

**Study of Mental Health Parity to
Better Understand Consumer
Experiences with Accessing Care**



August 2018

Texas Department of Insurance

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Executive Summary

Texas Insurance Code, Chapter 1355 addresses benefits for certain mental disorders. It requires health insurance plans that offer mental health or substance use disorder benefits to provide those benefits at the same level as they do for other medical and surgical benefits. This is referred to as parity.

Effective September 1, 2017, HB 10, 85th Regular Legislative Session, expanded and strengthened Texas parity requirements, which included data collection and reporting requirements. This report is prepared to comply with Section 3 of HB 10, which required TDI to conduct a one-time data collection and report assessing mental health parity, specifically related to non-quantitative treatment limitations. This report is separate and distinct from the biennial reports prepared by the Mental Health Condition and Substance Use Disorder Parity Workgroup in compliance with Section 1 of HB 10.

We focused on claims data submitted by 13 companies covering over 3.8 million lives. We identified differences in out-of-network utilization and utilization management for medical and surgical services compared to mental health and substance use disorder services.

Key Findings

- Across all treatment categories and markets, utilization of out-of-network services for mental health and substance use disorders was higher than for medical and surgical services.
- Overall, the percent of medical and surgical claims that were denied did not differ materially compared to mental health and substance use disorder claims. However, across treatment categories, significant differences were found, especially within the inpatient treatment category.
- Requests for prior authorization were more likely to be denied for medical and surgical services than for mental health and substance use disorder services.
- For both inpatient and outpatient treatment categories, companies tended to approve or deny prior authorization requests more quickly for mental health and substance use disorder treatments than for medical and surgical treatments.
- Overall, medical and surgical claims that were denied were 2.65 times as likely to be overturned through internal appeals as mental health and substance use disorder claims.
- In the small group and large group markets, a much larger proportion of prescription drugs for mental health and substance use disorders was subject to step therapy requirements compared to drugs for medical and surgical use.
- Consumers were 10 times as likely to complain about medical and surgical claims as mental health and substance use disorder claims.

Evaluating parity in non-quantitative treatment limitations is difficult without a detailed review of a company's health care management policies and procedures. As a result, this report is not meant to be a demonstration of whether parity does or does not exist, but is intended to highlight areas for further review.

Background

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that requires health insurance plans that offer mental health or substance use disorder benefits to provide those benefits at the same level as they do for other medical and surgical benefits. This equal treatment is commonly referred to as parity.

Parity requirements apply to both financial requirements and treatment limitations. Financial requirements include deductibles, copayments, coinsurance, and out-of-pocket expenses. Treatment limitations are defined as either quantitative or non-quantitative. Quantitative treatment limitations (QTLs) are those that can be counted, such as numerical limits on the number of visits or days of treatment. Non-quantitative treatment limitations (NQTLs) are not numerical, such as limiting benefits based on medical necessity or requiring prior authorization before receiving treatment.

Parity applies to benefits in the following six classifications:

- Inpatient in-network
- Inpatient out-of-network
- Outpatient in-network
- Outpatient out-of-network
- Emergency
- Prescription drugs

The MHPAEA originally applied to large group health plans only. The Affordable Care Act (ACA) indirectly expanded parity requirements to small group and individual coverage by adding mental health and substance use disorder benefits as one of the 10 essential health benefits required in these plans.

Before January 1, 2018, parity requirements under Texas law varied depending on whether the benefits were provided under a large employer plan, a small employer plan, or an individual plan. Large employer plans were required to provide coverage for mental health and substance use disorders. Parity protections applied, but only to QTLs. Small employer plans were only required to provide coverage for substance use disorders. Coverage for mental health benefits must be offered, but the small employer could

choose to reject the coverage. Similar to the large employer market, parity protections in the small employer market only applied to QTLs. Individual plans were not required to offer coverage for mental health or substance use disorders.

Effective September 1, 2017, HB 10, 85th Regular Legislative Session, expanded and strengthened Texas parity requirements by:

- Aligning existing Texas law with federal parity requirements.
- Providing for an ombudsman to track and report on consumer access to mental health and substance use disorder benefits.
- Establishing a work group to provide recommendations on improving compliance with state and federal parity laws, and making it easier for patients to file complaints.
- Establishing data collection and reporting requirements.

Section 3 of HB 10 required TDI to conduct a one-time study comparing data on medical and surgical benefits with mental health and substance use disorder benefits that are provided under Chapter 1355, Texas Insurance Code. The comparison applies to benefits that are:

- Subject to prior authorization or utilization review.
- Denied as not medically necessary, experimental, or investigational.
- Internally appealed, including whether the appeal was denied.
- Subject to an independent external review, including whether the denial was upheld.

TDI is required to submit a report of its findings to the Legislature by September 1, 2018.

Section 4 of the bill required the Texas Health and Human Services Commission (HHSC) to collect similar data, conduct a study, and prepare a separate report using data from Medicaid managed care organizations (MCOs).

Given the similarity of the data collection requirements under sections 3 and 4 of HB 10, TDI and HHSC worked together to develop separate, but similar, data collection templates. However, each agency's report was prepared separately based on data collected and analyzed by that agency.

Implementation

TDI began the study by hosting a meeting with mental health and substance use disorder advocates on August 9, 2017. TDI continued hosting regular meetings with HHSC to discuss the studies. TDI and HHSC drafted proposed data collection methodologies for the studies. On October 30, 2017, TDI hosted a stakeholder meeting to obtain feedback

from health plans and advocates to determine whether the methodologies would capture the information necessary to satisfy the requirements of HB 10. Through this collaborative process, and with input from interested parties, TDI developed and posted a draft data collection template on the agency website. After incorporating feedback from the group, final versions of the instructions and reporting templates were posted online on March 29, 2018. TDI mailed letters and sent notification emails to the plans subject to the data call. The data call was due on May 1, 2018. TDI reviewed the data for reasonableness and asked companies to make corrections as needed. Final data submissions were received in June and July.

Study overview

The data call applied to insurance companies and HMOs that reported 25,000 or more covered lives to the National Association of Insurance Commissioners (NAIC) during its most recent reporting period.¹ The threshold applied separately to individual, small group, and large group plans rather than to the total of the three market segments. Data was collected separately for the following plan types:

- Preferred Provider Organizations (PPOs)
- Exclusive Provider Organizations (EPOs)
- Health Maintenance Organizations (HMOs)

Companies not meeting the threshold for a market segment were not required to submit reports for that market segment. For example, if a company had 30,000 covered lives in the individual market, with 400 enrolled in PPO plans and the remainder in EPO plans, it was required to complete both the individual PPO and individual EPO data reports because it met the individual market threshold. Likewise, if the company had 10,000 covered lives in the small group market across all product types, it was exempt from reporting for the small group market.

This report reflects information submitted by 13 health plan companies. Of these, one submitted data for all three market segments, three for small and large group coverage, four for large group coverage only, and five for individual coverage only.

The data call consisted of two sets of data reporting forms: plan-specific and aggregate.

Plan-specific forms

The plan-specific forms pertained to the 2018 health benefit plan in each market segment (individual, small group, and large group) that corresponded to the company's plan with the largest enrollment in 2017. The company information form included questions about

¹ NAIC Supplemental Health Care Exhibit – Part 1.

subcontracting mental health and substance use disorder benefits to another entity. There were separate forms for each combination of market segment and service type (inpatient, outpatient, emergency, and pharmacy), for a total of 12 forms.

The companies answered these questions for each benefit listed on the applicable market segment forms:

- Inpatient and Outpatient
 - Is this benefit covered?
 - Does this benefit require prior authorization?
 - Does this benefit require concurrent review?
 - Is this benefit subject to a fail-first requirement?
- Emergency
 - Is this benefit covered?
- Pharmacy
 - How many drugs are covered in this category?
 - How many drugs in this category are subject to prior authorization?
 - How many drugs in this category are subject to fail-first therapy?
 - Are any drugs in this category subject to any other cost-saving method other than prior authorization or step therapy (e.g., cost sharing that varies by drug tier)?

Aggregate forms

Aggregate forms were used for reporting claims information for each of the three market segments and plan types (PPO, EPO, HMO), for a total of nine forms. Companies reported aggregate information, such as the number of claims, along with how many were approved, denied, or partially denied. In addition, the companies reported the number of claims subject to different types of utilization review, including prior authorization and concurrent and retrospective reviews. There was a separate form for companies to report numbers of complaints and numbers of lives covered by plan type for each market segment.

Appendices at the end of this report provide a glossary, parity timeline, review procedures for data submissions, and company-level detail.

Reporting limitations

There are several important reporting limitations to keep in mind when interpreting this information:

- Despite the use of standard terminology and a glossary of terms, companies interpreted some parts of the reporting forms differently. These differences could result in inconsistencies in the data reported.
- Pharmacy data differed for companies that used pharmacy benefit managers. Some pharmacy data was excluded due to logical inconsistencies.
- Some companies had difficulty reporting the data as requested. For example, one company was unable to separate generic from non-generic drug claims. Another classified all mental health and substance use disorder emergency visits as medical visits, because it did not view such claims as emergencies unless they had an associated medical or surgical component. As another example, one company only counted drug claims if a prescription was filled, so it had no prior authorizations or denials to report.
- Classifying claims as either medical and surgical or mental health and substance use disorder can be difficult because some claims may fit into both categories. The instructions advised companies to classify all claims with diagnostic codes F10-F99 (F chapter) of the ICD-10 as mental health and substance use disorder. Any inconsistencies in classifying claims could potentially distort the results presented in this report.
- It was suggested that TDI collect the dollar amounts of claims. However, because medical and surgical claims tend to be more expensive than mental health and substance use disorder claims, the former are much more likely to exceed a health plan's deductible. Therefore, a comparison of paid-to-allowed dollar amounts could reflect a lack of parity even when it in fact exists. Because of this, the decision was made to focus on numbers of claims to evaluate parity between benefit types.
- HB 10 required collecting data on claims that were "denied as not medically necessary or experimental or investigational." However, several companies reported the number of total denials and a significantly lower number of denials that were not medically necessary, experimental, or investigational. This suggests that there were a substantial number of denials for other reasons. This is an area that calls for follow up in future mental health parity inquiries.

Summary of findings

Findings are based on data call responses submitted to TDI. The findings are reported based on the following combinations of categories:

| Category | Reporting types |
|----------------|--|
| Treatment | Inpatient Outpatient Emergency Prescription drugs |
| Market segment | Individual Small group Large group |
| Plan type | PPO EPO HMO |
| Network | In-network Out-of-network |

Enrollment

This study was based on data from over 3.8 million covered lives. Companies reported the total number of lives covered in each type of plan separately for the individual, small group, and large group markets (see below).

| Market | Plan type | | | Total |
|--------------|------------------|----------------|------------------|------------------|
| | PPO | EPO | HMO | |
| Individual | 153,070 | 190,744 | 683,892 | 1,027,706 |
| Small group | 694,950 | 43,343 | 180,141 | 918,434 |
| Large group | 1,393,409 | 278,180 | 211,227 | 1,882,816 |
| Total | 2,241,429 | 512,267 | 1,075,260 | 3,828,956 |

Complaints

Companies reported complaint information for services relating to benefits covered under the plan in each market segment (see below).

| Market | Medical / Surgical | | | Mental health / Substance use disorder | | |
|--------------|--------------------|--------------|-------------------------------|--|------------|-------------------------------|
| | Claims | Complaints | Complaints per million claims | Claims | Complaints | Complaints per million claims |
| Individual | 18,785,013 | 4,966 | 264 | 3,664,977 | 61 | 17 |
| Small group | 11,186,749 | 385 | 34 | 2,439,239 | 25 | 10 |
| Large group | 36,500,556 | 816 | 22 | 5,833,720 | 29 | 5 |
| Total | 66,472,318 | 6,167 | 321 | 11,937,936 | 115 | 32 |

The number of complaints reported for medical and surgical services were significantly higher than those reported for mental health and substance use disorders. This is consistent with complaint data collected by TDI's Consumer Protection section. The low number of mental health and substance use disorder complaints does not necessarily mean an absence of claim problems. Other factors to consider include:

- Lack of clarity in identifying whether a complaint is related to a parity violation.
- Reluctance of consumers to complain due to a perceived stigma about mental health and substance use disorders.

The Mental Health Condition and Substance Use Disorder Workgroup, established under HB 10, is required to make recommendations to improve the process of parity complaints, concerns, and investigations. The workgroup will provide its recommendations in a separate report.

Use of in-network and out-of-network services

Across all treatment categories and markets, utilization of out-of-network services for mental health and substance use disorders was higher than medical and surgical services. Inpatient services were 114 percent more likely to be out-of-network for a mental health or substance use disorder claim than a medical or surgical claim. Outpatient services were 30 percent more likely to be out-of-network for a mental health or substance use disorder claim than for a medical or surgical claim. A high proportion of out-of-network claims could indicate network adequacy issues.

