WHY PARITY?

American Psychiatric Association

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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
ANTI-DISCRIMINATION LAW

- 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
• **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
  6. 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 than 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 is legally responsible
PARITY IS A COMPARISON – A BALANCE

• 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 statue 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.
  • Are there double co payments for medical surgical add on codes?
WHAT ARE TREATMENT LIMITATIONS?

• 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!
NQTLs

• 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
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.
NQTL TEST

• “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
STATE PARITY LAWS—IMPORTANT

• 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 much comply with federal parity law (HHS enforces)
IS THIS YOU RIGHT ABOUT NOW?
APA Enforcement Focus
NETWORK ADEQUACY TIES IT UP

DISCLOSURE

Network Adequacy

Rates

Medical Necessity Denials

Company just has to represent it is in compliance with MHPAEA

Contract Terms

Documentation/Audits

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NETWORK INADEQUACY

• 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
NETWORK [IN]ADEQUACY--PROOF

• 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 (?)
EXAMPLE OF PROOF YOU NEED – STATS AND DATA (NOT JUST COMPLAINING)

• Psychiatry’s Use of Outpatient E/M Codes
  • 99211 – 2%
  • 99212 – 9%
  • 99213 – 56%
  • 99214 – 28%
  • 99215 – 4%
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# EXTRAPOLATIONS

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IMPACT OF . . . LOWER RATES

- 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)
DISCRIMINATION

- 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
- 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 clients to press
• Memorandum from President Obama re: task force on parity enforcement
• Congressional bills re: comprehensive mental health reform
• Model network adequacy act
• 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%
- Other Public, 12%
- Self-Pay, 25%
- **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 – no requirement to have a psychiatrist
• Next gen practice – players will be participants
• Need to find a way to change to practice mix to include more covered lives at reasonable costs with little interference
• Enforcement of MHPAEA – better rates, less hassle, equal treatment
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?
• What if there were a group you could join . . .
WE ARE ALL IN IT TOGETHER-
STRENGTH IN NUMBERS

"A boat doesn't go forward if each rower is rowing their own way."
STILL AWAKE?
QUESTIONS?

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