015
TOTAL # COMPLAINTS	0	7	10
CONFIRMED* COMPLAINTS	0	3	0

*A "confirmed complaint" is one for which TDI receives information indicating that:

(1) an insurer committed any violation of:

(A) an applicable state insurance law or regulation;

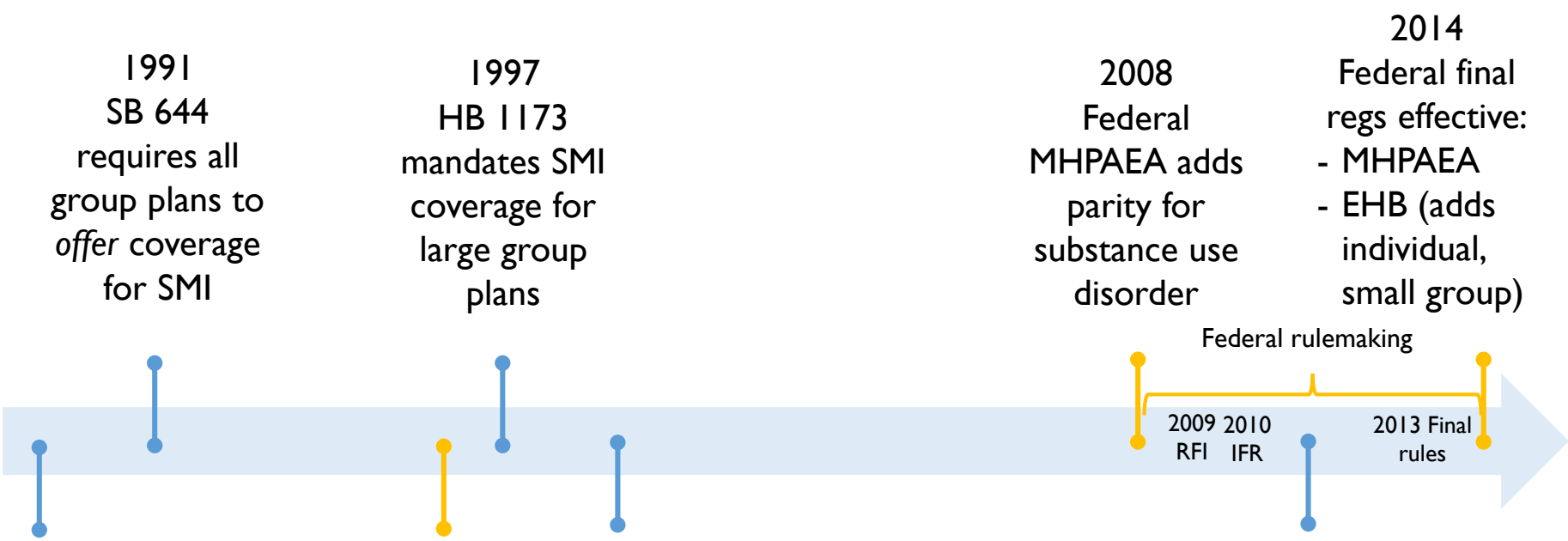
(B) a federal requirement TDI has authority to enforce; or

