Testimony of
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Good morning Chairwoman Conroy and Members of the Committee on Mental Health. Thank you for the opportunity to participate in this hearing on Reported Barriers to Mental Health and Addiction Coverage By Illinois Providers. I am the Director of Policy and Programs at The Kennedy Forum Illinois, a nonpartisan, nonprofit organization founded nationally by former U.S. Rep. Patrick J. Kennedy and in Illinois by a group of civic leaders. Our mission is to end stigma and discrimination against those with mental health and substance use disorders.

In 2008, Congress passed and President Bush signed the Mental Health Parity and Addiction Equity Act, which prohibits discrimination against mental health and addiction coverage in health plans that offer it. When coupled with the Affordable Care Act's essential health benefits that mandate that most health plans offer mental health and addiction coverage, the federal parity act offers broad protections to millions of Illinoisans that their health plans must offer mental health and addiction coverage on the same terms and conditions that are no more restrictive than for other types of medical conditions.

Illinois has followed the federal government's lead, both incorporating the federal parity act into state law and even making it stronger. These laws promise an end to coverage discrimination and are, at heart, civil rights statutes. **However, without effective enforcement, our state and federal parity laws are too often an unfulfilled promise, and barriers to coverage stand in the way of people accessing the mental health and addiction treatment they need.**

For years, we have had anecdotal reports from individuals and providers about the difficulties they have had accessing mental health and addiction coverage when they need it. But, they were just that, anecdotes. Therefore, The Kennedy Forum Illinois and our partners -- the Community Behavioral Healthcare Association of Illinois, Illinois Association for Behavioral Health, IARF, Illinois Health and Hospital Association, Illinois Psychiatric Society, and Health & Medicine Policy Research Group -- designed a survey of providers with input from legal experts

on parity as well as experts on survey design to collect data on providers' experiences with mental health and addiction coverage.

The survey results from psychiatrists, community behavioral health providers, and hospitals are startling.[1] Illinois mental health and addiction providers reported encountering frequent barriers from both Medicaid managed care organizations (MCOs) and commercial insurers to treatment coverage for their patients. These results raise important red flags that need to be investigated further to both identify and remove coverage barriers and to ensure that health plans are in compliance with state and federal parity laws.

Treatment Denials

The survey data showed that providers frequently experienced denials of treatment:

- More than 7 in 10 responding providers reported Medicaid MCOs sometimes, often, or always denied coverage for intensive outpatient treatment and medication-assisted treatment.
- More than 8 in 10 responding providers reported Medicaid MCOs sometimes/ often/always denied coverage for inpatient treatment and partial hospitalization.
- Nearly 50% of responding providers reported commercial insurers denied coverage for inpatient mental health and addiction treatment occurred at least sometimes.
- Approximately one-third or more of responding providers reported that commercial plans at least sometimes denied coverage for partial hospitalization, intensive outpatient, and medication-assisted treatment.
- Over 80% of responding providers reported that Medicaid MCOs sometimes/ often/always decided that requested acute mental health and addiction treatment was not medically necessary. Over half of responding providers said the same of commercial payers.
- More than 7 in 10 responding providers reported that Medicaid MCOs sometimes/often/always require a patient to "fail-first." Nearly 6 in 10 responding providers reported the same with respect to commercial plans.
- Over 60% of responding providers reported that Medicaid MCOs sometimes/ often/always approved only a lower level of care than the level of care requested, while 54% of responding providers reported commercial insurers did the same.

While none of the above data points proves a parity violation exists, the frequency with which providers report problems raise important red flags that regulators need to investigate further.

Difficulty Joining Networks

[1] For the full report describing the survey results, see: The Kennedy Forum, Community Behavioral Healthcare Association of Illinois, Health & Medicine Policy Research Group, IARF, Illinois Association for Behavioral Health, Illinois Health and Hospital Association, and Illinois Psychiatric Society, *Illinois Providers Report Barriers to Mental Health and Addiction Coverage for Their Patients*, September 2017.

Responding providers also reported that they had difficulty joining health plans' networks, despite a nationwide shortage of in-network behavioral health providers.