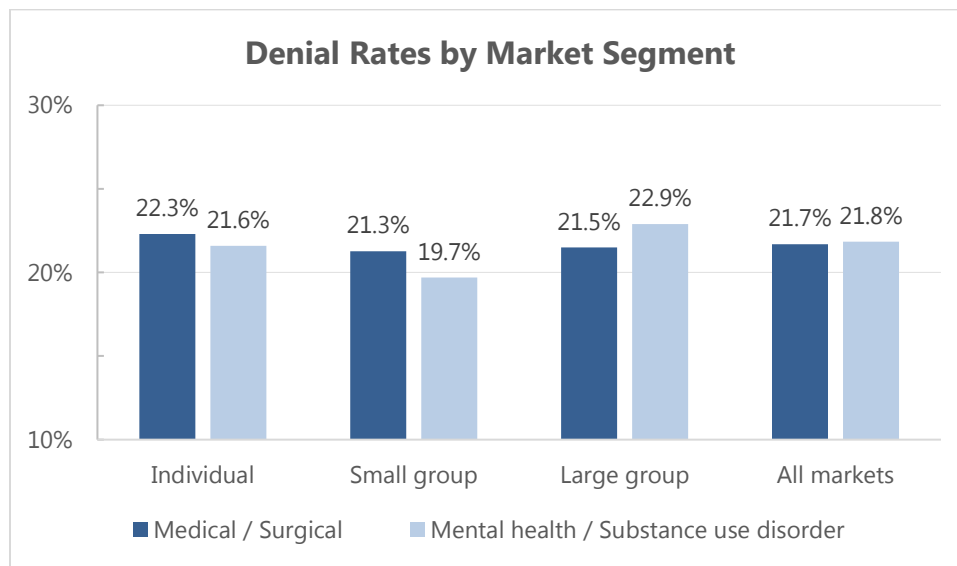
Inpatient services were further broken down between services received at a residential treatment facility and services received at other inpatient facilities. Mental health and substance use disorder services received at residential treatment facilities were 890 percent more likely to be received out-of-network than medical and surgical services.

| Out-of-network utilization | | | |
|-----------------------------------|---------------------------|---|--|
| Treatment category | Medical / Surgical | Mental health / Substance use disorder | Higher percentage of out-of-network use for Mental health / Substance use disorder services |
| Inpatient (residential) | 6.5% | 64.4% | 890% |
| Inpatient (all other) | 25.8% | 37.9% | 47% |
| Total inpatient | 19.7% | 42.2% | 114% |
| PHP/IOP* | | 40.6% | N/A |
| All other | | 20.7% | N/A |
| Total outpatient | 16.3% | 21.3% | 31% |

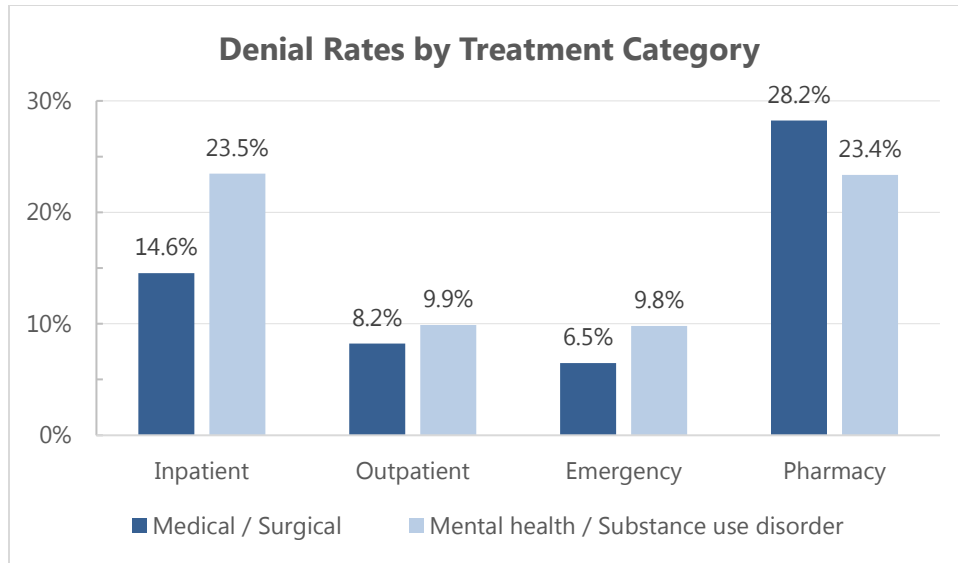
* Partial hospitalization programs / Intensive outpatient programs.

Percentage of claims denied

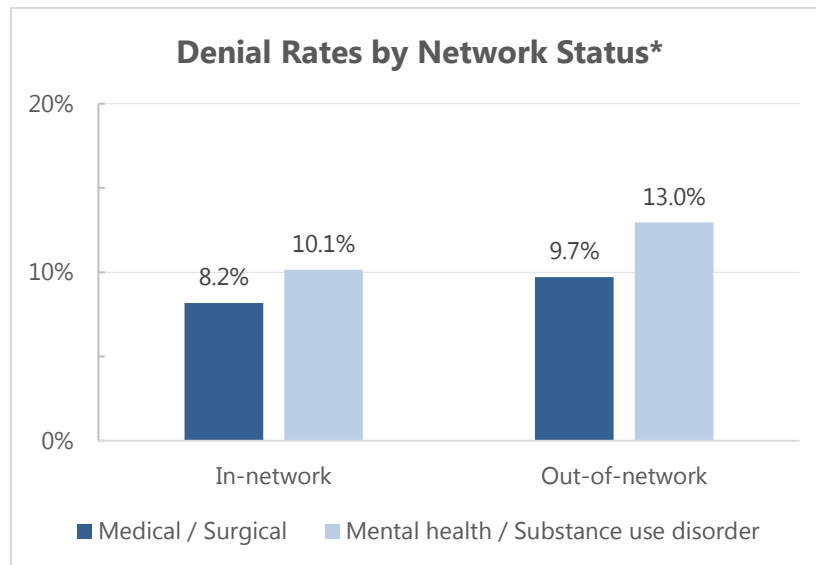
A total of 21.7 percent of medical and surgical claims were denied, compared to 21.8 percent of mental health and substance use disorder claims. Overall, the percent of claims that were denied did not vary significantly between the two claim categories.



However, larger differences were seen when comparing different treatment and network categories. The charts below show differences by treatment category and network status.



The percent of claims that were denied was highest in the inpatient and pharmacy categories. The largest difference between the denial rates occurred in the inpatient category, where mental health and substance use disorder claims were denied over 60 percent more often than medical and surgical claims.

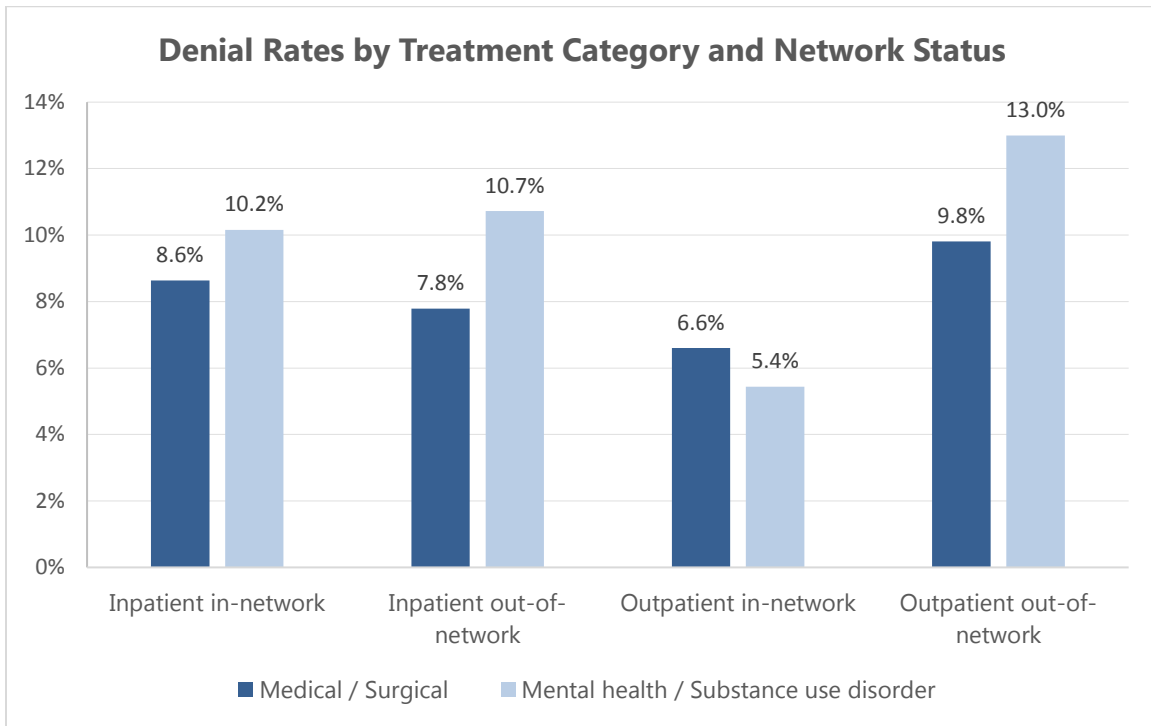


* Excludes pharmaceutical claims

A comparison of denial rates for in-network and out-of-network claims among PPO plans shows that mental health and substance use disorder claims were denied approximately 30 percent more often than medical and surgical claims.

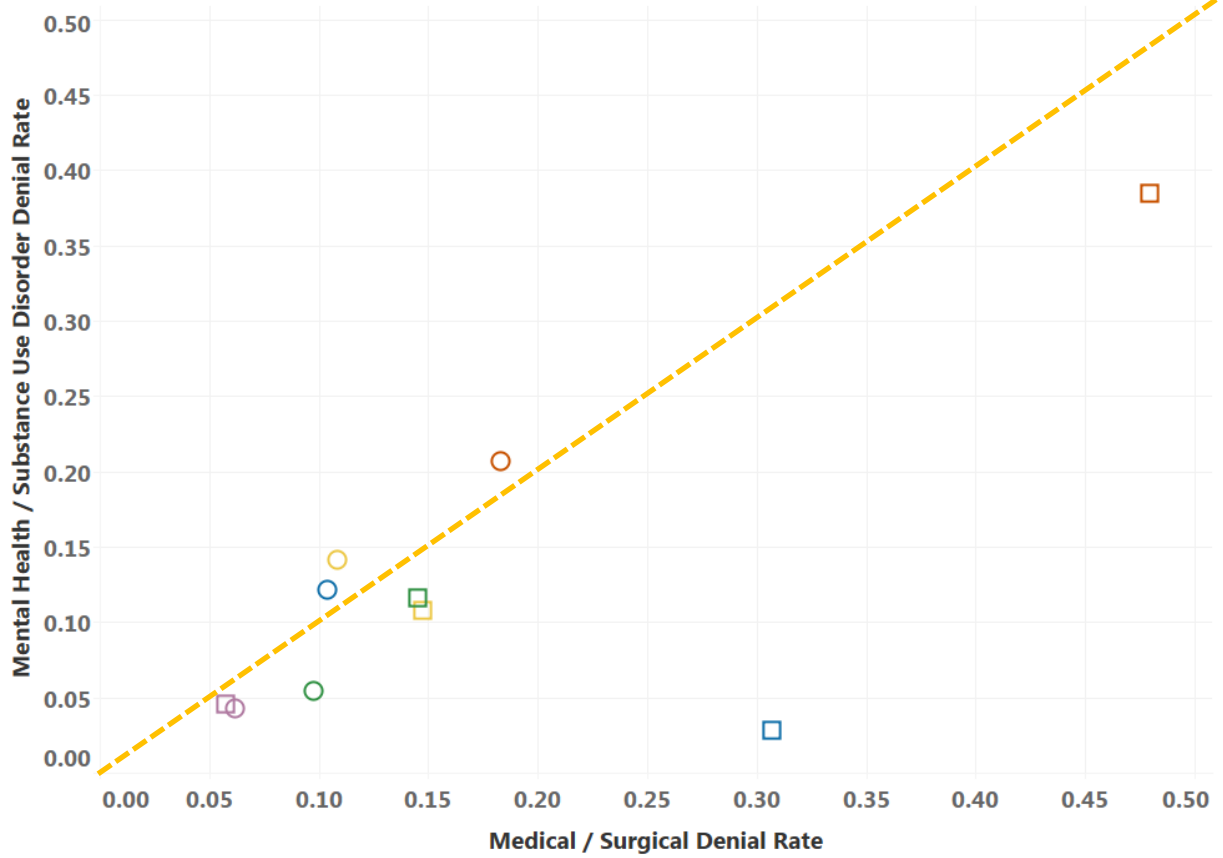
The chart below shows this data further broken down by treatment category. Mental health and substance use disorder denial rates were higher than medical and surgical in

every category except outpatient in-network claims. However, it's important to note that the largest number of claims fell into this category, with outpatient in-network claims accounting for nearly 80 percent of the total claims reported.