(C) the term or condition of an insurance policy or certificate; or

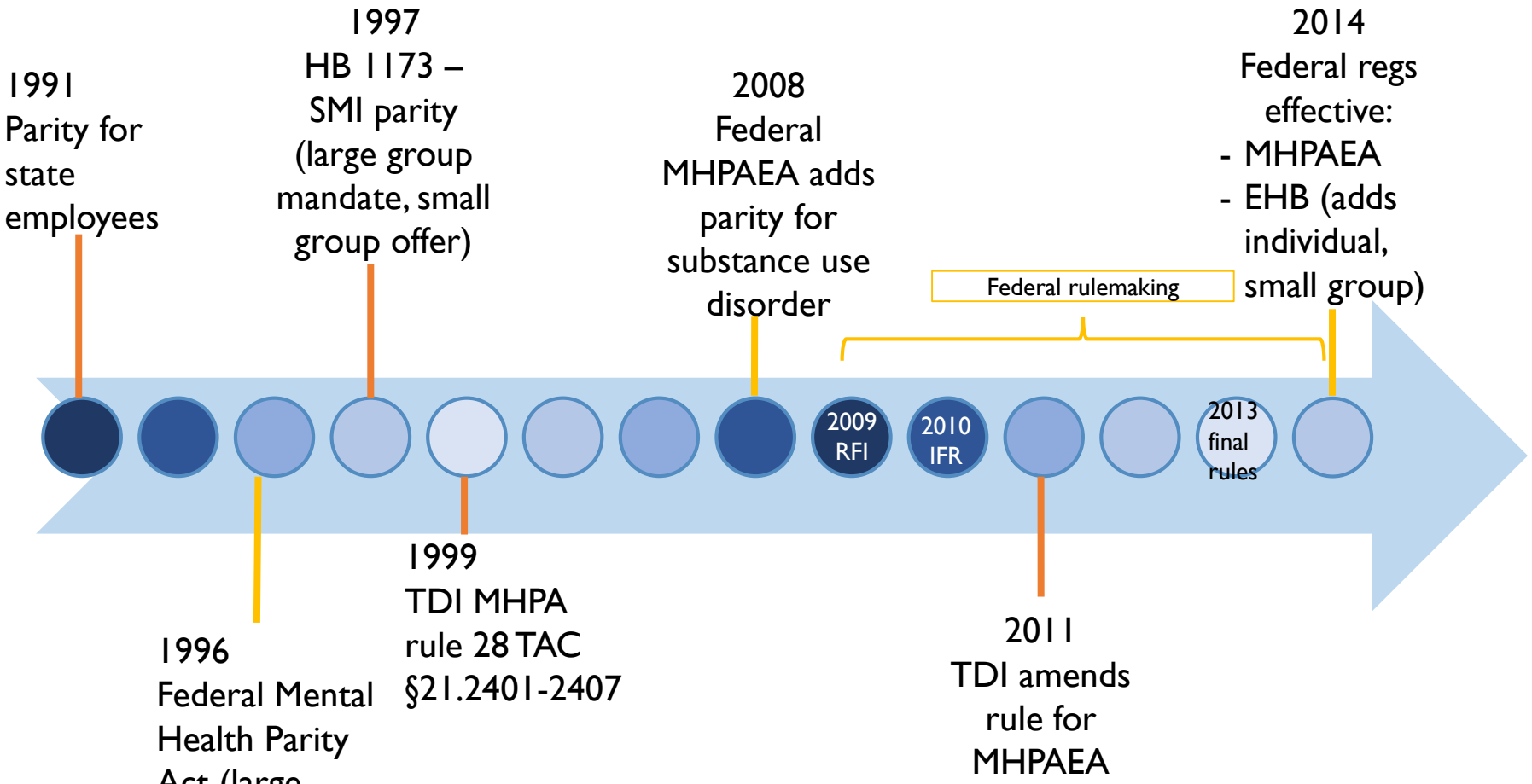
(2) the complaint and insurer's response, considered together, suggest the insurer was in error or the complainant had a valid reason for the complaint.

28 Tex. Admin. Code 1.603

Mental Health Parity Timeline



Mental Health Parity Timeline



SB 911, 71st Texas Legislature, 1989

Mandates coverage for the treatment of chemical dependency (previously limited to alcohol dependency) in both small and large group plans

- Requires benefits no less favorable than those for physical illness and subject to the same durational limits, dollar limits, deductibles, and coinsurance factors

Requires TDI to adopt rules that include guidelines addressing cost control, treatment periods, extensions, and utilization review

Current requirements in TIC Chapter 1368 and 28 TAC, Chapter 21, Subchapter P

SB 644, 72nd Texas Legislature, 1991

Defines Serious Mental Illness (SMI) to include:

- Schizophrenia
- Paranoid and other psychotic disorders
- Bipolar disorders (mixed, manic, and depressive)
- Major depressive disorders (single episode or recurrent)
- Schizo-affective disorders (bipolar or depressive)

