Joint Hearing – Senate Health and Select Committee on Mental Health
Oversight hearing re Mental Health Parity and Access Oversight

California Department of Insurance

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Thank you for the opportunity to participate in today's hearing. Mental Health Parity, including access to medically necessary health care services in a timely manner is a critical issue for millions of Californians, their families and our community generally.

The Committee background materials provide information about the state and federal mental health care laws that the Department of Insurance and the Department of Managed Health Care enforce. While some of these laws have been on the books for many years, we have also seen the law strengthened, including by changes in the law brought by the Affordable Care Act and recent federal regulations that prevent cost-sharing and service limitations for mental health and substance use disorder treatment from being more restrictive than for other health care services. Insurance Commissioner Dave Jones also strengthened the Insurance Code provider network adequacy regulations in January by issuing emergency regulations that went into effect immediately and are in the final stages of the permanent rulemaking process. The Department of Insurance also issued emergency regulations a few years earlier specific to Essential Health Benefits and mental health parity that increased consumer protections as well.

One of the areas of focus of today's hearing is timely access to mental health care. Although the Department receives a relatively small number of complaints from policyholders and medical providers about timely access to mental health care services, enforcement of the law in this area is critical and in some instances can even help save lives. Commissioner Dave Jones has made it a top priority to improve access to mental health care through the issuance of emergency regulations, through administrative actions against insurers that were out of compliance with the law, by filing amicus briefs in lawsuits supporting the position taking by the patients who were seeking care, and through the Department's enforcement of the new laws as they have come into place. I'll talk about a few of the areas where new laws have given us additional authority to protect consumers – in terms of coverage requirements, mental health parity and timely access to care.

Network Adequacy - Emergency Regulations

CDI's emergency regulations strengthen network adequacy requirements generally, but also include provisions that relate specifically to mental health. For example, the regulations including include special network requirements for conditions that require frequent therapy, such as behavioral health treatment. As you know, ABA therapy is often required daily and for many hours a day, so more providers are needed than for many other medical conditions.

The regulations also include new wait time and reporting requirements to help the Department monitor whether patients are getting the care they need when they need it.

The regulations include requirements that the directories or lists of medical providers are accurate and are updated on a weekly basis.

And require that when the health insurer does not have adequate medical providers in its network in a particular geographic area, that the insurer arrange for out-of-network care at the in-network share of cost.

Network Adequacy Review

The Department reviews product filings for legal compliance in a number of areas including:

- Adequate networks must include providers and facilities to provide all mental health and substance use disorder (MH/SUD) essential health benefits, including inpatient and outpatient treatment, behavioral health treatment, and residential care for severe mental illnesses and serious emotional disturbances of a child (per the *Harlick* and *Rea* cases).
- Networks must include MH/SUD providers of sufficient number and type to provide diagnosis and medically necessary treatment, taking into account normal utilization patterns. This includes providers who are qualified to treat severe mental illness and serious emotional disturbances of a child, including qualified autism service providers (QASP, CIC § 10144.51(c)).
- Insurers must ensure that covered persons can access information about mental health and substance use disorder services, including benefits, providers, coverage, and other relevant information, by calling a customer service representative.
- We receive separate network adequacy reports for the following provider types:
    - MH/SUD professionals: Standard is within 30 minutes or 15 miles of a covered person's residence or workplace.
    - Qualified Autism Service Provider: Historically the standard was the specialist standard (within 60 minutes or 30 miles). The emergency regulations changed the standard to 30 minutes/15 miles.

Policy form review

The ACA has imposed a number of new requirements and health insurers have been filing new products that must comply with all the new laws.

Some of the kinds of things we look at when reviewing policies include:

Ensuring coverage for all EHBs and that the coverage is in compliance with Mental Health Parity laws.

1) **Prior authorization for outpatient mental health services**. While insurers may require prior authorization for some outpatient mental health services, they cannot require prior auth for all mental health practitioner office visits because insurers do not subject all physician office visits to prior authorization. This rule also applies to mental health outpatient facilities as compared to outpatient facilities for physical illnesses (like rehab facilities), which may require prior authorization for both.

2. Equality in cost sharing between physician office visits and mental health practitioner office visits – evaluation of compliance with the recent mental health regulations is a complicated process.

Financial Requirements (Cost Sharing)

Beginning for plan year 2016 filings, CDI requires carriers to submit a **quantitative analysis** demonstrating that the type and amount of cost sharing applied to MH/SUD benefits meets the federal requirements. (for example is the cost sharing the policyholder is responsible for a co-pay or co-insurance). We also require plans to provide a narrative

explanation of their methodology to allow the Department to verify the analysis was done in compliance with the federal rule.

Carriers must submit a **quantitative analysis** for each plan in a filing. The analysis must show the type and amount of cost sharing in each classification that meets the federal thresholds. The analysis for each classification must also clearly show the following:

- The medical/surgical benefits in that classification
- The applicable cost sharing for each benefit
- The total expected plan payments for each benefit for the applicable plan year (may be expressed as a percentage)
- Results of the analysis as to the type and amount of cost sharing permissible in that classification
- If a plan sub-classifies the outpatient classification (into office visits, and all other outpatient items and services), the analysis must show both the classification and sub-classification levels.