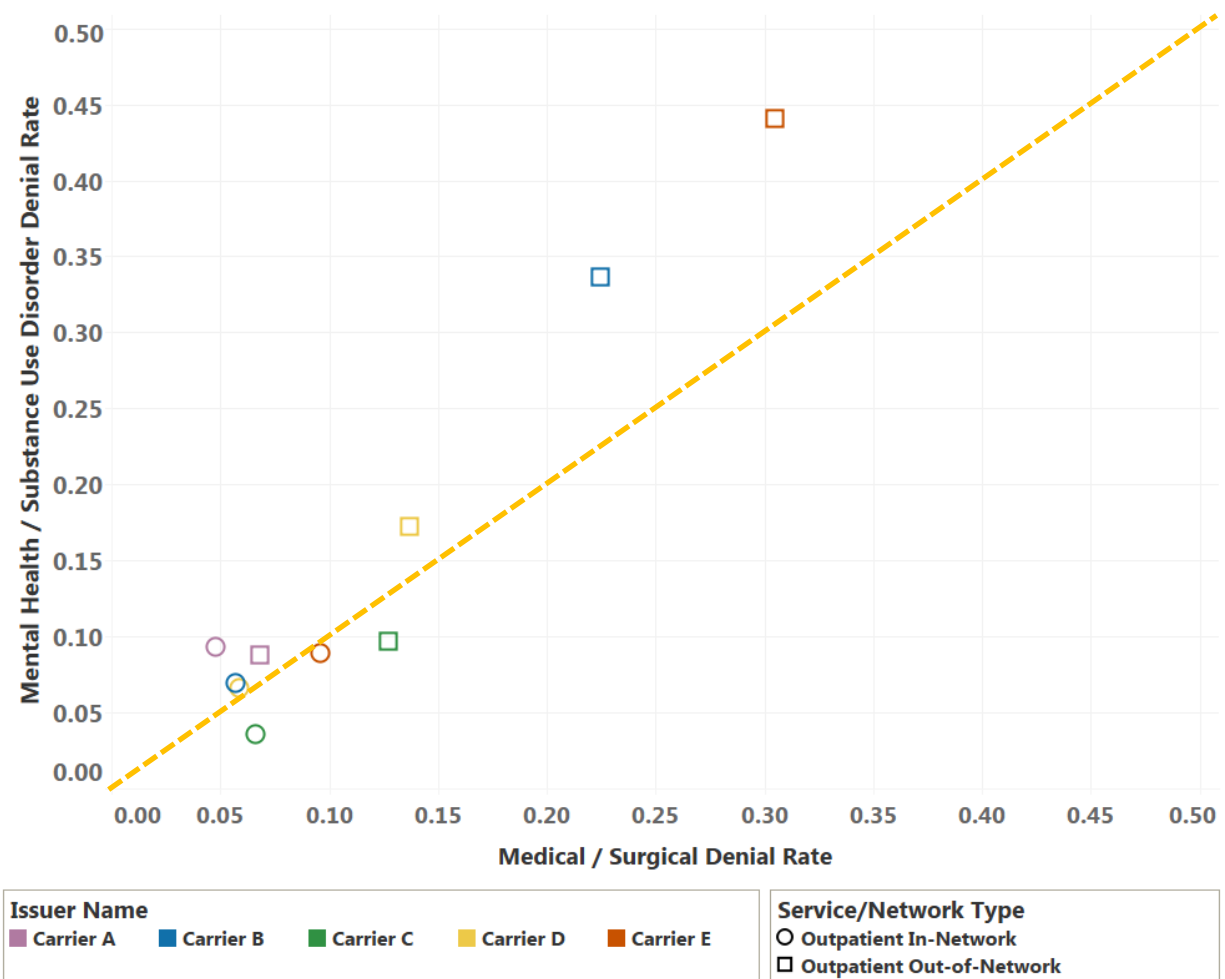
The charts below compare denial rates by company for each of the treatment categories. Because PPO coverage in the individual and small group markets is limited and small and large group results were similar, data is shown only for the large group market. Companies are represented by the various colors. Circles represent services provided in-network. Squares represent services provided out-of-network. The orange line represents complete parity between the two benefit categories. Circles and squares below the orange line represent companies with higher denial rates for medical and surgical benefits compared to mental health and substance use disorder benefits. Circles and squares above the orange line represent companies with higher denial rates for mental health and substance use disorder benefits.

Inpatient Large Group

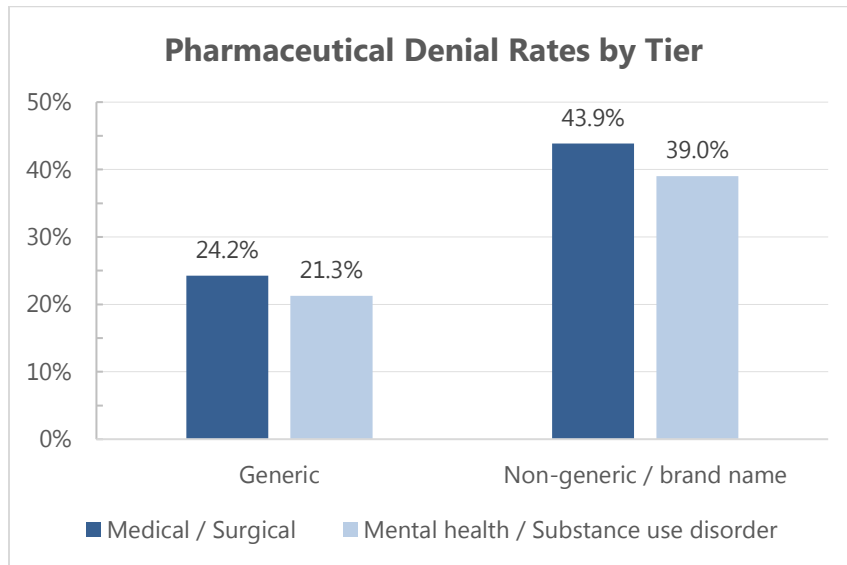


| Issuer Name | | | | | Service/Network Type | |
|-------------|-----------|-----------|-----------|-----------|----------------------|--------------------------|
| Carrier A | Carrier B | Carrier C | Carrier D | Carrier E | ○ | Inpatient In-Network |
| | | | | | □ | Inpatient Out-of-Network |

Outpatient Large Group



The chart below shows denial rates for pharmacy claims. Pharmacy claims were denied at a slightly higher rate for medical and surgical benefits, while brand name drugs were denied at a much higher rate than generics.



Utilization review

Utilization review is a process a company uses to keep costs down and improve the quality of care by requiring certain services to be approved as medically necessary. Companies decide which services are subject to utilization review. Without approval, the company might not pay the claim.

Utilization reviews differ depending on when they occur in the treatment process:

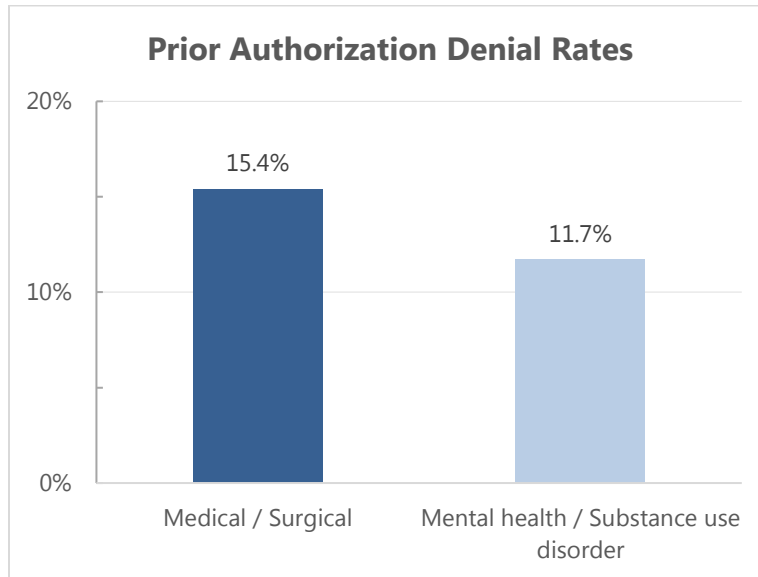
- Prior authorization occurs before a treatment is received.
- Concurrent review happens as the care is provided to make sure that the patient gets the right level of care at the right time.
- Retrospective review happens after treatment has been completed to determine whether it was appropriate.

The utilization process starts when a patient or provider makes a request to the company for prior authorization of a service. The company reviews the request to make sure the service is covered under the health plan and is medically necessary and appropriate. The company will either approve or deny the request.

Denials can be appealed to the company and, if necessary, to an outside third party.

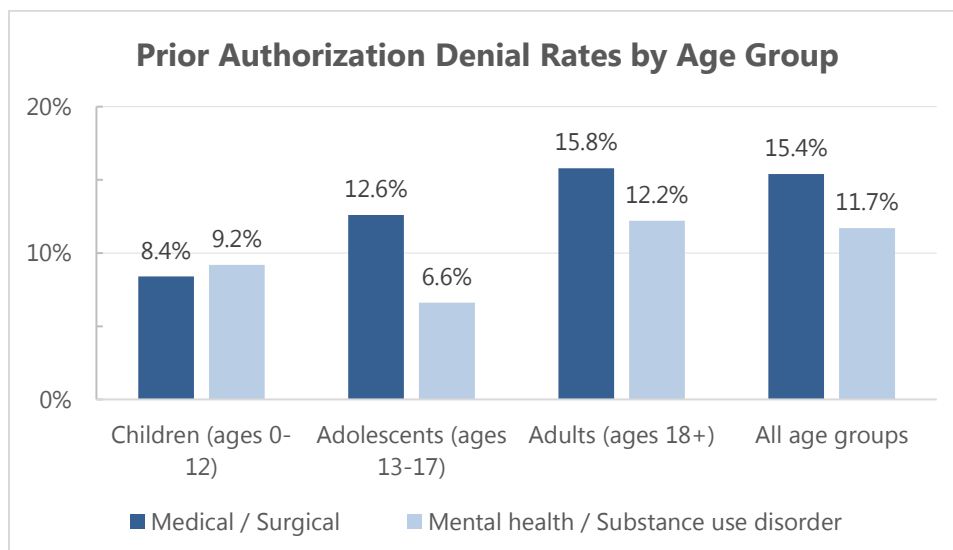
Prior authorization denial rates

The charts below show how often prior authorization requests were denied. Across all treatment categories and market segments, requests for medical and surgical services were denied 15.4 percent of the time. Mental health and substance use disorder services were denied 11.7 percent of the time.

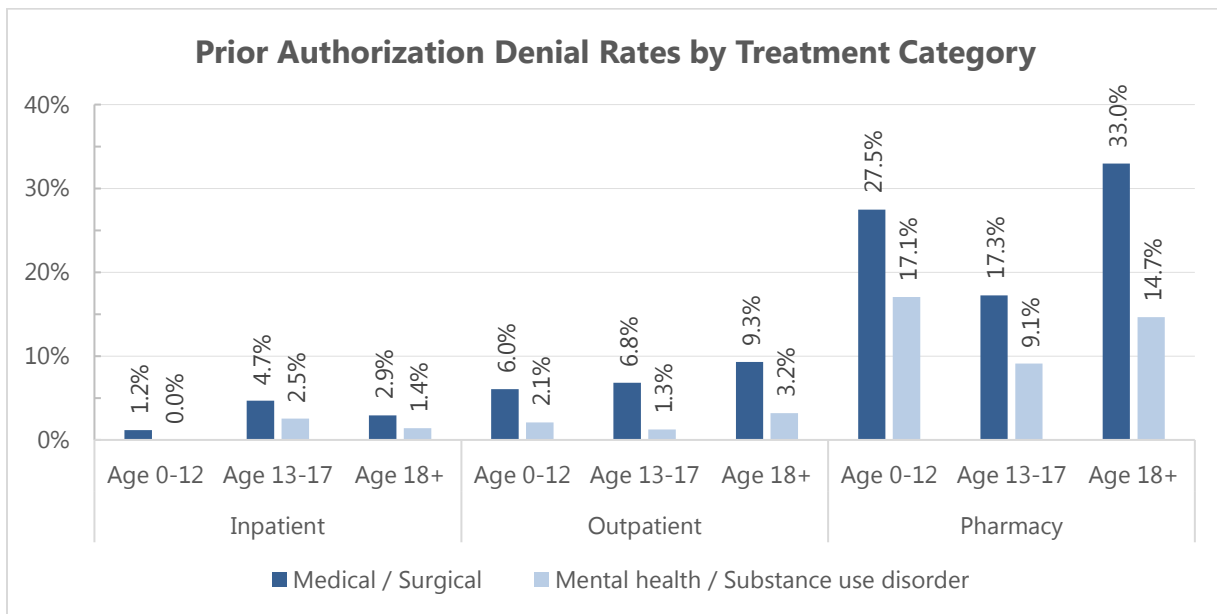


The number of prior authorization requests that were denied was reported separately for children, adolescents, and adults. The charts below show differences by age group and treatment.

With the exception of children, prior authorization requests for medical and surgical services were denied at a higher rate than those for mental health and substance use disorders.



Denial rates for pharmacy claims were significantly higher than those for inpatient and outpatient services.



Number of days to respond to prior authorization requests

This section highlights how long it takes to get an approval or denial of a prior authorization request for a treatment. A breakdown by inpatient, outpatient, and pharmacy treatment categories is shown below. Emergency claims are not included because prior approval of a service is usually not required in emergency situations.