Requires group health plans for state and local government, public university, and school district employees to cover SMI

- Coverage for SMI may not be less extensive than for physical illness

Requires issuers to offer coverage for SMI to all major medical group health plans

- Coverage offered must be at least as favorable as coverage for other major illnesses and include the same durational limits, amount limits, deductibles, and coinsurance factors

Federal Mental Health Parity Act of 1996

Only applied to large employer health plans
Did not mandate coverage of mental health services
Large group plans that cover mental health services must do so in parity only with respect to • Annual dollar limits • Aggregate lifetime limits
Did not require parity for broader coverage terms
Did not extend to substance use disorder services

HB 1173, 75th Texas Legislature, 1997

Adds the following diagnoses to the definition of SMI: • Pervasive developmental disorders • Obsessive-compulsive disorders • Depression in childhood and adolescence
Mandates SMI coverage for large employer plans and continues to require an offer of coverage for small employer plans
Replaces "at least as favorable" standard with 45/60 days of inpatient/outpatient treatment
Prohibits lifetime limits on the number of inpatient/outpatient days
Requires the same amount limits, deductibles, and coinsurance factors for SMI and physical illness
Prohibited counting medication management visits toward any outpatient visit limit
Current requirements in TIC Chapter 1355

TDI MHPA Rules 1999

Created 28 TAC, Chapter 21, Subchapter P
Implemented Federal Mental Health Parity Act of 1996 (MHPA)
Applies only to large employer plans (50+ employees); small employer plans are exempt
Consistent with MHPA, a group health plan may qualify for an exemption if parity increases the cost of coverage at least 1%

Wellstone-Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008

Effective for plan years beginning on or after October 3, 2009
Extended parity to substance use disorder (SUD) benefits in addition to mental health
Expanded parity to coverage terms related to: • Financial requirements, including deductibles, copayments, coinsurance, and out-of-pocket expenses • Treatment limitations, including limits on the frequency of treatment, number of visits, days of coverage, or similar limits on scope/duration of treatment
Coverage terms for MH/SUD benefits cannot be more restrictive than the predominant coverage terms that apply to substantially all of the medical/surgical benefits

MHPAEA Requirements

Plans may not impose any financial requirements or treatment limitations that only apply to MH/SUD benefits
If a plan covers out-of-network coverage for medical/surgical benefits, it must provide out-of-network coverage for MH/SUD
Requires plans to use the same type of processes and standards to determine medical necessity and require prior authorization
Standards for medical necessity criteria and reasons for denial of MH/SUD services must be disclosed upon request

TDI MHPA Rules 2011

Updated 28 TAC, Chapter 21, Subchapter P to apply MHPAEA standards, prohibiting financial requirements and treatment limits from being more restrictive than the predominant requirements or limits applied to substantially all medical and surgical benefits covered by the plan

- Predominant – most common or frequent type of financial requirement or treatment limitation
- Substantially all – applies to at least 2/3 of all benefits (based on dollar amount of expected claims)within a classification of benefits

Includes classifications of benefits consistent with federal rules, within which predominant requirements and limits are determined

Requires out-of-network benefits for MH/SUD if available for medical/surgical benefits

Federal MHPAEA Rules

Issued by Departments of Treasury, Labor, and Health and Human Services
2009 – Request for Information (RFI) published in April, with comments due in May
2010 – Interim Final Rules (IFR) published in February, with majority of rules effective in April
2013 – Rules finalized in November with changes and clarifications to rules concerning non-quantitative treatment limits
2014 – Rules effective in July, upon plan renewal

Federal MHPAEA Rules

Creates classifications of benefits under which parity rules apply

A financial requirement or treatment limit that applies to MH/SUD may not be more restrictive than the predominant requirement or limit that applies to substantially all medical/surgical benefits in the same classification:

- Inpatient in-network; inpatient out-of-network
- Outpatient in-network; outpatient out-of-network
- Emergency
- Prescription drugs

