Meadows Mental Health Policy Institute

Follow-Up Information to House Select Committee on Mental Health Parity

June 14, 2016

The Meadows Mental Health Policy Institute (MMHPI) listened with interest to the presentations at the House Select Committee on Mental Health hearing on June 2, 2016. We would like to provide some follow-up information to that testimony to help clarify key issues related to state and federal parity laws and the Affordable Care Act (ACA).

Bottom Line: The Affordable Care Act Has Nothing to Do with State and Federal Parity Laws.

Parity legislation at both the state and federal levels for mental health and chemical dependency (MH/CD) predates the ACA and is rooted in separate regulations and statutes.

Parity regulations actually date back to the 1990s. At that time, employers and insurers either declined to cover MH/CD treatments or covered them in a more limited way than they covered medical treatments. In 1996, Congress passed the Mental Health Parity Act (MHPA), which prohibited large group health plans (plans with more than 50 employees) from applying annual or lifetime dollar limits to mental health benefits that were lower than dollar limits for medical and surgical benefits.

At the same time, states were passing their own parity laws and MH/CD coverage mandates. In 2007, Texas mandated benefits for certain serious mental illnesses (SMIs)[1] under the Texas Insurance Code through 80(R) HB 1919 (which became effective on September 1, 2007). This law provided regulations for SMI coverage under Chapter 1355 of the Texas Insurance Code. These regulations require group health benefit plans[2] (to the extent permitted by the Employee

[1] "Serious mental illness" as described under Chapter 1355, Texas Insurance Code, means the "following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM): (A) bipolar disorders (hypomanic, manic, depressive, and mixed); (B) depression in childhood and adolescence; (C) major depressive disorders (single episode or recurrent); (D) obsessive-compulsive disorders; (E) paranoid and other psychotic disorders; (F) schizo-affective disorders (bipolar or depressive); and (G) schizophrenia." Specific treatments (and provider qualifications) for children under ten years of age with autism spectrum disorder were also included as mandated coverage.

[2] Group health benefit plans means any plan, fund, or program established or maintained by an employer or by an employee organization for the purpose of providing for its participants, or their beneficiaries, medical or surgical expenses incurred as a result of a health condition, accident, or sickness, through the purchase of coverage from a health plan issuer. A health plan issuer is any entity authorized under the Insurance Code or another insurance law of this state that provides health insurance or health benefits in this state, including an insurance company, a group hospital service corporation operating under the Insurance Code Chapter 842, a fraternal benefit society operating under the Insurance Code Chapter 885, a stipulated premium insurance company operating under the Insurance Code Chapter 884, a health maintenance organization operating under the Texas Health Maintenance

Retirement Income Security Act of 1974 [ERISA])[3] with 50 or more employees to provide at least 45 inpatient days and 60 outpatient visits[4] annually for treatment of SMI. No lifetime limits are permitted on the number of days or visits, and SMI treatment must be covered with the same amount of limitations, deductibles, copayments, and coinsurance factors as applicable to physical illnesses.[5] The Texas SMI mandate also requires coverage of certain alternative mental health treatment benefits[6] with at least as favorable coverage as mental health hospital treatment for SMIs.[7] In addition, an issuer of a group health benefit plan to a small employer (fewer than 50 employees) must offer this coverage to the small employer.

In 2005, the Texas Department of Insurance (TDI) adopted rules for mandated coverage of chemical dependency treatment under Chapter 1368, Texas Insurance Code. The chemical dependency coverage mandate requires a group health benefit plan with more than 250 employees to provide coverage for the necessary care and treatment of chemical dependency that is no less favorable than coverage provided for physical illness and is subject to the same durational limits, dollar limits, deductibles, and coinsurance factors.[8] The required chemical dependency coverage has a lifetime limit, however, of three separate treatment series (as defined by rule).

In 2008, President George W. Bush signed the Mental Health Parity and Addiction Equity Act (MHPAEA) into law. Proposed MHPAEA regulations were issued in 2009, interim regulations followed in 2010, and final regulations were published in 2013, which became effective for commercial plans beginning on or after July 1, 2014. New federal Medicaid managed care, CHIP and alternative benefit plan (ABP) MHPAEA requirements will become effective in October

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Organization Act (Chapter 843), an approved nonprofit health corporation that is certified under the Occupations Code Chapter 151 (Medical Practice Act) and that holds a certificate of authority under the Insurance Code Chapter 844, or a multiple employer welfare arrangement that holds a certificate of authority under the Insurance Code Chapter 846 (Texas Administrative Code, Part 1, Chapter 21, Subpart P: Mental Health Parity §21.241).

