



Behavioral Health Parity—

Where Are We Now and Where Do We Need to Go?

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On the 10th anniversary of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, many stakeholders including the Kennedy Forum, the Association for Behavioral Health and Wellness, America's Health Insurance Plans, National Alliance on Mental Illness, and National Council for Behavioral Health declared continued support for, and further commitment to, creating parity in behavioral health treatment and coverage. The largest share of health spending in this country is on mental disorders,¹ signaling the need for more and better mental health/substance use disorder (MH/SUD) treatment. Indeed, the opioid and suicide epidemics annually claim tens of thousands of lives and cost the economy hundreds of billions of dollars.

Mental health parity is a right. Everyone deserves access to equitable, affordable, medically appropriate, high-quality mental health and addiction services and treatment. Although more work needs to be done to implement this complex law, it is important to recognize the progress that payers specifically have made to date, including:

- » Aligning behavioral health co-payments with medical visit co-pays;
- » Eliminating arbitrary treatment limitations on the number of days of coverage for a condition, as well as financial limits on annual and lifetime dollar caps;
- » Adjusting prior authorization requirements for MH/SUD services so that they are comparable to medical benefits;
- » Removing blanket exclusions for residential treatments for eating disorders;
- » Recommending that self-funded employers cover newer therapies like Applied Behavior Analysis; and
- » Credentialing changes to allow non-M.D. MH/SUD providers to match medical/surgical requirements.

As with any transformative legislation, regulators, payers, providers, and public interest groups still have substantial work ahead to help consumers understand their MH/SUD benefits and ensure that they receive the right type of individualized care. MHPAEA's goals of non-discrimination and comparability with medical/surgical services are laudable. As we know, however, from a clinical and common-sense perspective, MH/SUD services and treatment are not amenable to a cookie-cutter approach, making achieving those goals more challenging.

Parity Is Not a Panacea for All MH/SUD Treatment Issues

Parity is not the only issue vexing the MH/SUD system. Shortages of MH/SUD treatment providers exist in many parts of the country, as well as a dearth of research and funding for innovative MH/SUD treatments. Although questions regarding how best to effectuate certain facets of MHPAEA remain, parity in and of itself does not solve the myriad issues facing MH/SUD patients.

Nonquantitative Treatment Limitations (NQTLS)

Even ten years after enactment, one of the thorniest areas related to MHPAEA implementation is the confusion around NQTLS. NQTL compliance, as set forth in the MHPAEA regulations, requires that

as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying [a] nonquantitative treatment limitation /to mental health or substance use disorder benefits in the classification [must be] comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.²

NQTLS include medical management processes, benefit exclusions, and provider network admission standards, such as reimbursement rates and licensure requirements.

With regard to NQTLS, some stakeholders argue that patients with MH/SUD are not treated the same as patients with other chronic conditions and illnesses, such as cancer or diabetes.³ But utilization management routinely occurs on the medical/surgical side and does so within the context of major provider organizations, such as hospitals. Utilization management occurs because it is the right clinical approach in reviewing the medical necessity of a course of treatment or service for the patient's condition. For example, the Centers for Medicare & Medicaid Services (CMS) proposed prior authorization for Medicare home health services.⁴ Step-downs from inpatient to outpatient settings occur regularly on the medical/surgical side because it is medically appropriate to do so.⁵

A key issue that arises upon conducting an NQTL compliance analysis concerns how a payer should conduct the NQTL comparability/stringency analysis. Does a plan use a one-to-one benefit comparison? Or is a plan supposed to look across the entire group of benefits? One public advocate offered the following comparisons as part of an MHPAEA analysis: inpatient detoxification vs. inpatient appendicitis, giving birth or salmonella poisoning, and outpatient psychological vs. outpatient primary care visit for flu. Another public advocate

compared psychiatry vs. oncology in its MHPAEA analysis. These comparisons are arbitrary and confusing. There is no directive that such interpretations are correct from either MHPAEA itself or the implementation regulations.

