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The SAE Perspective on the Current Status of Parity Implementation

The Issues, Challenges and Opportunities

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In October 2016, the Mental Health and Substance Use Disorder Parity Task Force issued its final report on the implementation status of the landmark federal legislation, the Mental Health and Addiction Equity Act of 2008 (the ñparity lawò, MHPAEA). The Task Forceôs conclusion was that there has been progress in achieving equity between the design and management of administration of behavioral health benefits and medical/surgical benefits, but that much work remains to be done.

The Task Force was commissioned in March 2016 by President Obama to review the progress to date in implementing parity and:

- Increase awareness of the protections that parity provides.
- Improve understanding of the requirements of parity and of its protections among key stakeholders, such as consumers and providers.
- Increase the transparency of the compliance process and the support, resources and tools available to ensure compliance and to improve enforcement.

Several federal agencies were appointed to the Task Force, including the three that issued the ñthe final rulesò for implementing the parity law in 2014, the Departments of the Treasury, Labor and Health and Human Services. (To learn more about the Task Force and to download a copy of its final report, visit: http://www.hhs.gov/about/agencies/advisory-committees/parity/).

The Task Force found that health plans and insurance companies have made substantial progress in eliminating unequal financial requirements for consumers who access behavioral health benefits (e.g., setting lower lifetime reimbursement ceilings or higher visit co-pays for behavioral health care than for medical/surgical care). A second area where the Task Force noted substantial progress was in the elimination of differences in health plan requirements known as ñQuantitative Treatment Limitationsò or QTLs. QTLs are types of limitations that can be counted, such as setting a lower number of reimbursable visits or days allowed for behavioral health care as compared with the limits set for medical/surgical care.

There are indications that the changes in benefit design and management brought about by passage of the MHPAEA have resulted in an increased utilization of behavioral health care services nationwide and a decrease in the reported number of individuals who cite cost as a factor for not seeking care for mental health or substance use-related issues. (For more information on these findings, see: http://www.healthcostinstitute.org/news-and-events/issue-brief-impact-mental-health-parity-and-addiction-equity-act-inpatient-admission; and http://www.samhsa.gov/data/population-data-nsduh/reports).

In the seven months between its commission and its Final Report, the Task Force held Listening Sessions across the country and received over 1,000 written comments from consumers, providers and regulators. While acknowledging the progress made since the passage of the law in 2008 and the issuance of the final set of implementation regulations by three Federal agencies in 2014, the Task Force found that all stakeholdersð from insurance issuers to government regulators to providers and consumersð faced significant challenges in implementing and/or benefitting from the parity law. Implementing the parity law, as is often the case in other areas of health care reform in America, is a complicated undertaking for all stakeholders.

One area of particular concern in moving toward full parity is the design and administration of ñNon-Quantitative Treatment Limitationsò or NQTLs. NQTLs are processes and standards that canôt be counted but are part of the management and decision-making apparatus for administering benefits, such as the need for pre-authorization before covering a benefit, the frequency of reviews, the requirement that a patient ñfail firstò at a lower level of care before authorizing a higher level of care, or the application of medical necessity criteria. A health planôs use of NQTLs must be the same for their management of behavioral health benefits as for their management of medical surgical benefits.

The misuse of NQTLs was a common theme in the Task Forceôs listening sessions. Interestingly, many of the stakeholders who attended the listening session or submitted written comments acknowledged the need for further federal guidance on how best to ensure equity in applying NQTLs.

Four areas in particular were frequently mentioned by provider and consumer advocates as rife with inequities: The use of prior authorization processes; the utilization review process; ñfail firstò policies; and though not technically part of the MHPAEA, provider reimbursement rates.

SAEôs current experience in monitoring compliance with the MHPAEA for a large health plan in New York State with multiple lines of business is similar to the issues raised in the Task Forceôs listening sessions. It is a fairly straightforward process through such actions as benefit plan review to determine if financial requirements or QTLs are the same for behavioral health and medical surgical services, (e.g., equitable co-pays and deductibles for both types of care). The administration of a planôs NQTLs, however, particularly in areas such as the correct application of medical necessity criteria and the often inequitable burden placed on providers and consumers by such processes as pre-authorization and concurrent reviews for continuing stays, are challenges for insurers to correct, providers to address, and consumers to understand.

Other potential areas for parity non-compliance raised in the Task Forceôs work that SAE has also found to be problematic over the two plus years that it has fielded an Independent Parity Compliance Administrator (ICA) team can be found in the appeals process for providers and communication of benefit denials and appeal rights to consumers. For consumers, the reason for benefit denial may be buried in legalistic language, or in a litany of related factors to the case that serve to obfuscate rather than illuminate the exact reason why a person was denied a particular level of care. Providers receiving an adverse determination of coverage are often faced with deciding whether the costs of launching a time-consuming appeal (particularly in terms of credentialed staff time) is worth it, or just accepting the loss in revenue based on providing care that was not reimbursed.