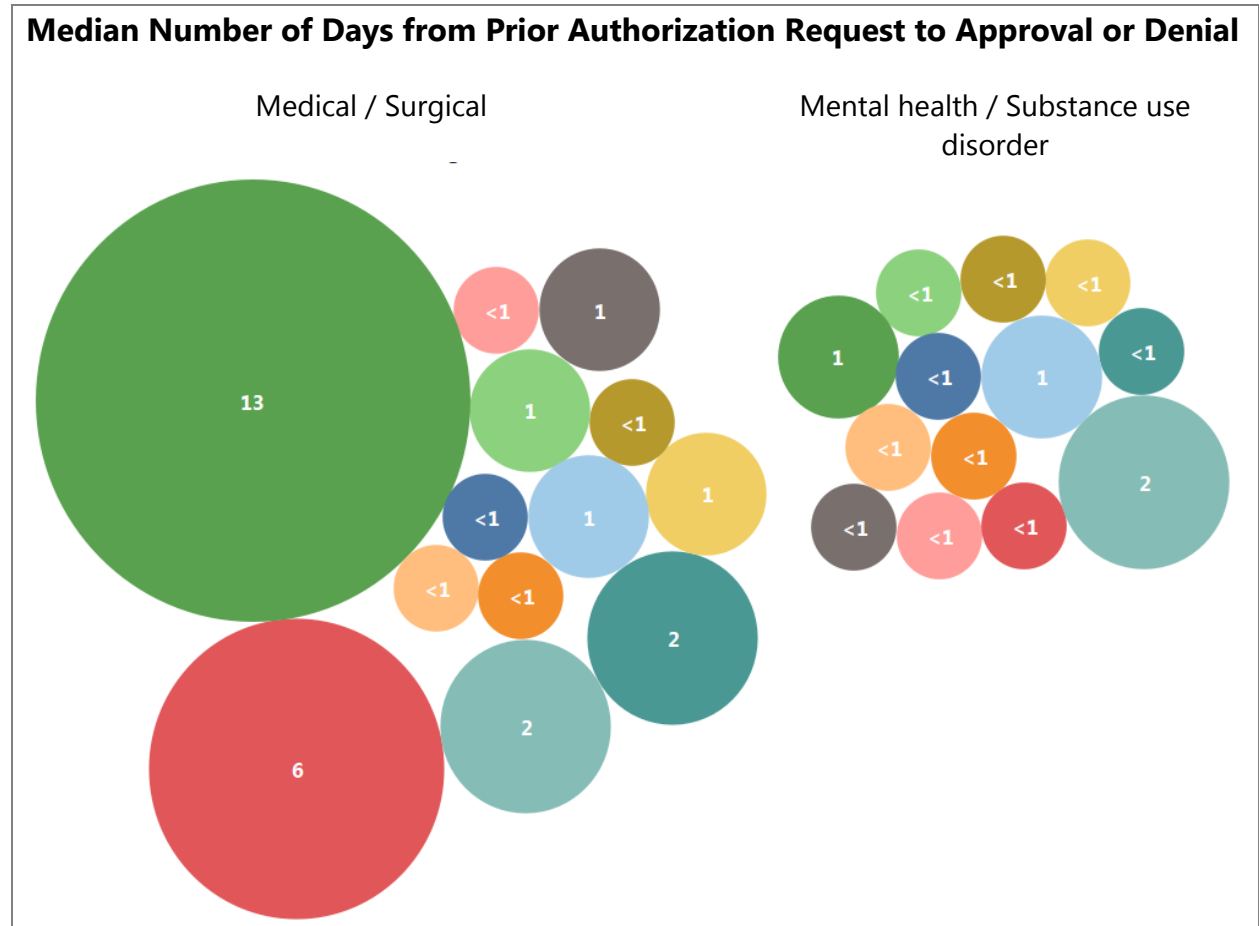
Companies reported both the median and maximum number of days it takes to respond to a request for prior authorization. The median number of days shown means that half of all prior authorization requests were either approved or denied within this number of days. For example, a median of two days means half of all prior authorization requests were approved or denied in two days or less.

In the charts below, each company is represented by a different colored bubble. The size of each bubble reflects the median number of days it took the company to make a decision. For example, the company illustrated in red reported a median of six days to approve or deny prior authorization requests for inpatient medical and surgical services, compared to a less than one day for mental health and substance use disorder services.

Similar charts showing the maximum number of days that a company took to either approve or deny a request for prior authorization can be found in the appendix.

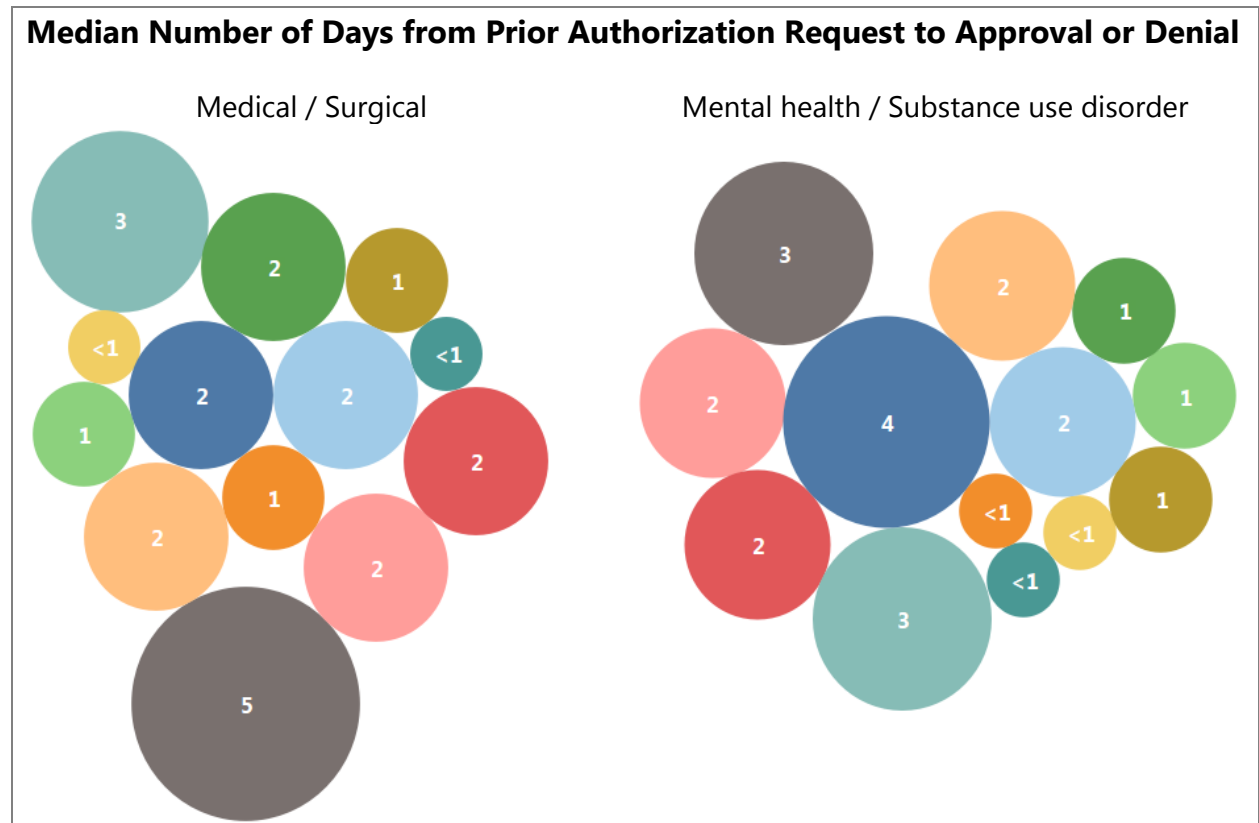
For both inpatient and outpatient services, companies tend to approve or deny prior authorization requests far more quickly for mental health and substance use disorder services. Over 60 percent of companies took one day or less in both categories.

Inpatient



For pharmacy benefits, approval or denial times were similar for both claim types. The 13 companies took a median of one to five days to approve or deny a request for both medical and surgical and mental health and substance use disorder services. Over 75 percent of these companies took two days or less.

Pharmacy



The following table shows the median numbers of days between a request for prior authorization and approval or denial by company. This table differs from the bubble charts above in that it distinguishes between in-network and out-of-network claims.

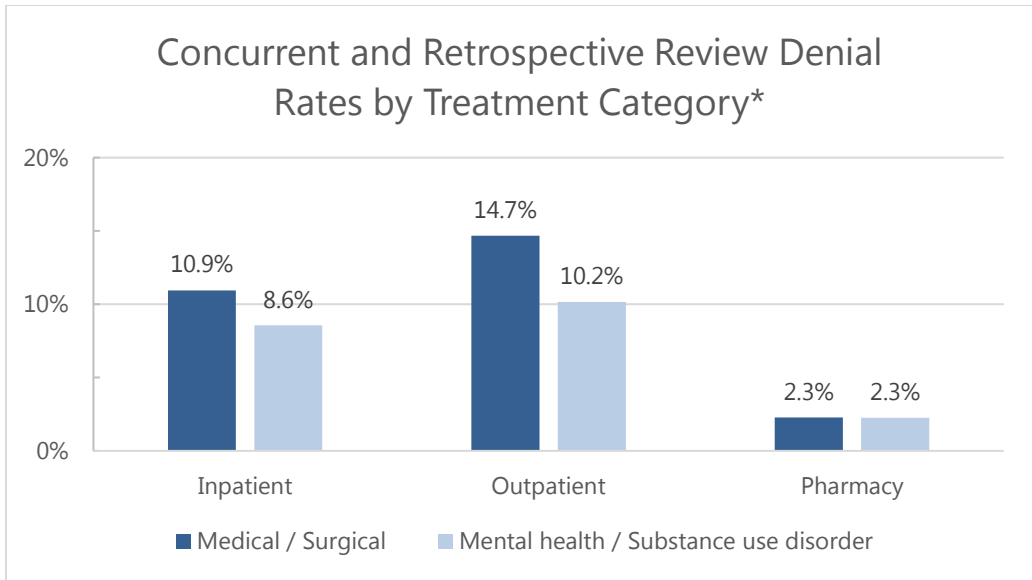
| Company | Median number of days to approve or deny prior authorization requests | | | | | | | | | |
|---------|---|-----|------------|-----|----|--|-----|------------|-----|----|
| | Medical and surgical | | | | | Mental health and substance use disorder | | | | |
| | Inpatient | | Outpatient | | Rx | Inpatient | | Outpatient | | Rx |
| | IN | OON | IN | OON | | IN | OON | IN | OON | |
| 1 | <1 | | 1 | 0 | 2 | <1 | | 1 | | 2 |
| 2 | <1 | <1 | 1 | 1 | 1 | 0 | 0 | 0 | <1 | 1 |
| 3 | 1 | 1 | 2 | 1 | 5 | 1 | 0 | 4 | 1 | 3 |
| 4 | <1 | 1 | 1 | 1 | 1 | 0 | 0 | <1 | <1 | 0 |
| 5 | 2 | | 1 | 0 | 3 | 2 | | 2 | | 3 |
| 6 | 15 | 12 | 24 | 42 | 2 | 1 | 1 | 11 | 0 | 1 |
| 7 | <1 | <1 | 1 | 1 | 2 | <1 | 0 | 0 | 0 | 4 |
| 8 | 2 | | 2 | 0 | 0 | 0 | | 2 | | 0 |
| 9 | 1 | | 1 | 0 | 1 | 0 | | 0 | | 1 |
| 10 | 1 | | 0 | 0 | 0 | <1 | | 0 | | 0 |
| 11 | 1 | | 4 | 0 | 2 | 1 | | 2 | | 2 |
| 12 | <1 | | 1 | 0 | 2 | 0 | | 0 | | 2 |
| 13 | 6 | | 12 | 0 | 2 | 0 | | 0 | | 2 |

IN = in-network; OON = out-of-network

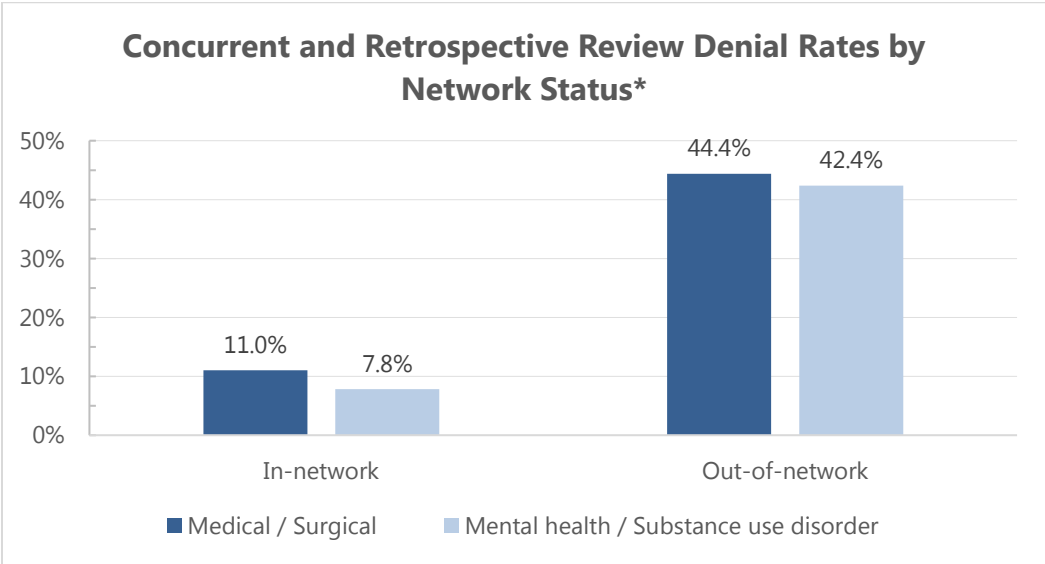
Concurrent and retrospective review denial rates

Concurrent review looks at ongoing care to make sure that the patient gets the right level of care at the right time. For example, a doctor may request that the company approve additional days of hospital care for a patient who has already been admitted. Retrospective review happens after the treatment has occurred.

Companies were asked to report the number of requests for concurrent and retrospective review, and the number of those requests that were either completely or partially denied. Overall, of claims that were subject to review, 5.25 percent of medical and surgical claims were denied, compared to 3.1 percent of mental health and substance use disorder claims. These claims are broken down by treatment category below.



Requests for concurrent or retrospective review were much more likely to be denied for out-of-network claims than in-network claims.