As federal and state regulators grapple with further NQTL guidance, it is important to recognize that differences exist between behavioral health and physical health in order to ensure that the best quality, evidence-based care is being provided to consumers. Parity should not just be about the correct comparability/stringency analysis; we should be asking whether this comparison results in good care for the patient. Differences in practice may be justifiable if they result in better patient care.

Where Is Parity Going?

Medicaid Expansion

Health care was a high priority among voters in the 2018 mid-term elections, with 41% of national voters stating that health care was their “most important” issue. Indeed, a November 2, 2018 Gallup poll found that 80% of respondents said health care would be extremely or very important in their vote for Congress.⁶

A key place where high-voter interest in health care and parity intersect is a renewed push for states to expand their Medicaid programs. Notably, voters in three states—Nebraska, Utah, and Idaho—passed ballot initiatives in favor of Medicaid expansion in the mid-term elections. Changes in other state legislatures and governorships, including Kansas, Wisconsin, New Hampshire, Michigan, and North Carolina, also may increase the likelihood of Medicaid expansion across the country.

In addition to increasing the insured population, Medicaid expansion may result in the increased availability of MH/SUD services by ensuring licensed professional counselors are reimbursed for the services they provide to low-income patients.

Although Medicaid expansion is a good first step in increasing access to care generally, it will only help address parity issues for behavioral health if it also includes increased access to substance use disorder and mental health care. Some research has shown that Medicaid expansion is associated with better outcomes for those being treated for mental health issues.⁷ In addition, numerous analyses, including a report by the National Council for Behavioral Health, have found that Medicaid is a vital source of care for people living with mental illness or addiction.⁸

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The Opioid Crisis

Unsurprisingly, the opioid epidemic was a major focus for candidates, especially in rural areas where, according to some polls, drug addiction was considered the biggest problem facing communities, ahead of even economic concerns.⁹

The bipartisan Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)¹⁰ enacted in October 2018 includes wide-ranging provisions aimed at addressing the opioid crisis on multiple fronts, including advancing treatment and recovery initiatives, improving prevention, and protecting communities. The measure also includes specific provisions to address the effects of trauma stemming from opioid use on children and families; requires the Department of Health and Human Services to develop guidance to states on identifying funding for family-focused residential substance use disorder treatment programs; and provides a new grant program to replicate a “recovery coach” program for parents with children in foster care due to parental substance use disorder. Some states have already incorporated these peer- and community-based programs.¹¹

The Institute for Mental Disease (IMD) Exclusion

The IMD exclusion has been a major impediment to increased access to substance use disorder treatment. Passed in 1965, the IMD exclusion was well-intentioned but based upon now-antiquated treatment methods, prohibiting Medicaid payment for residential mental health and substance use disorder treatment in facilities with more than 16 beds. As part of the SUPPORT Act, Congress partially lifted the IMD exclusion for federal Medicaid program funding for five years. But the legislation did not mandate state coverage of the benefit.

Significantly, the Centers for Medicare & Medicaid Services (CMS) in a November 13, 2018 letter to state Medicaid directors, indicated that the agency will now allow states to waive the IMD exclusion for short-term stays (around 30 days) for mental health treatment in IMD settings.¹² To date, Section 1115 waivers have been used to waive IMD restrictions for residential substance use disorder treatment, but the letter marks the first time CMS has encouraged their use for mental health treatment.

CMS explained that these waiver demonstrations must provide a full continuum of care for individuals with mental illness. While residential treatment in IMDs may be included, states also are expected to improve community-based mental health care and must adhere to strict budget-neutrality requirements, meaning that the demonstration cannot cost the federal government more than what it would have paid absent the demonstration. Some states mandate that community-based mental health providers must be nonprofit organizations, which limits the number of eligible providers. Because access to care remains a critical issue, it is anticipated that this distinction will gradually be phased out.