The implementation of the parity law is still in its early stages, and the Task Force report points out the many actions underway by the federal agencies to move toward full parity. Implementation of the MHPAEA, with proper enforcement by state and federal authorities, offers hope to persons and families suffering with mental health and addictive disorders of greater access to care, of more equitable treatment of their conditionsð financially and clinicallyð and perhaps, as a result, of less stigma for having a behavioral health disorder.

To achieve full parity will require a strong, enduring commitment to implementation and enforcement from governmental regulators, consumers, and providers. Here are some initial actions to be taken:

Educate

It is clear from the Task Forceôs work (and SAEôs experience supports this) that the parity law and the federal rules governing implementation are not well understood. The law and the rules are complex. Regulators may not know how these rules apply in their state, what violations may exist, or what actions should be taken to improve compliance. Providers may have only a cursory understanding of the implications of the law and its governing rules, and how they may apply to their consumers. Their knowledge base may be limited, with perhaps only a few of the billing staff or supervisory staff being grounded in the parity rules, with direct care staff less well-informed. Consumers may have little or no understanding of their rights under parity, or of their choices in health care coverage based on a planôs performance in ensuring compliance. Thus, a ñfull court pressò to educate all stakeholder on the rules and benefits of parity is needed, including government, provider and consumer organizations.

With the release of its Final Report, the Task Force announced that CMS has set aside $9.3 million in grant funding to state insurance regulators to support parity implementation. This is a small amount of funding for such a large task confronting the primary enforcers of the MHPAEA, the state insurance commissioners. However, it is a start.

The Task Force report contains a number of online resources to learn more about the parity law and its implementation. SAMHSA has published a brochure for consumers (http://store.samhsa.gov/shin/content//SMA16-4971/SMA16-4971.pdf). The Department of Labor has published a ñWarning Signsò document that providers might use in considering if some of their payorsô practices might be in violation of the MHPAEA (https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf).

There are a number of parity implementation toolkits that can assist providers and consumers in understanding the law and in educating all stakeholders in parity compliance (https://parityispersonal.org/media/documents/KennedyForum-ResourceGuide_FINAL_1.pdf; http://www.asam.org/advocacy/toolkits/parity). The Coalition for Whole Health, which has done so much to advocate for the inclusion of behavioral health benefits in health care reform and in implementing the parity law has a list of online resources for parity at its website: http://www.coalitionforwholehealth.org/resources-for-local-advocates/mental-health-and-addiction-parity/.

SAE & Associates, which has been doing compliance monitoring work in New York, has a series of podcasts and issue briefs on its website that may also prove helpful in educating stakeholders on the parity rules and what to look for in terms of parity violations (http://saeandassociates.com/parity-compliance/).

Advocate

Education is the first step in mounting a ñfull court pressò on parity, but the changes envisioned in the parity law and the Affordable Care Act require a change in the culture of institutions responsible for health care, its delivery, its financing and its outcomes. Such change does not come easily. Advocacy from all stakeholders will be needed to make parity the norm and not simply a hope. SAMHSA has published a report on the promising practices of states in the forefront of parity implementation (http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act). Parity Track is ña collaborative forum that works to aggregate and elevate the parity implementation work taking place across the country. Parity Track aims to be the central site for mental health and substance use disorder parity information and to offer an exclusive look at parity issues. Parity Track seeks to help consumers understand their rights under the Federal Parity Law and state parity laws and to help consumers feel empowered to exercise those rights.ò Parity Track is a creation of the Kennedy Forum and the Scattergood Foundation, in partnership with the Parity Implementation Coalition, whose members comprise some of the leading policy, research and consumer organizations in the country. Parity Track can be found at: https://www.paritytrack.org/.

Evaluate

Full implementation of parity lags for many reasons, one of which is the lack of resources available to providers and consumers to learn the rules, engage the plans and persist through the appeal and denial process to a successful outcome. Likewise, advocates for parity compliance within the insurance and regulatory industry face their own challenges in bringing the case for parity into the foreground of their respective institutions. Parity makes sense, common sense and dollars sense. The costs for parity compliance are minimal, but the benefits of a fully integrated system of healthcare, which would include easy access to clinically indicated levels of care for appropriate lengths of stay, are tremendous. Milliman and Associates project that an estimated $26 - $48 billion can potentially be saved annually through effective integration of medical and behavioral services (Integrated Medical-Behavioral Healthcare, Implications for Psychiatry April 2014). Effective integration requires full parity. All stakeholders in the oversight, management, funding, delivery and consumption of care must take a critical eye to the current system, identify the deficiencies, and act in concert to overcome them.