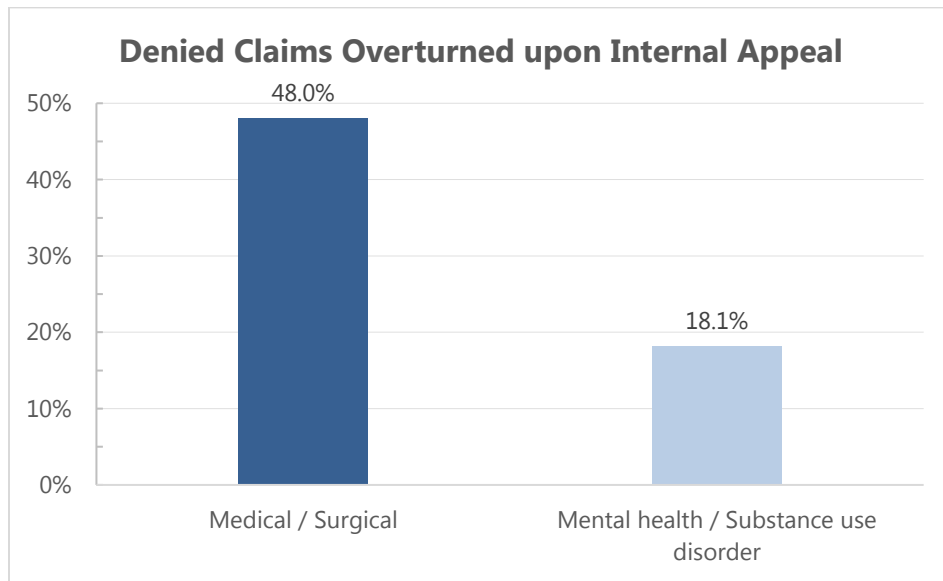
* Excludes pharmaceutical claims

Appeals of denied claims

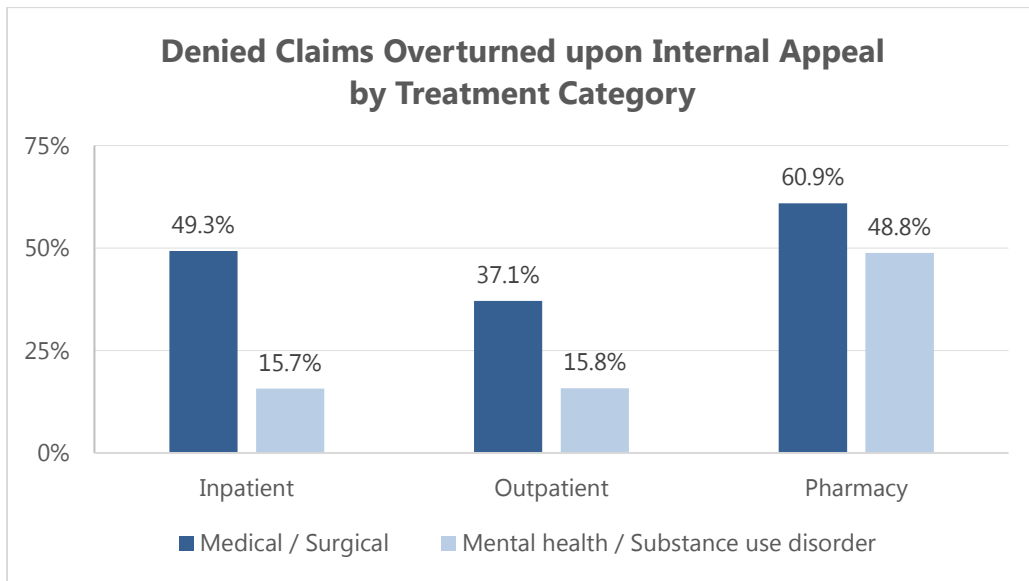
If a company denies a claim, the patient has a right to appeal its decision. An internal appeal is a request to the company to review its decision. If the company denies the claim again, the patient can appeal to an independent third party. This is called an external appeal.

TDI requested the number of internal and external appeals that were either overturned or upheld.

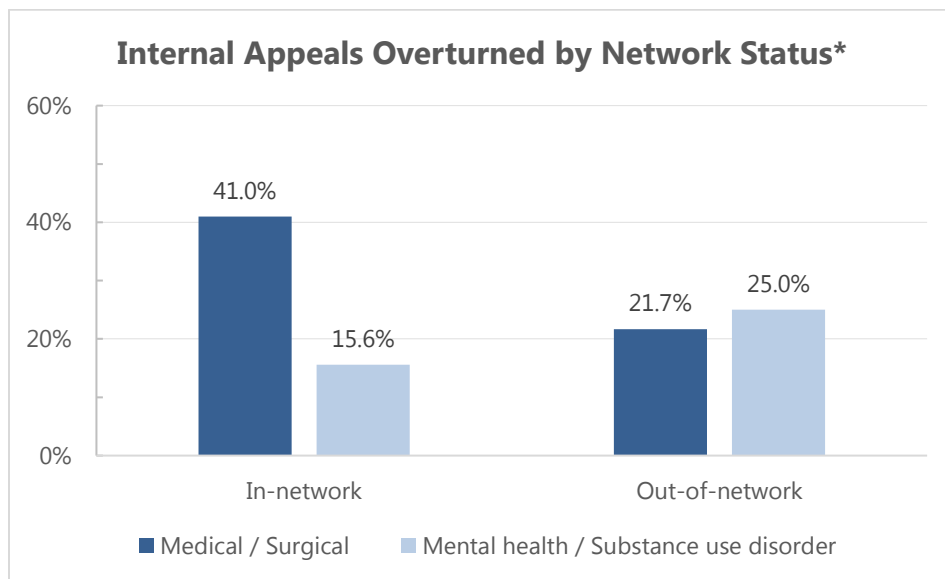
Overall, 48.0 percent of denials for medical and surgical claims were overturned through internal appeals, compared to only 18.1 percent of denials for mental health and substance use disorders.



Internal appeals were more likely to be overturned for denials of pharmacy claims compared to those for inpatient and outpatient claims.



For in-network claims, denials of medical and surgical claims were overturned significantly more often than claims for mental health and substance use disorders. For out-of-network claims, the difference was not as great.



* Excludes pharmaceutical claims

External appeals of denied claims

The number of claim denials that were overturned upon external appeal are summarized in the table below:

| External appeals | | |
|--|---------------------|---------------------|
| Category | # of Appeals | % Overturned |
| Medical and surgical | 446 | 40.8% |
| Mental health and substance use disorder | 34 | 26.5% |

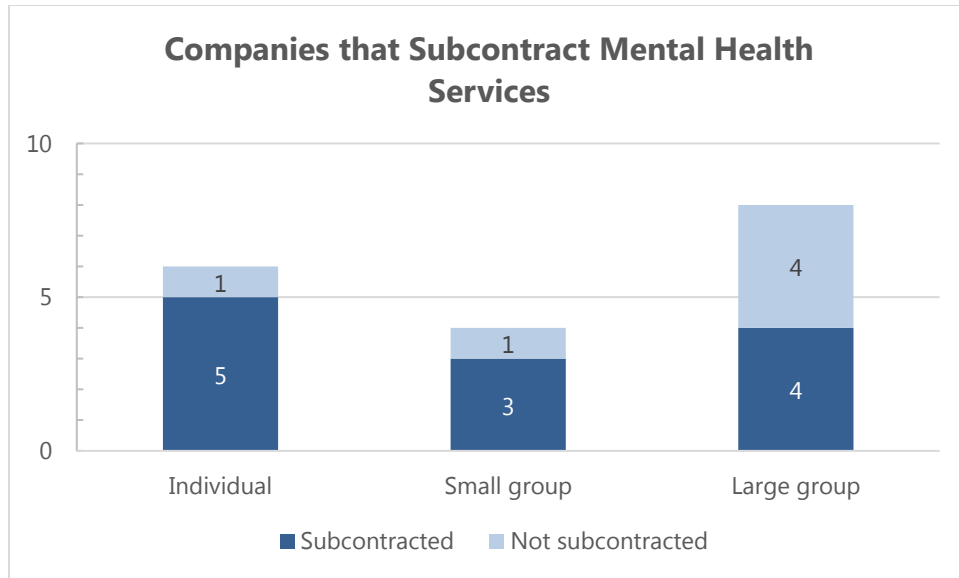
The small numbers did not allow for a meaningful analysis by market segment, plan type, or network status.

Quantitative treatment limits

Of the 13 companies included in this study, 12 reported that they imposed QTLs on some medical and surgical services, while 5 reported QTLs on some mental health and substance use disorder services. Depending on the category, diagnosis, and treatment, QTLs ranged anywhere from 1 to 365 days. Within treatment categories, no company reported a QTL for mental health and substance use disorder that was more restrictive than medical and surgical.

Subcontractual agreements

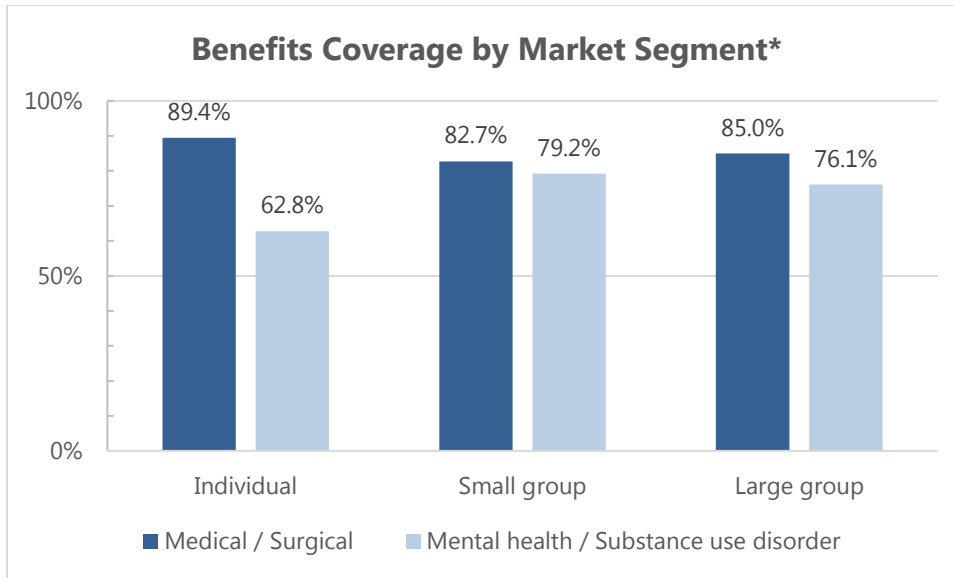
The number of companies that subcontract mental health services is given below for each market segment. In 11 out of 12 instances in which a company subcontracted these services, they also reported that providers are required to have a separate contract with the subcontracted service provider to be in the network for behavioral health services. In the individual market, most of the subcontracting providers were not affiliated with the company, while in the group markets, the subcontracting providers were all company subsidiaries.



Plan-specific data: benefit coverage

The plan-specific data form included a list of inpatient, outpatient, and emergency benefits. In response to stakeholder comments, the benefits and categories are based on those used by HHSC in its parity analysis for MCOs. These benefits and categories include the comprehensive benefit package available to children in Medicaid and include almost all commercially covered benefits. This ensured consistency among companies in the identification and categorization of benefits.

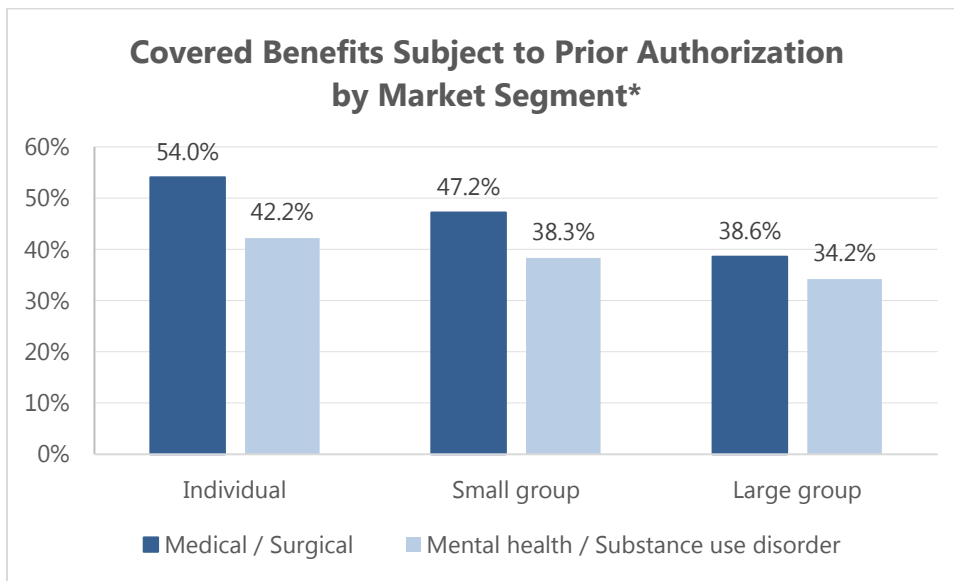
Each company reported whether each of the benefits was covered in their most popular plan. A higher percent of benefits was covered for medical and surgical benefits than for mental health and substance use disorders. The difference is especially clear in the individual market.



* Excludes prescription drugs

Prior authorization

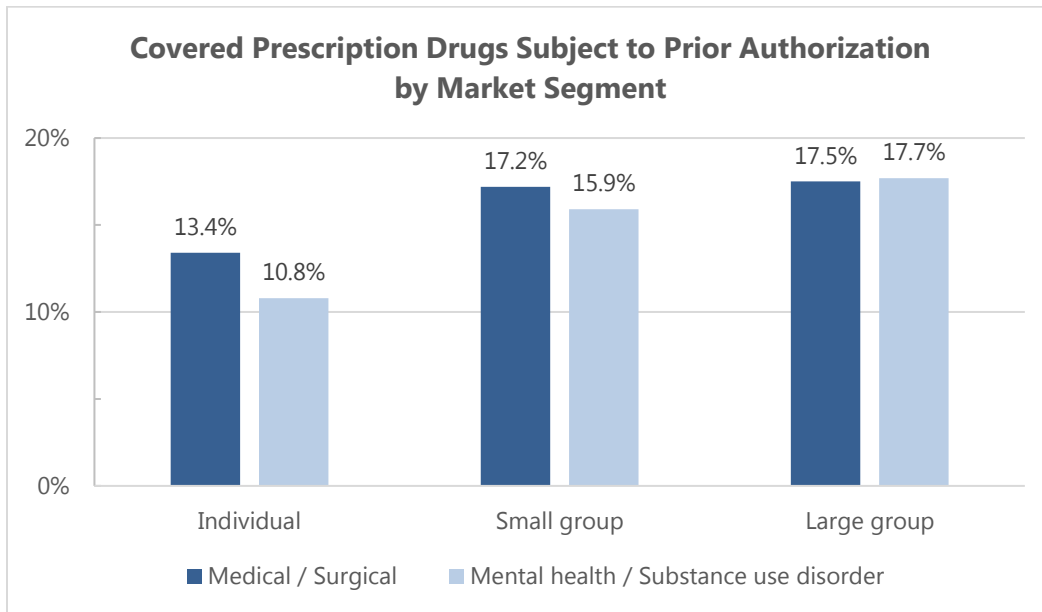
More medical and surgical benefits required prior authorization than those for mental health and substance use disorders.