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Integration with Primary Care

Integrating primary care with mental health care also can help to advance parity. To increase this integration, CMS suggested states explore screening for mental health disorders in primary care settings and supporting primary care providers (PCPs) and pediatricians to provide treatment and/or referrals for mental health services with the support of consultations with specialists and care coordinators.¹³ Numerous states are using grants for Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs in many different settings including the criminal justice system and adolescent programs.¹⁴

CMS also cited the need to build up the availability of intensive outpatient and crisis stabilization programs as a way to prevent frequent emergency room visits for individuals with mental illness as well as any criminal justice involvement.¹⁵ This poses a challenge in states where such programs are primarily state-funded and limited in number. Some states that operate their own health insurance exchanges require participating third-party payers to pay for mental health and substance use disorder treatment. As a result, some private health systems have been adding crisis stabilization programs, but most remain state-funded.

CMS highlighted Certified Community Behavioral Health Clinics (CCBHCs) as a model that states could use to address a wide variety of system improvements simultaneously.¹⁶ CCBHCs are required by law to provide a comprehensive array of community-based behavioral health care, including screening and assessment, 24-hour crisis care, integration of mental health, SUD and physical health care, utilization of evidence-based practices, care coordination, and more. According to CMS, “States may be able to adapt the CCBHC model of care using different authorities, depending on the services provided, beneficiaries served, and payment methodologies.”¹⁷ Numerous states already have implemented CCBHC waiver programs and preliminary data tends to show an increased access to care.

Judicial Enforcement

People are increasingly taking the fight for parity to court, with the initiation of class actions. For example, two class actions against United Behavioral Health (UBH), filed in 2014 in the U.S. District Court for the Northern District of California, allege that UBH violated the Employee Retirement Income Security Act (ERISA) by applying overly restrictive criteria in adjudicating claims for mental health benefits. Following an October 2017 bench trial, the court issued a strongly worded order dated March 5, 2019, ruling that UBH had created internal policies that the court said effectively discriminated against patients with mental health and substance use disorder to save money.¹⁸ While this case alleged violations of ERISA fiduciary duties rather than MHPAEA, the court’s decision may prompt payers to revisit their level of care guidelines. UBH disputed the court’s findings and is expected to appeal the decision.

In another lawsuit filed in October 2018 against United Healthcare and UBH, the plaintiffs allege that UBH again


violated health plan requirements by applying arbitrary restrictions on reimbursement for psychotherapy provided by psychologists and master’s level counselors.¹⁹ A hearing on UBH’s motion to dismiss is scheduled for March 2019.

The Way Forward

While great strides have been made, more can be done to ensure that mental health and addiction parity is being implemented in the manner in which it was intended. Some possible ways to move the needle toward full MHPAEA implementation include:

- » *Accreditation.* Currently there is no parity accreditation standard that would deem a health plan parity compliant. Recognition of such an accreditation by consumers, federal and state governments, employers, and providers would support consistent interpretation and assessment of parity compliance.
- » *National Association of Insurance Commissioners (NAIC) model.* The NAIC recently discussed a NQTL framework that could be helpful going forward with market conduct examination uniformity.
- » *Best Practice Examples.* Additional illustrations from federal regulatory agencies of health plans that are implementing MHPAEA correctly or states that are accurately enforcing MHPAEA would be very helpful in advancing parity compliance. If regulating agencies release de-identified information related to non-compliance issues it would provide interested parties with a thorough picture of the regulator’s intent related to MHPAEA and would lead to improved compliance. Unfortunately, the MHPAEA regulations do not define the terms ‘processes,’ ‘strategies,’ ‘evidentiary standards,’ and ‘factors’ but rather contextualize them in fact-specific illustrative examples that do not explain how to demonstrate compliance.
- » *Substance Use Disorder.* Currently, there is not parity in the way health care professionals access SUD records. This puts SUD patients at greater risk and inhibits integrated care for these individuals. Since SUD patients and their records are siloed from the rest of medicine, many individuals are receiving substandard, uncoordinated care.
- » *Workforce Issues.* There is a well-documented shortage of behavioral health providers in the United States. As a result, it is not always possible to have identical provider networks for behavioral health and medical/surgical health. A focus on network size ignores the fact that the behavioral health workforce shortage is a factor outside a plan’s control. Insurance providers have put in place ways to enhance access to behavioral health providers, such as telehealth, and assisting members in securing in-person appointments, but additional action is needed. Policymakers should explore ways to increase the capacity of the behavioral health workforce to give patients better access to these providers.

