WHY PARITY?

American Psychiatric Association
April 2016

Colleen M. Coyle
General Counsel
ROAD MAP

Good news

Not so good news

Objectives today
MHPAEA – IT IS COMPLICATED

Oops, No I meant the First
You’ll have to go round again (M32, M4)
(M32)

Take the second exit
Look I said I was Sorry
The Paul Wellstone & Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), “[is] designed to end discrimination in the provision of coverage for mental health and substance use disorders as compared to medical and surgical conditions.”


Affordable Care Act – Section 1557 – potential additional opportunities
MHPAEA BASIC RULE

In general:
Applies to:
1. group health plan (or health insurance coverage offered in connection with such a plan) (will explain in a minute);
2. ACA plans
3. Medicare plans
4. Medicaid plans
5. Federal Employee benefit plans. . .
   That provide both medical/surgical and mental health/SUD benefits

Requires that:
Financial requirements and treatment limitations are similar on both sides of the house and there are no separate cost sharing requirements applicable only to mental health/SUD.
WHO HAS TO COMPLY?

- **Group health plan** -- self insured employer plan, employer plan with more that 50 employees
  - e.g. IBM self insures, hires Cigna to administer plan, but when a claim is made money is from IBM, not Cigna.
  - *New York State Psychiatric Assn. v. United Health Care*, expanded to include Cigna if Cigna has significant discretion in determining benefits under the employer’s plan
- Or **insurance coverage offered in connection with a group health plan**. Fully insured plan. Benefit payment comes from Cigna directly, not IBM
- Funding mechanism and control of benefits tells you who may be legally responsible
Parity analysis is comparison of what happens with mental health vs. what happens with medical/surgical claims.

- Showing only what happens with mental health is only half the story
- Coverage does not have to be good; just as good as medical/surgical

- You cannot discriminate – it is an equal opportunity statute that Congress believed would be regulated by market economics
NEED BOTH PARTS OF THE INFORMATION TO SEE IF THERE IS A BALANCE
WHAT DO YOU NEED TO FIGURE IT OUT?

PLAN DOCUMENTS

Summary usually ok
WHAT ARE FINANCIAL REQUIREMENTS?

• “Deductibles, copayments, coinsurance, or out-of-pocket maximums.”
  - 29 C.F.R.2590.712(a)

• Should be fairly obvious on face of plan, e.g. double co-payments for E/M and psychotherapy in one visit
  • Are there double co payments for medical surgical add on codes?
There are 2 kinds of treatment limitations:

1. Quantitative Treatment Limitations (QTLs)

2. Non-Quantitative Treatment Limitations (NQTLs)

- 29 C.F.R. 2590.712(a)
**QTLs**

Quantitative treatment limitations are those expressed numerically, such as

- Limits on the number of **days** or **visits** covered
- Limits on the **frequency** of treatment
- Prior authorizations after **X number** of visits

QTL Test:

- Does limitation apply to substantially all (i.e., at least 2/3) of med/surg benefits?
- No? violation; yes? Is the number selected the predominant one (i.e. applies more than 50% of the time on the med/surg side?) No? Violation
ARE YA WITH ME STILL? – THAT WAS THE EASY PART!
Non-Quantitative treatment limitations (NQTL) are not expressed numerically – they are anything that is not numerical but otherwise limits the scope or duration of treatment (much room for imagination)

- Network Adequacy
- Medical necessity criteria
- Preauthorization requirements
- Standards for provider admission to participate in-network, including provider reimbursement rates
- Determination of usual, customary, reasonable amounts for OON
NQTL = APA AND DB/SA PLAYGROUND

SHOW ME WHERE THE BULLIES ARE
For non-quantitative treatment limitations (NQTLs), plan cannot impose any limitations on MH/SUD that are not comparable to those used for medical/surgical, and cannot apply them more stringently to MH/SUD than medical/surgical.
“under the terms of the plan as written and in operation,
  • any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to mental health or substance use disorder benefits in the classification are
  • comparable to, and are 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.”