* Excludes prescription drugs

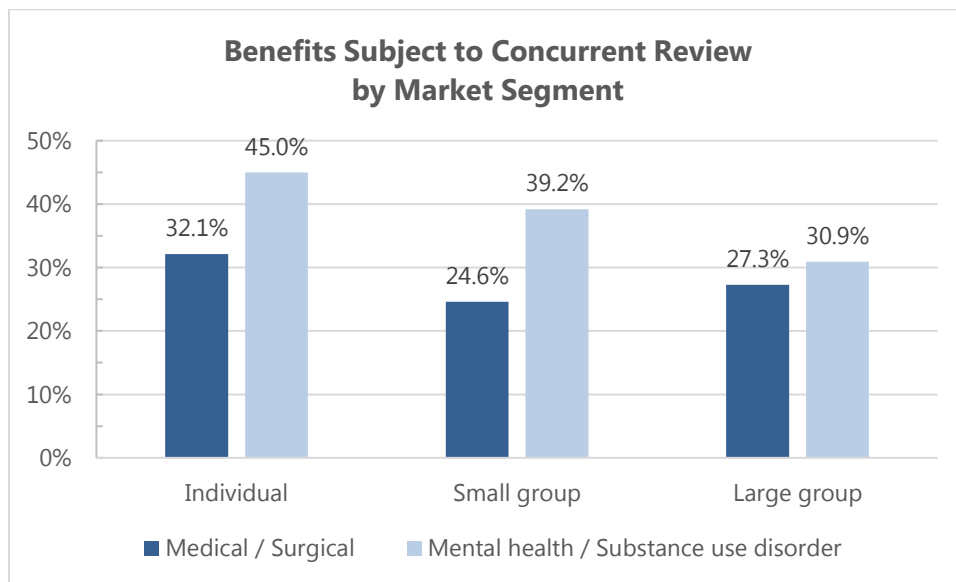
Companies reported the number of prescription drugs covered within each of the categories. The charts below show the percent of benefits covered in the individual and small group markets. In the individual and small group markets, prescription drugs in the medical and surgical category were more likely to require prior authorization than for

those in the mental health and substance use disorder category. No significant difference was seen in the large group market.



Concurrent review

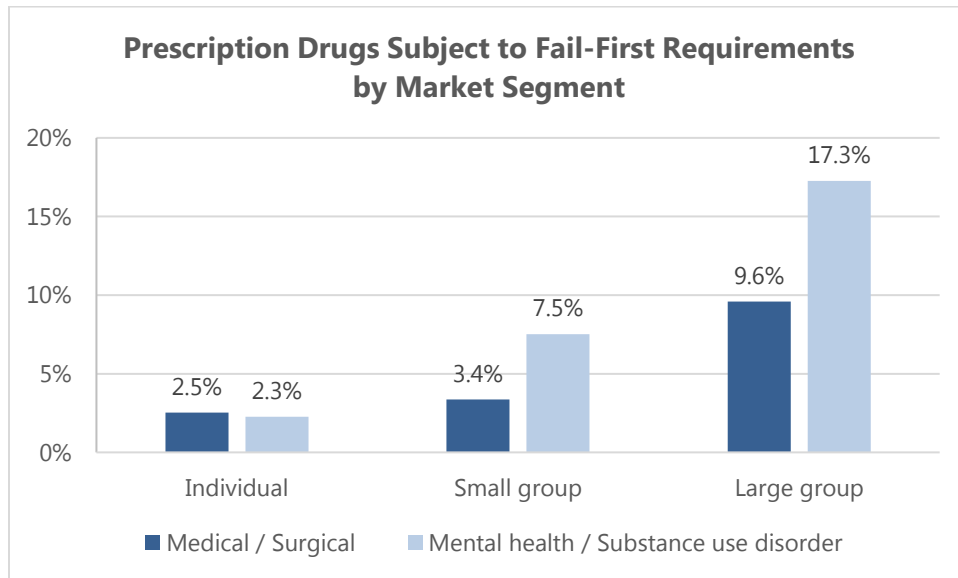
A higher percent of mental health and substance use disorder benefits are subject to concurrent review than medical and surgical benefits. This is especially evident in the individual and small group markets.



Plan-specific data: fail-first requirements

To help reduce costs, many companies use fail-first policies, also called step therapy, for prescription drug coverage. A fail-first policy requires a patient to try a less expensive drug before being prescribed a more expensive drug.

In the small and large group markets, a much larger proportion of prescription drugs for mental health and substance use disorders is subject to fail-first requirements than for medical and surgical use.



Conclusion

These data suggest that parity issues may exist in NQTLs. A detailed review would be needed to confirm the degree of the disparity. This report provides a basis for future study and may be a useful resource for companies, regulators, and stakeholders working to further evaluate benefit parity.

APPENDIX A: Glossary of common terms

- **Adverse determination** – a determination by a utilization review agent that health care services provided, or proposed to be provided, to a patient are not medically necessary, or are experimental or investigational.
- **Allowed amount** – the dollar amount covered under the health insurance plan for a particular service, including the amount of cost sharing owed by the enrollee and the amount to be paid by the plan. This term refers both to the contracted amount for in-network services and the amount designated by the plan for out-of-network services.
- **Approved claim** – a claim for a service that is determined, at initial review or on receipt of additional information, to be covered and payable at the plan’s allowed amount, instead of being denied.
- **Concurrent review** – a form of utilization review for ongoing health care or for an extension of treatment beyond previously approved health care.
- **Emergency** – health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize sudden and severe medical conditions.
- **Exclusive provider benefit plan (EPO or EPO plan)** – a type of health insurance plan in which services are covered only if the enrollee goes to preferred providers. Out-of-network care is only covered in an emergency. EPO plans are similar to HMO plans, but EPO plans are offered by insurance companies, which are regulated differently than HMO plans.
- **External appeal/independent review** – a system for final administrative review by a designated Independent Review Organization (IRO) of an adverse determination about the medical necessity, appropriateness, or the experimental or investigational nature of health care services. 28 TAC, Section 12.5(19).
- **Fail-first requirement** – a practice in which a patient must first try a less expensive course of treatment or drug that has been proven effective for most people before moving up to a more expensive course of treatment or drug. Also referred to as step therapy.
- **Health benefit plan** – a policy, certificate, or evidence of coverage that provides benefits for health care services. For the purposes of this report, the term “health benefit plan” is limited to comprehensive major medical plans only.
- **Health maintenance organization benefit plan (HMO or HMO plan)** – A type of health benefit plan that usually limits coverage to care from the doctors who work for or contract with the HMO. Out-of-network care is only covered in an emergency, or if care can't be accessed in-network. In an HMO plan, care is managed by a primary care provider and a referral is needed in order to see a specialist. HMO plans are similar to EPO plans, but HMOs are regulated differently than insurance companies.

- **Individual health coverage** – a health benefit plan purchased for an individual or family in which the policyholder is also personally enrolled under the plan. This includes coverage obtained through an exchange or marketplace and excludes coverage obtained through an employer.
- **Inpatient** – health care provided in a hospital, skilled nursing home, or residential treatment center.
- **Intensive outpatient program (IOP)** – a treatment service and support program used primarily to treat eating disorders, depression, self-harm, and chemical dependency that does not rely on detoxification.
- **Internal appeal** – a formal process by which an enrollee, an individual acting on behalf of an enrollee, or an enrollee's provider of record may request reconsideration of an adverse determination.
- **Large group coverage** – a group health benefit plan covering employees of a large employer with more than 50 employees.
- **Median (or 50th percentile)** – the middle number in a set of numbers that is sorted from smallest to largest.
- **Member months** – the aggregate number of months of coverage for all members covered by the insurance company during any part of a given year.
- **Mental health benefit** – a benefit relating to a treatment or service for a mental health condition, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law.
- **Non-quantitative treatment limitation (NQTL)** – a limit on the scope or duration of treatment that is not expressed numerically. The term includes:
 - A medical management standard limiting or excluding benefits based on medical necessity, medical appropriateness, or whether a treatment is experimental or investigational.
 - A list for prescription drugs, also known as a formulary.
 - Network tier design.
 - A standard for health care provider participation in a network, including reimbursement rates.
 - A method by which the health benefit plan determines usual, customary, and reasonable charges.
 - A step therapy protocol, also known as fail-first.
 - An exclusion based on failure to complete a course of treatment.
 - A restriction based on geographic location, facility type, provider specialty, or other criteria that limit the scope or duration of a benefit.
- **Outpatient** – services usually provided in clinics, doctor offices, hospital-based outpatient departments, home health services, ambulatory surgical centers, hospices, and kidney dialysis centers.

- **Partial hospitalization program (PHP)** – a nonresidential, hospital-based treatment program that provides diagnostic and treatment services on a level of intensity similar to an inpatient program, but on less than a 24-hour basis.
- **Partially denied prior authorization** – a request for prior authorization in which only part of the request is approved. For example, a request for a five day hospital stay is approved for only three days.
- **Partially upheld appeal** – an appeal in which an adverse determination approves a lesser amount of benefits. For example, a denied request for a five day hospital stay is approved for three days.
- **Peer-to-peer or physician-to-physician review** – an appeal, typically over the phone, to the insurance company of the necessity of a treatment for which pre-authorization was denied or partially denied. The main parties are the enrollee’s physician and a physician representing the company.
- **Pending determination** – in reference to reported claims, a claim that has not yet been approved or denied.
- **Pharmacy** – services for dispensing pharmaceutical drugs outside of an inpatient facility based on a prescription from a health care provider.
- **Preferred provider benefit plan (PPO or PPO plan)** – a type of health insurance plan that contracts with doctors and hospitals to create a network of preferred providers that can provide care to enrollees at a discounted cost. PPO plans will cover some out-of-network costs, but the enrollee will usually pay a greater portion of the cost.
- **Prior authorization** – a review process implemented by the company before treatment, to determine whether it will cover a prescribed procedure, service, or medication.
- **Prospective review** – a utilization review conducted before the delivery of a requested inpatient or outpatient medical service.
- **Residential treatment facility** – a live-in health care facility providing therapy for medical conditions, substance abuse, mental illness, or other behavioral problems.
- **Retrospective review** – a utilization review conducted after treatment has been provided.
- **Quantitative treatment limitation (QTL)** – a limit on the scope or duration of treatment based on an accumulated amount, such as an annual or lifetime limit on days of coverage or number of visits. The term includes a deductible, a copayment, coinsurance, or another out-of-pocket expense or annual or lifetime limit, or another financial requirement. Texas Insurance Code, Section 1355.251(3).
- **Reported claims** – for purposes of this report, claims reported by providers, or by the insured, to companies in 2017 regardless of the incurred date, final decision date, or pending status. For example, claims reported in 2017 could include claims

incurred in 2016, claims with final decisions made in the first few months of 2018, or claims awaiting a determination.

- **Requests for prior authorization** – for purposes of this report, requests received during the reporting period, regardless of the incurred date.
- **Small group coverage** – a group health benefit plan covering employees of a small employer with 2 to 50 employees.
- **Subcontracted mental health** – when a company contracts with a behavioral health organization or other entity to manage the mental health and substance use treatment needs of members covered under a health benefit plan.
- **Substance use disorder benefit** – a benefit relating to an item, treatment, or service for a substance use disorder, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law. Texas Insurance Code, Section 1355.251(4).
- **Utilization review** – a system for prospective, concurrent, or retrospective review of the medical necessity or appropriateness of health care services, or to determine the experimental or investigational nature of the services. For purposes of this report, the term does not include a review in response to an elective request for clarification of coverage. Texas Insurance Code, Section 4201.002(13).

APPENDIX B: Timeline

These are significant events in the history of mental health parity. Events specific to Texas are shown in bold.

- 1961 – President Kennedy directed the Civil Service Commission (now the Office of Personnel Management) to implement parity.
- **1989 – Texas SB 911, 71st Legislature, Regular Session (1989) required parity for the coverage of chemical dependency treatment in both small and large group plans.**
- **1991 – Texas provided parity for state and local government employees.**
- 1992 – The first federal parity legislation (S. 2696) was introduced in Congress.
- 1996 – The Mental Health Parity Act (MHPA) 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.
- **1997 – Texas HB 1173, 75th Legislature, Regular Session (1997) required parity in the treatment of serious mental illness as a mandate in large group plans and as an offer in small group plans.**
- 1999 – President Clinton directed the Office of Personnel Management to implement parity in the Federal Employee Health Benefit Plan.
- **1999 – TDI adopted mental health parity rules to implement the MHPA (28 TAC Chapter 21, Subchapter P, Sections 21.2401 – 21.2407).**
- 2003 – President Bush’s New Freedom Commission on Mental Health included a recommendation about parity in the Commission’s Final Report.
- 2008 – The Mental Health Parity and Addiction Equity Act (MHPAEA) was signed into law. The act extended parity requirements to substance use disorders and applied to large group health plans, including employer-sponsored plans. Effective for most plans starting in 2010.
- 2010 – The Affordable Care Act (ACA) was enacted and extended parity protections to individual health insurance policies.
- 2010 – Interim final rules issued to implement MHPAEA. Effective for most policies and plans in 2011.
- **2011 – TDI amended mental health parity rules to implement the MHPAEA.**
- 2013 – Final rules issued to implement MHPAEA. Effective for most policies and plans in 2015.
- 2013 – Final rules on Essential Health Benefits (EHB) issued, which implemented mental health and substance use disorder as a category. Also extended MHPAEA final rule parity requirements to small group insurance and individual insurance plans starting in 2015.
- **2017 – Texas HB 10, 85th Legislature, Regular Session (2017) required individual and group health plans that include coverage for mental health or**

substance use disorders to provide services in parity with coverage for medical or surgical services, with respect to both quantitative and non-quantitative treatment limits. The bill required TDI to conduct a study on benefits for medical and surgical expenses and for mental health conditions and substance use disorders. This report is the result of that study.