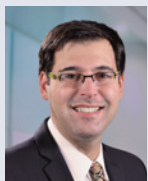
Conclusion

Payers continue to implement innovative programs that improve access to quality, affordable, and evidence-based behavioral health care. NQTLs analysis and frameworks remain a source of contention among various stakeholders but progress continues to be made on various fronts; for example, NAIC examination of the issue. With additional attention to these issues, the future looks brighter for improved parity fluency, awareness, and compliance. 



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Endnotes

- 1 See Charles Roehrig, *Mental Disorders Top the List of the Most Costly Conditions in the United States: \$201 Billion*, HEALTH AFFAIRS (June 2016), <http://content.healthaffairs.org/content/early/2016/05/13/hlthaff.2015.1659.abstract>.
- 2 45 C.F.R. § 146.136(c)(4)(i).

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- 3 See, e.g., Anjalee Khemlani, *Patrick Kennedy rails against unequal treatment for mental health patients*, NJBIZ, Apr. 22, 2016, <http://www.njbiz.com/article/20160422/NJBIZ01/160429929/patrick-kennedy-rails-against-unequal-treatment-for-mental-health-patients>.
- 4 81 Fed. Reg. 37598 (June 10, 2016). CMS later paused the five-state "Pre-Claim Review" demonstration for home health, but also issued a notice requesting input on reviving the proposal. 83 Fed. Reg. 25012 (May 29, 2018).
- 5 For example, a growing number of surgeons around the country are moving more of their total joint replacement procedures out of the hospital, performing these operations in outpatient facilities. See Harris Meyer, *Replacing joints faster, cheaper and better?*, MODERN HEALTHCARE, June 4, 2016, <http://www.modernhealthcare.com/article/20160604/MAGAZINE/306049986/hospitals-fret-as-joint-replacements-move-to-outpatient-centers?AID=/20160604/MAGAZINE/306049986>.
- 6 Frank Newport, *Top Issues for Voters: Healthcare, Economy, Immigration*, Gallup, Nov. 2, 2018, <https://news.gallup.com/poll/244367/top-issues-voters-healthcare-economy-immigration.aspx>.
- 7 See, e.g., TNA Winkelman and WWC Chang, *Medicaid Expansion, Mental Health, and Access to Care among Childless Adults with and without Chronic Conditions*, 33 J. GEN. INTERN. MED. 376-383 (Mar. 2018), <https://europepmc.org/abstract/med/29181792>.
- 8 NAT'L COUNCIL OF BEHAVIORAL HEALTH, *Americans with Mental Health and Substance Abuse Disorders: The Single Largest Beneficiaries of the Medicaid Expansion*, <https://www.thenationalcouncil.org/wp-content/uploads/2017/04/Medicaid-Expansion-Behavioral-Health-UPDATED-5-1-17.pdf>.
- 9 Danielle Kurtzleben, *Poll: Rural Americans Rattled By Opioid Epidemic; Many Want Government Help*, NPR, <https://www.npr.org/2018/10/17/656515170/poll-rural-americans-rattled-by-opioid-epidemic-many-want-government-help>.
- 10 Pub. L. No. 115-271 (2018).
- 11 For example, Minnesota, as part of efforts to reform its substance use disorder treatment system, enacted additional services comparable to the federal legislation, including the addition of peer-support recovery services to the Medicaid benefit set. See <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/alcohol-drug-other-addictions/sudreform/>.
- 12 CMS, State Medicaid Director Letter 18-011 (SMD 18-011), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>.
- 13 *Id.*
- 14 Substance Abuse and Mental Health Services Administration, <https://www.samhsa.gov/sbirt>.
- 15 See CMS Letter, *supra* note 12.
- 16 *Id.*
- 17 *Id.*
- 18 *Wit v. United Behavioral Health*, Nos. 3:14-cv-02346-JCS and 3:14-cv-5337-JCS (N.D. Cal. Mar. 5, 2019).
- 19 *Smith v. United Healthcare Ins. Co.*, No. 3:18-cv-06336 (complaint filed, N.D. Cal. Oct. 16, 2018).