If MH/SUD is covered under the plan, benefits must be provided in all classifications in which medical/surgical benefits are provided

All cumulative financial requirements (e.g., deductible, out-of-pocket limit) in a classification must combine medical/surgical and MH/SUD benefits

Federal MHPAEA Rules

Distinguishes between quantitative and nonquantitative treatment limitations and requires parity for both

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 limit for MH/SUD benefits must be comparable to and applied no more stringently than medical/surgical limits, including with respect to the processes and standards used to apply the limit

State vs. Federal Requirements

	State		Federal	
	Mental Health	**Substance Use**	**Mental Health**	**Substance Use**
Individual			EHB, MHPAEA	EHB, MHPAEA
- Mandate	No	No	Yes	Yes
- Parity	No	No	Yes	Yes
Small Group	TIC §1355.007	TIC §1368.005	EHB, MHPAEA	EHB, MHPAEA
- Mandate	Offer	Yes	Yes	Yes
- Parity	Offer	Yes	Yes	Yes
Large Group	TIC §1355.004	TIC §1368.005	MHPAEA	MHPAEA
- Mandate	Yes	Yes	No	No
- Parity	Yes	Yes	Yes	Yes

Parity Regulation

Dual regulatory approach
TDI reviews group health policy forms for compliance with Texas requirements (SMI, quantitative parity)
Federal regulators review individual and small group policies for compliance with essential health benefits
Federal regulators enforce parity consistent with rules that address quantitative and non-quantitative limits

Network Adequacy

Health plans are required to provide an adequate network for an entire service area.

All covered services must be accessible and available so that travel from any point in a service area to a point of service is no greater than:

- 30 miles for primary and general hospital care; and
- 75 miles for specialty care, specialty hospitals, and single healthcare service plan physicians or providers.

Access Plans

Must be submitted by health plan if any covered health care service or participating physician/provider is not available to an enrollee

Key elements of access plans:

- Geographic area(s) where services are not available and the reason(s) covered health care services cannot be made available for each area
- The plan for making health care services available in each area; the procedures to be followed by the plan to assure health care services are made available and accessible to enrollees; and any carrier plans for developing future networks

PPO and EPO Waiver Requests

Waiver request must include a list of the providers or physicians within the relevant service area that the insurer attempted to contract with

An insurer may apply for a waiver from one or more of the network adequacy requirements if the insurer demonstrates that providers or physicians necessary for an adequate local market network:

- Are not available to contract; or
- Have refused to contract on any terms or on reasonable terms

The insurer must provide a description of how and when they last contacted each provider and physician and a description of any reason the provider gave for refusing to contract with the insurer.

The insurer must also submit a copy of the waiver request to any provider or physician named in the waiver request at the same time the waiver request is submitted to TDI.

Approved waiver requests are posted on TDI'website

An insurer may apply for renewal of a waiver annually

Process for Approval/Denial of Medical Services

TDI does not define or determine what is "medically necessary." Medical necessity decisions are made through a system of utilization review, defined at TIC §4201.002(13) as "a system for prospective, concurrent or retrospective review of medical necessity and appropriateness of health care services…."

Each health plan defines "medically necessary" in accordance with the health plan's policies and benefits described in the evidence or coverage.

TDI reviews and approves processes and policies of certified or registered URAs. However, TDI does not review or approve medical/clinical guidelines that these entities utilize to determine medical necessity.

Process for Approval/Denial of Medical Services

Process begins when patient or physician requests a service that requires preauthorization.

If the request is denied as not medically necessary, the provider, enrollee or person acting on behalf of the enrollee, can appeal the denial.

If the denial is upheld by the second reviewer, the provider or enrollee can request a review by an **Independent Review Organization (IRO)**.

URAs must submit IRO requests to TDI within 1 day of receipt

TDI assigns request to certified IRO

- Expedited reviews – 3 days to respond; non-expedited reviews – 20 days to respond
- IRO decision is binding on health plan; decision provided to all parties by IRO
- Health plan must pay for IRO review
- If parties disagree with IRO decision, may pursue in district court