Compares processes and strategies and how they are applied . . . Not results
Alabama:
- Ranked 39/50 in access to mental health care
- Division of Insurance claims no authority to enforce MHPAEA
- Does have authority to enforce state parity law – less restrictive than federal law (and preempted)
  - Does not cover SUD
  - Does not cover small employer plans (<50 employees)
  - Covers only in patient, out patient and partial hospitalization (day treatment)
  - Terms and conditions can be “no less extensive” than other medical services
  - Requires plans to file “Alabama Group mental Health Parity Cost Report” certifying compliance with state parity law
  - DOI Bulletin (2009) informing plans they must comply with federal parity law (HHS enforces)
IS THIS YOU RIGHT ABOUT NOW?

You are not alone . . .
APA enforcement focus
NETWORK ADEQUACY TIES IT UP

DISCLOSURE

Network Adequacy

NQTL

Rates

Medical Necessity Denials

Contract Terms

Documentation/Audits

© 2016 American Psychiatric Association. All rights reserved.
Buy XYZ insurance for its robust network of psychiatrists
Network Adequacy is an NQTL and a derivative of a number of other NQTLs (e.g., contract fairness, rates, credentialing, etc.)

Adequacy of a network can be measured on its face (e.g., claims filed in- and out-of-network for MH/SUD versus medical/surgical)

If substantially greater OON on MH/SUD side, need to find out why
THE PROBLEM OF NETWORK [IN]ADEQUACY

No standard definition – state by state
• “Robust” “Sufficient” networks
• Time and distance requirements
• Plan-driven geo-access analysis
• What should standard be?

No real monitoring
• Plans submit list of providers that meets standards
Lists or Provider Directories not real
• “Phantom” networks
• Can you and allies develop proof like this?
  • Yes ... stay tuned

• New Jersey
  • 33% listed had incorrect contact
  • 16% not taking new patients
  • 8% were not psychiatrists
  • 13% were hospitalists [inpatient only]
  • 51% were taking new patients
    • 24% had wait times of + 2 months
    • 25% had wait times of 1-2 months
    • 25% had appointments in 2-4 weeks
    • 25% had appointments in < 2 weeks
NETWORK [IN]ADEQUACY

Maryland

- Only 43% in directory could be reached
- 19% “psychiatrists” – were not psychiatrists
- 40% accepted insurance they were listed as accepting
- 18% accepted insurance noted and new patients
- 1/7 accepted new patients and could provide appointment within 45 days

NAMI Study

- 21% nationwide cannot find in-network psychiatrist

APA DC Study
ROOT CAUSES INADEQUACY—

- Lower rates for psychiatrists for same CPT codes
- Excessive audits of higher intensity treatment
  - Makes it difficult to treat SMI
- Excessive medical necessity denials:
  - More rigorous and frequent utilization review for mental health
  - More frequent denials
  - In network, no payment for denied care, claw-backs on review
  - Improper disclosure as to how decisions are made
- Prior authorization
- Contracts of Adhesion (members accepting that)
- Pharmacy benefit issues (?)
Psychiatry’s Use of Outpatient E/M Codes

99211 – 2%
99212 – 9%
99213 – 56%
99214 – 28%
99215 – 4%
## BCBS (FL)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Medicare</th>
<th>Psychiatrist / Other Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>75.56</td>
<td>72 / 131</td>
</tr>
</tbody>
</table>

## Anthem (CT)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Medicare</th>
<th>Psychiatrist / Other Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>78.64</td>
<td>74 / 86.45</td>
</tr>
<tr>
<td></td>
<td>116.64</td>
<td>110 / 127.79</td>
</tr>
<tr>
<td></td>
<td>157.25</td>
<td>132 / 171.64</td>
</tr>
</tbody>
</table>
### Area: Columbia, MD

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Medicare</th>
<th>Blue Cross</th>
<th>VO</th>
<th>Aetna</th>
<th>Cigna</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>76.08</td>
<td>56.43</td>
<td>36</td>
<td>46</td>
<td>54.96</td>
</tr>
<tr>
<td>99214</td>
<td>112.88</td>
<td>95.62</td>
<td>53</td>
<td>84.40</td>
<td>86.06</td>
</tr>
<tr>
<td>99215</td>
<td>151.31</td>
<td>79.25</td>
<td>72</td>
<td>126.62</td>
<td>124.68</td>
</tr>
</tbody>
</table>