APPENDIX C: Review procedures for data submissions

Staff performed several tests on the data submitted by the insurance companies to detect errors and improve consistency. If any of the tests below failed, the company was asked to fix the problem unless the amounts in question were immaterial. In addition to the tests below, the data submissions were given a subjective review to identify potential issues.

Aggregate workbook

- If a company reported claims within a category, it should also provide detail on utilization reviews of those claims. Conversely, if the company reported utilization reviews or other detail within a category, it should also report the number of claims, as well as approvals and denials.
- Within any claim category, the reported number of claims should equal the sum of approved, denied, and pending claims.
- Within any claim category, the number of requests for prior authorization should equal the sum of approved, denied, partially denied, and pending requests.
- Within the inpatient and outpatient categories, if the reported mental health and substance use disorder claims was zero, the company was asked to verify or revise and provide an explanation if necessary.
- Within the generic and non-generic pharmacy categories, if the reported mental health and substance use disorder claims was zero, the company was asked to verify or revise, and provide an explanation if necessary.
- Within any claim category, a company should report "Y" to quantitative treatment limitations (QTLs) if it provided detail regarding the QTLs.
- Any round numbers that appeared artificial, such as 1,000, were questioned.

Plan-specific workbook

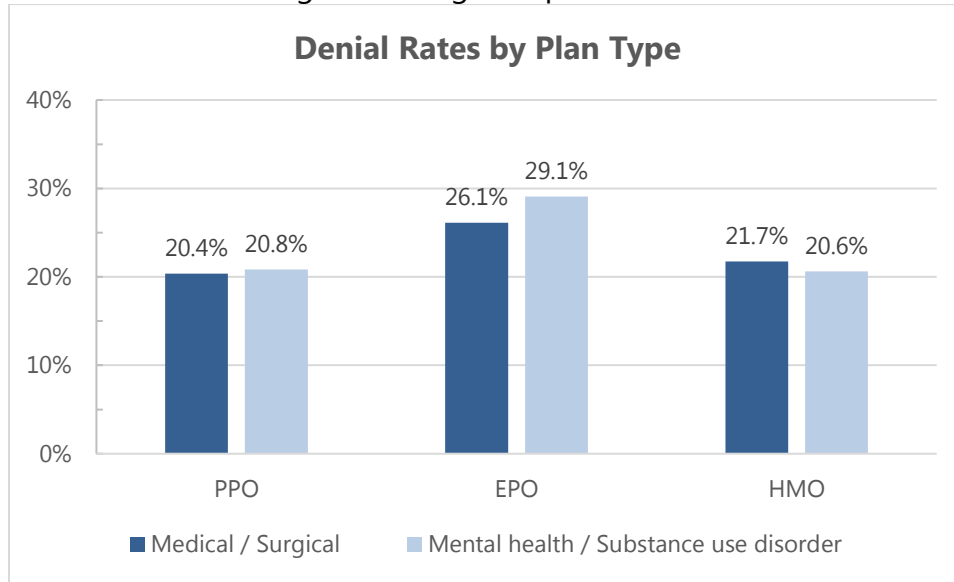
- For each listed benefit, the company should answer either "Y" or "N" as to whether the benefit is covered.
- If a company reported "Y" to a particular benefit being covered, it should also answer whether the benefit requires prior authorization or concurrent review, and whether it is subject to a fail-first requirement. Conversely, if a company responded "Y" to a benefit category requiring prior authorization, concurrent review, or fail-first, but responded "N" to being a covered benefit, the "N" response was corrected to "Y".
- On the pharmacy data sheets, the reported number of covered drugs within a category should be equal to or greater than the reported number of drugs requiring prior authorization, fail-first therapy, or other medical management.

APPENDIX D: Additional detail

This appendix provides additional detail relating to the charts contained in the body of the report.

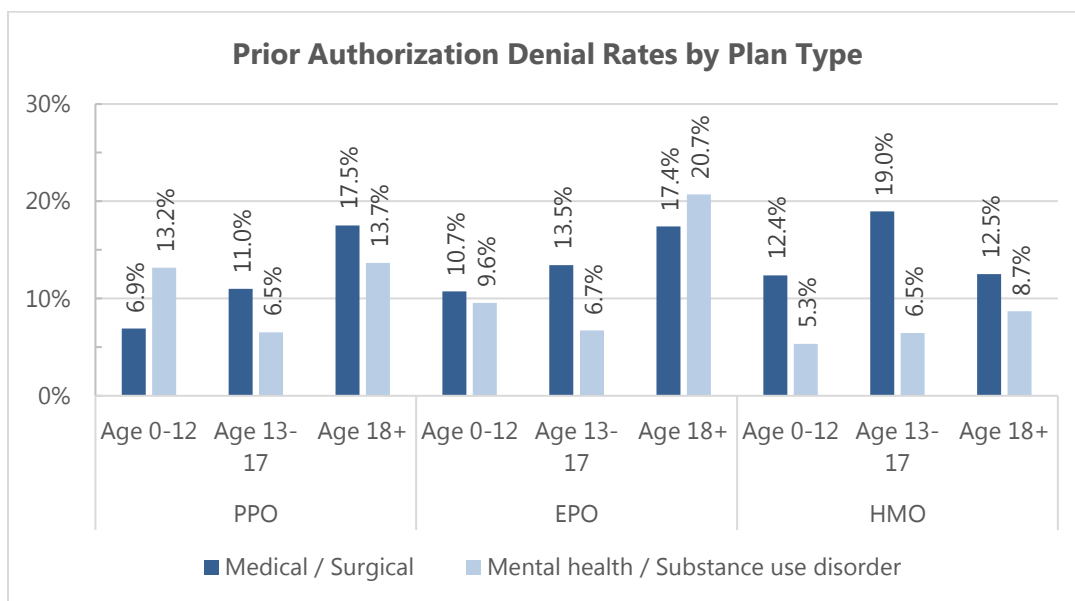
Claim denial rates

Denial rates were somewhat higher among EPO plans.

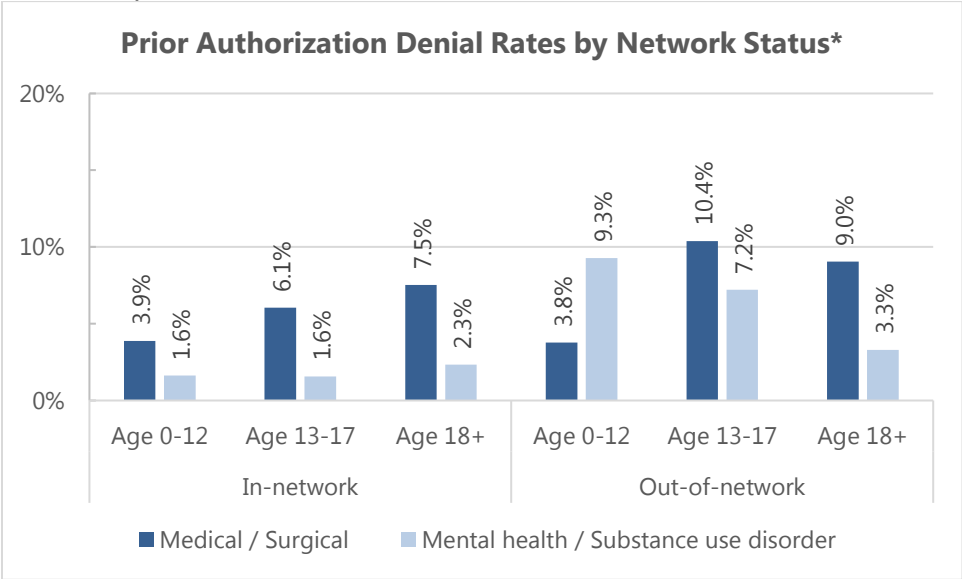


Prior authorization

Approximately 90 percent of prior authorization requests were for adults. The denial rate of prior authorization requests for that age group was lower for HMO plans than other plan types.



Out-of-network prior authorization requests were denied at a somewhat higher rate than in-network requests.



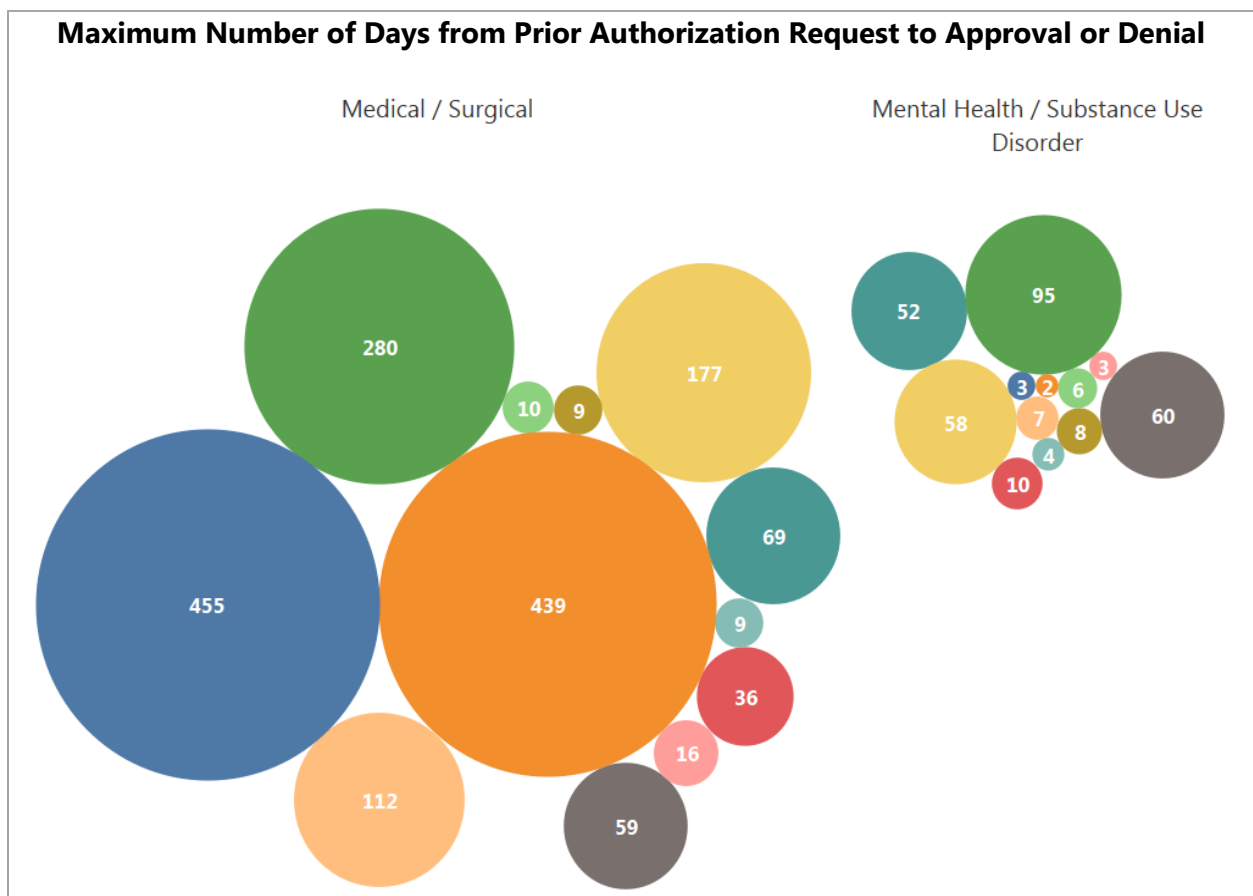
* Excludes pharmacy claims

Maximum number of days to approve or deny prior authorization requests

Inpatient services

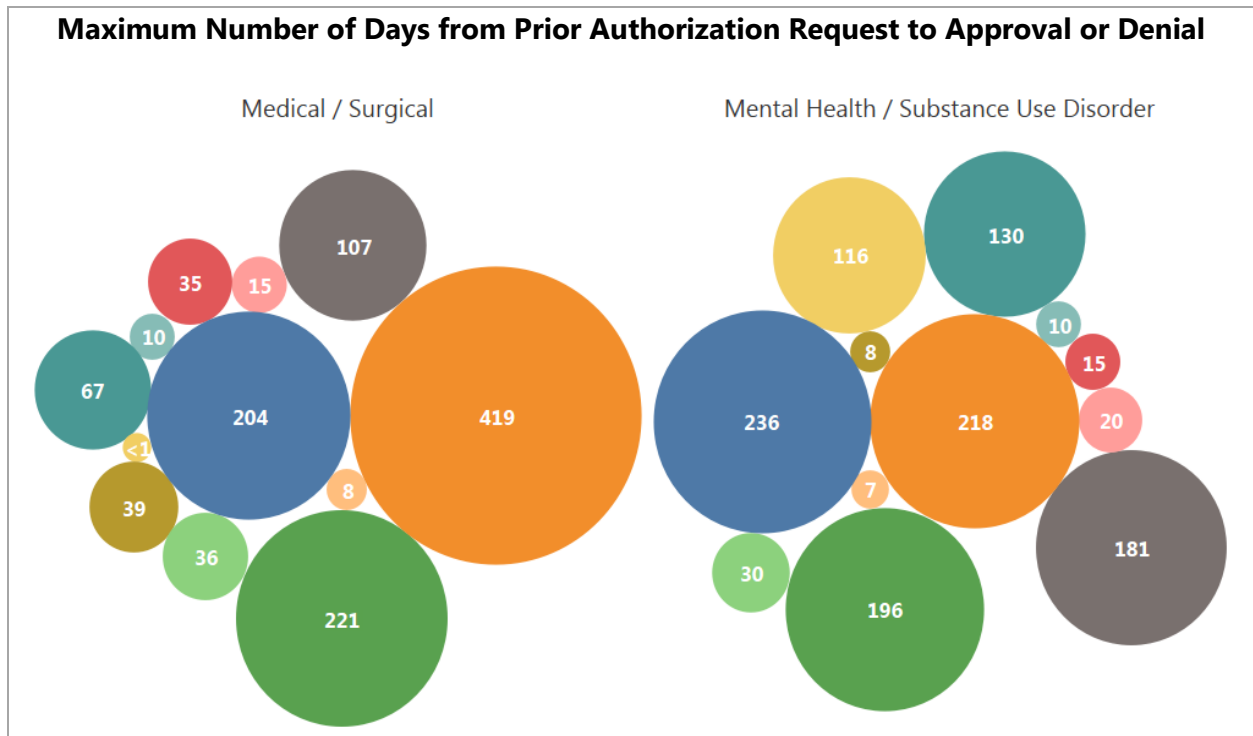
For inpatient services, the maximum number of days varied from less than 9 days to 455 days (15 months) for medical and surgical services, and 2 to 95 days (three months) for mental health and substance use disorder services. It's difficult to draw a conclusion from the maximum days reported because the result can be driven by a single outlying claim.