CDI reviews the insurer's assignment of benefits to ensure the insurer used the same criteria and applied them consistently to assign med/surg and MH/SUD benefits to each classification. We also review to ensure the analysis accounts for all covered med/surg benefits and uses the correct cost sharing per the applicable plan design. We then use the total expected plan payment data to confirm the insurer's calculations and verify the insurer's results as to the permissible cost sharing. This plan payment data is based on past claims history and thus is different for each insurer.

Carriers must also submit a **narrative explanation of methodology**, consisting of the following:

- A description of the methodology used to perform the quantitative analysis, such as the steps used to calculate expected payments, and the assumptions and data used to project costs.
- The standards/criteria used to assign benefits for each classification.

CDI reviews the methodology documentation to ensure it complies with the analytical requirements of the federal rule.

Quantitative Treatment Limitations

While the same process applies to Quantitative Treatment Limits, we generally do not need to see a quantitative analysis for QTLs in non-grandfathered individual and small group plans. This is because the current Kaiser base benchmark plan does not apply any QTLs to MH/SUD benefits. Thus, under CIC 10112.27(b), non-GF individual and small group plans may not impose any QTLs on MH/SUD benefits (which constitute EHBs).

When we encounter QTLs on MH/SUD benefits in grandfathered or large group plans, we require the carrier to demonstrate the QTL passes the federal parity test by providing the above documentation. Often carriers respond by removing the QTL.

Non-Quantitative Treatment Limitations

CDI reviews policy forms for NQTLs specific to MH/SUD benefits. If we see a NQTL imposed on a MH/SUD benefit, such as **prior authorization or step therapy requirements** for mental health office visits, we require

the carrier to provide a summary of the processes, strategies, evidentiary standards, and other factors the plan uses in applying the NQTL to MH/SUD benefits and to med/surg benefits in the same classification. We also require the carrier to demonstrate that those processes and standards are comparable to and not applied more stringently than those used for med/surg benefits. Plans that cannot demonstrate parity must remove the limitation in question.

Scope: Market Segments and Plan Years

We apply the above process to individual, small group, and large group health filings, including both grandfathered and non-grandfathered plans, for plan years beginning on or after 7/1/14.

Common Problems Seen in Form Review

Cost Sharing Revisions

The parity issue we see most commonly in form review is the use of impermissible cost sharing in plan designs, most often in the *outpatient* classification or the *all other outpatient items and services* sub-classification.

Nearly all standard plans have had to change the MH/SUD cost sharing for the *all other outpatient* sub-class from a copayment (per the SBPD) to a coinsurance under the federal law. Because CDI treats the SBPD as the upper limit on cost sharing, we then require plans to cap the coinsurance at the copayment amount specified in the SBPD for that year. For plan years 2015 and 2016, most carriers have told us they cannot implement a capped coinsurance. In those cases, we have directed those plans to set zero cost sharing for the affected

classification in order to comply with the federal parity rule without exceeding the SBPD's cost sharing.

Quantitative Treatment Limitations

We occasionally see QTLs for MH/SUD benefits, such as per day or per visit dollar limits, or frequency limits (e.g., 20 counseling visits per year).

In non-grandfathered individual and small group plans, such QTLs are impermissible outright based on multiple legal grounds. First, as an essential health benefit, MH/SUD benefits cannot be subject to any treatment limitations more restrictive than the base benchmark plan. CIC 10112.27(b). The current base benchmark plan does not place any QTLs on MH/SUD, so no QTLs are permissible in non-grandfathered individual and small group plans. Additionally, dollar limits on EHBs are prohibited in any non-grandfathered plans. In these cases, CDI objects to such QTLs and directs carriers to remove them on the foregoing legal bases, without considering whether they also raise mental health parity implications.

When QTLs are permissible for MH/SUD benefits, such as in large group or grandfathered products, we require carriers to submit a quantitative analysis and narrative explanation of methodology to show the QTL meets the federal parity thresholds. Common examples include as frequency and dollar limits on MH/SUD benefits. Generally, carriers have responded by removing such limits from their filings.

Prescription Drug Coverage – for mental health conditions

Each new individual and small group filing that comes to the Department has its formulary reviewed in detail. The Department

conducts a Category and Class Count evaluation and a Non-Discrimination analysis.

The Category and Class Count analyzes the formulary that each insurer submits and generates a unique count of chemically distinct drugs that were submitted in each category and class pairing. It then checks those against the state mandated benchmarks. If any insurer's formulary fails to meet the threshold, the Department requires it to come into compliance before it is authorized for issue.

Two of the conditions looked out for Clinical Appropriateness of drug coverage are Bipolar Disorder and Schizophrenia. We analyze the number of drugs available for consumers to use for each of the conditions, as well as which drug tier it is placed on, and whether prior authorization or step therapy are required. For each of these conditions, the insurer must cover an adequate number of drugs in each of the specified classes.

It is not uncommon to for CDI to require an insurer to increase the number of covered drugs after completing our analysis.

Complaints and Market Conduct

I've been discussing some of the areas where we enforce the law in advance of the health insurance product being sold in an effort to prevent consumers from having coverage problems when they seek care. The Department also assists consumers (and their medical providers) who make complaints to the department about mental health coverage issues. And the Department conducts Market Conduct Exams to look for problems that may not have come to our attention through consumer complaints OR to look more closely at some areas

where we receive complaints. Those Market Conduct exams can then result in more targeted exams to look even more closely at specific areas, such as autism coverage or other mental health coverage issues.

Thank you for including the Department in your hearing today.