### Area: Delaware

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Medicare</th>
<th>Blue Cross</th>
<th>Optum</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>74.55</td>
<td>60.27</td>
<td>29.75</td>
</tr>
<tr>
<td>99214</td>
<td>108.10</td>
<td>91.34</td>
<td>54.75</td>
</tr>
<tr>
<td>99215</td>
<td>144.79</td>
<td>123.49</td>
<td>91</td>
</tr>
<tr>
<td>Magellan (NC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-----</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>CPT Code</td>
<td>Medicare</td>
<td>Psychiatrist</td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td>68.91</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>99214</td>
<td>103.93</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>99215</td>
<td>140.35</td>
<td>80</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VO (CT)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT Code</td>
<td>Medicare</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>99213</td>
<td>78.64</td>
<td>45</td>
</tr>
<tr>
<td>99214</td>
<td>116.64</td>
<td>51</td>
</tr>
<tr>
<td>99215</td>
<td>157.25</td>
<td>82</td>
</tr>
</tbody>
</table>
Drive psychiatrists out of network; shifting higher costs to MH/SUD patients – contrary to intent of MHPAEA

- Higher cost to mental health user (OON); UCR percentage of network (FINANCIAL LIMITATION –QTL)
- Driving in-network psychiatry to medication-only treatment
  - Limit psychotherapy visits and payment for psychotherapy (NQTL)
  - Encourage split visits between providers that patients will not make (NQTL)
    - Double co-payments (FINANCIAL LIMITATION –QTL)
  - Do not access care at all (no mental health coverage – Pre-MHPAEA)
• Much higher OON use for mental illness; higher cost
  48% vs. 8%
• Only 38% of those with mental illness receive care
• 58% patients taking psychotropic drugs have no psychiatric diagnosis
  • Given by primary care physicians
    • Paid less if diagnosis is a mental illness or maybe just don’t diagnose correctly
    • Depression = Insomnia = antidepressant
APA WORK SO FAR

- *Savulak v. Anthem*
- *NYSPA v. United Health Care*
- Network of attorneys thinking through legal issues
- Challenged mergers; invited by DOJ to explain
- Regular contact with DOL re: enforcement problems and issues
- Consulting with HHS re: enforcement
- Networking with patient groups to find complainants
- Educating members, like you – poster ([www.psychiatry.org](http://www.psychiatry.org))
- Educating the public, post cards
- Meetings with state attorneys general; group looking at fraud issues
APA WORK SO FAR

- “Go to” for press background
- Introducing patients to press
- Memorandum from President Obama re: task force on parity enforcement
- Employer coalitions
- Congressional bills re: comprehensive mental health reform
- Model network adequacy act
- Secret shopper surveys
- Working with Insurance companies who are interested
- We can help at the state level, but need state level engagement for:
  1. Identifying patients to complain
  2. Understanding local laws and what is happening in the industry
  3. Knowing key players and how to persuade them
Psychiatrists’ Patients by Payment Source (Mean %)

- **Private Insurance, 28%**
- **Medicaid, 17%**
- **Medicare, 13%**
- **Self-Pay, 25%**
- Other Public, 12%
- **Other, 5%**

*26% of self-pay patients received receipts/bills from their psychiatrist to submit for insurance reimbursement.

**Other includes no charge/uncompensated, worker’s compensation.
WHY SHOULD YOU CARE?

• I don’t participate in the network . . .
  • Patient does
  • Plans eliminating OON benefits; only pay for in-network care
• Scope of practice; if not you, then who?
• Put yourselves out of the market – requirement to have a psychiatrist?
• Next gen practice – players will be participants
• Need to find a way to change practice mix to include more covered lives at reasonable costs with less interference with patient care
• Enforcement of MHPAEA – better rates, less hassle, equal treatment
Current Supply/Demand Economics
DISCUSSION – WHAT WOULD IT TAKE?

- To get you to participate in a network if you do not already?
- To get you to see more patients who have insurance?
- To get you to consider alternate payment models?
- What if there were a group you could join . . .
"A boat doesn't go forward if each one is rowing their own way."

© 2016 American Psychiatric Association. All rights reserved.
STILL AWAKE?
QUESTIONS?

Colleen Coyle
ccoyle@psych.org