Note: one of the 13 companies did not report prior authorization data for inpatient and outpatient services. Therefore, the following two charts only include data for 12 companies.



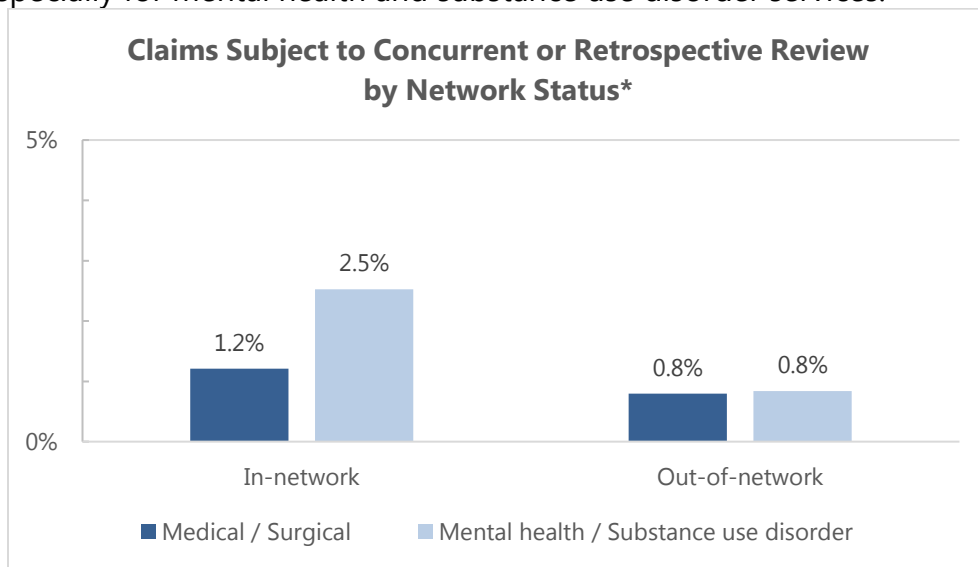
Outpatient services

For both benefit types, some companies reported taking more than 200 days to approve or deny the request for prior authorization.



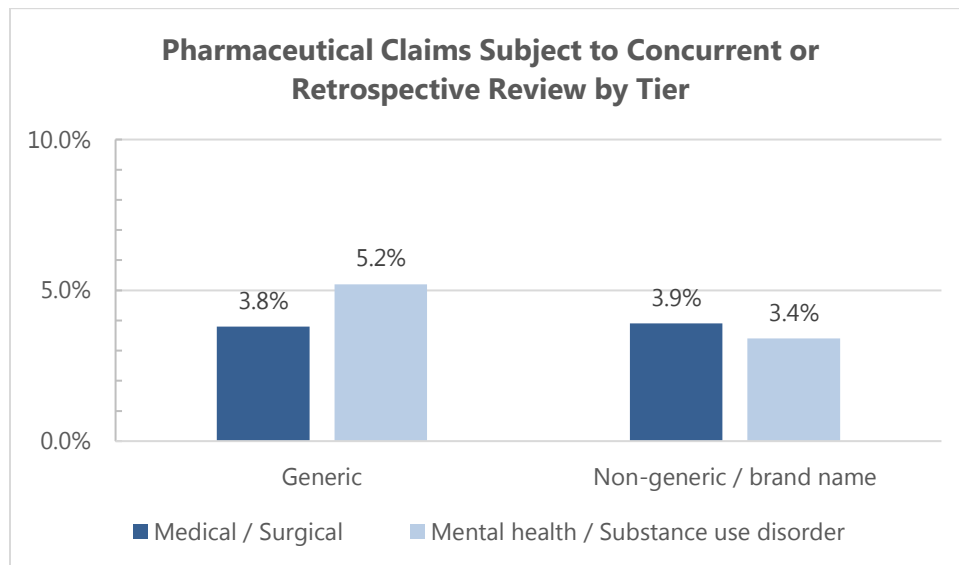
Concurrent and retrospective utilization review

In-network claims were subject to utilization review at a higher rate than out-of-network claims, especially for mental health and substance use disorder services.



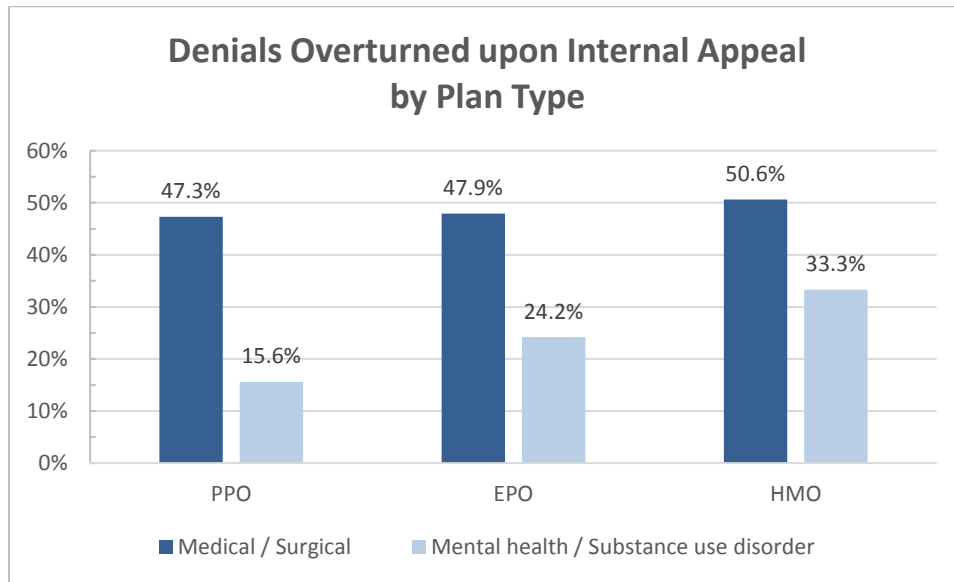
* Excludes pharmacy claims

For mental health and substance use disorder pharmacy claims, generics were subject to utilization review at a higher rate than brand name drugs.



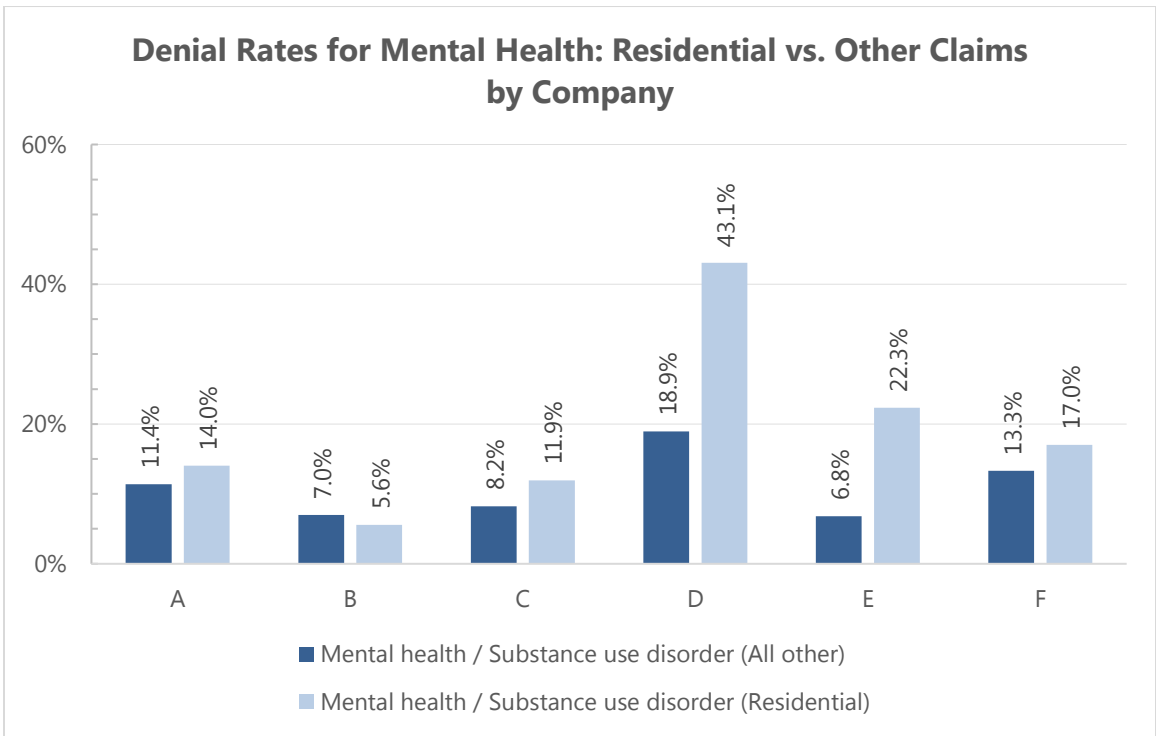
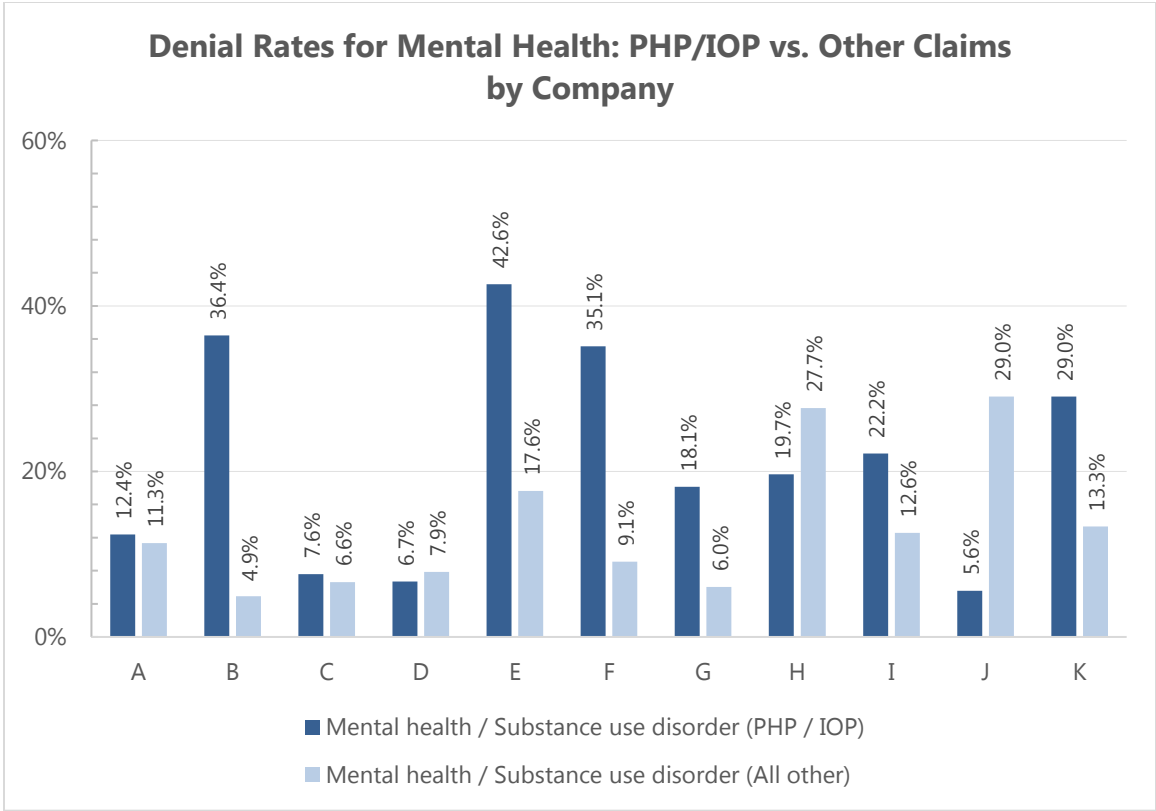
Denials that were overturned upon internal appeal

HMO plans had a higher rate of adverse determinations overturned through internal appeal. PPO and EPO plans had similar percentages overturned.



Denial rates within classes of treatment

The following charts provide further detail on denial rates for companies that reported sufficient data. These charts combine data from the individual, small group, and large group markets. To protect confidentiality, each company shown in the charts is labeled with a letter. The companies appear in random order, and the order varies for each set of charts.



Denial Rates for Medical/Surgical: Residential vs. Other Claims by Company