[3] The SMI and chemical dependency mandates apply primarily to fully-insured health plans in Texas (where the employer pays a fixed premium to an insurer who assumes the financial risk for the coverage of health care benefits for company employees), but not to large self-insured health plans (where the employer assumes the financial risk for providing health care benefits to its employees) that are exempted by ERISA.

[4] Medication management visits do not count toward the 60 visits.

[5] After legislative inquiry into the number of sessions required under this statue, the Attorney General concluded that group health plans that provide more than 60 outpatient visits for physical illness must provide the same number of visits for serious mental illness.

[6] Includes mental health residential treatment, crisis stabilization unit, and psychiatric day treatment. Prohibits exclusion of mental health or mental retardation services provided by a tax-supported Texas institution or community center that regularly charges patients who are not indigent for those services.

[7] The law provides specific ratios to determine comparable coverage.

[8] Unless guidelines and standards adopted under Section 1368.007 indicate less favorable coverage is sufficient.

2017. None of these regulations had anything to do with the ACA, other than the fact that the ACA must comply with the pre-existing MHPAEA law.

MHPAEA made permanent the prohibition on lower annual and lifetime dollar limits from the 1996 MHPA and expanded this prohibition to include chemical dependency benefits. MHPAEA also prohibited large group health plans (benefit plans established by employers to cover treatment costs for more than 50 employees) from imposing financial requirements (e.g., co-pays, deductibles), quantitative treatment limits (e.g., a 60 visit limit on therapy sessions, 30-day visit limit on residential treatment), or non-quantitative limits (e.g., a precertification requirement for all inpatient mental health treatment) on MH/CD benefits that were more restrictive than the predominant financial requirements or limits that applied to substantially all medical and surgical benefits. In addition, MHPAEA required plans to cover MH/CD benefits in each of six classifications in which medical benefits are covered (in-network inpatient, in-network outpatient, out-of-network inpatient, out-of-network outpatient, pharmacy, and emergency). MHPAEA did not, however, require large group health plans to cover MH/CD services. In addition, MHPAEA only applies if a plan covers MH/CD services.

In 2011, to coordinate the requirements of Texas law with federal parity law, Texas implemented mental health parity regulations under the Texas Administrative Code, Title 28, Part 1, Chapter 21, Subchapter P, Mental Health Parity Sections 21.240-21.2047. These regulations became effective in March 2011.

The more recent ACA requirements discussed during the June 2 hearing referred to ACA provisions that extend federal MHPAEA requirements to a relatively small part of the population, namely ACA issuers in the individual market and qualified health plans offered through an exchange or marketplace. The ACA also created a MH/CD benefit mandate for these plans. But, it is critical to point out that the ACA did not create parity; rather, the ACA was obligated to comply with the regulations President Bush signed into law in 2008.

Despite these statutes and regulations, the complexities and gaps of current parity laws, combined with ineffective enforcement, have allowed most large group health plans and insurers to continue with business as usual.[9] Federal law does not require large employer

[9] Creedon, T.B.& Lê Cook, B. (2016 June). DataWatch: Access to mental health care increased but not for substance use, while disparities remain. *Health Affairs, 35*:1017-1021; doi:10.1377/hlthaff.2016.0098. Retrieved at: http://content.healthaffairs.org/content/35/6/1017.abstract?etoc. Montz, E., Layton, T., Busch, A.B., Ellis, R.P., Rose, S. & McGuire, T.G. (2016 June). Risk-adjustment simulation: Plans may have incentives to distort mental health and substance use coverage. *Health Affairs, 35*:1022-1028; doi:10.1377/hlthaff.2015.1668. Retrieved at: http://content.healthaffairs.org/content/35/6/1022.abstract?etoc.

groups to cover MH/CD services and state mandates primarily reach only fully-insured plans. In addition, it is possible for group health plans to "appear" to be in compliance with parity laws by adjusting their plan designs, when the real world application of non-quantitative treatment limits such as utilization review and medical necessity determinations result in more frequent denials for MH/CD inpatient levels of care than those for inpatient medical care. In addition, collaborative care interventions, which have been shown to uniquely enhance MH/CD treatment outcomes and reduce unnecessary costs, are not commonly reimbursed by benefit plans. While some testimony indicated that plans are investing in this approach, MMHPI is not aware of any availability in markets we have examined closely (e.g., Dallas County).