- Nearly 9 in 10 responding providers reported that Medicaid MCO requirements for joining their networks were sometimes/often/always "unusually burdensome." More than 3 in 4 responding providers reported the same about commercial insurer requirements.
- More than 6 in 10 responding providers were often or always told that Medicaid MCO networks were closed, while nearly half of providers were often or always told the same by commercial payers.

Not being able to find needed in-network providers is a major barrier to care for patients. If health plans are putting in place more stringent requirements for mental health and addiction providers to join their networks than they are for other medical providers, that could be a parity violation.

Cannot Obtain Legally Required Information

Under federal and state law, patients must receive a health plans' medical necessity criteria and reasons for denying a claim, when requested. However, providers report they are not always receiving this requested information as required:

- 9 in 10 responding providers reported that health plans have refused to provide requested medical necessity criteria.
- 2 in 3 responding providers reported that health plans have refused to provide requested reasons for denying a claim.

If health plans are not always following these very simple, bright line requirements, it calls into question whether they are following other requirements of state and federal parity laws.

Other Evidence Supports Survey Data

While it might be easy to dismiss this provider survey as one self-reported survey, it is much harder to argue that the data doesn't represent reality when report after report comes to the same conclusion: mental health and addiction care is not being offered on par with coverage of other types of medical conditions.

In fact, just last week, two major reports were released that come to this conclusion. The first was the latest national survey from the National Alliance on Mental Illness that, among other things, found much higher out-of-network utilization for outpatient care for mental health care than for other types of medical conditions. For instance, only 3% of those surveyed visited an

out-of-network primary care doctor, while 21% of those surveyed -- 7 times more -- visited an out-of-network mental health prescriber.[2]

The other report, which reviewed never before analyzed claims data from across the country, found that reimbursement rates for mental health and addiction providers were far below reimbursement rates of other medical providers, as well as that out-of-network utilization that was many times higher for mental health and addiction care than for other types of care.[3] The report, conducted by the independent firm Milliman, Inc., contained state-specific data as well. In Illinois, out-of-network usage was higher for mental health and addiction care than for physical care by the following factors in 2015:

- Outpatient Facilities -- 2.49 times higher
- Inpatient Facilities -- 1.77 times higher
- Office Visits -- 3.63 times higher

Primary care payments were also 13.4% higher in Illinois than payments for mental health and addiction care in 2015. These payment disparities can decrease the availability of in-network mental health and addiction care providers and raise important parity issues.

When New York Attorney General Eric Schneiderman investigated insurers' coverage of mental health and addiction care, he found numerous violations of New York and federal laws, reaching settlements with six insurers and returning millions of dollars to consumers.[4] In the wake of these settlements, nearly half of the mental health and addiction claims that had been rejected were overturned on appeal.[5]

Finally, after hearings and intensive study, President Trump's Commission on Combating Drug Addiction and the Opioid Crisis found that improving compliance with parity laws is essential to

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[2] *The Doctor Is Out: Continuing Disparities in Access to Mental Health and Physical Health Care*, National Alliance on Mental Illness, November 2017, https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out/DoctorIsOut.pdf.

[3] Stephen Melek, Daniel Perlman, and Stoddard Davenport, *Addiction and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates*, Milliman, Inc., November 2017, http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf.

[4] Legal Action Center, "New York Attorney General Parity Enforcement," https://lac.org/resources/substance-use-resources/parityhealth-care-access-resources/new-york-attorney-general-parity-enforcement/.

[5] Michael Ollove, The Pew Charitable Trusts, "Despite Laws, Mental Health Still Getting Short Shrift," May 7, 2015, http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/5/07/despite-laws-mental-health-still-getting-short-shrift.

turning the tide on the nationwide opioid crisis. The Commission recommended that state and federal regulators take steps to increase parity enforcement.[6]

What Needs to be Done

Consumers and Providers Not Positioned to Enforce Parity Law

Too often in insurance regulation, the responsibility for enforcement seems to be placed upon consumers and providers. However, this is a completely unacceptable approach to enforcing the state and federal parity law. Besides the fact that the Illinois Department of Insurance (for marketplace and many group health plans) and the Illinois Department of Healthcare and Family Services (for Medicaid) have statutory responsibility to enforce state and federal parity laws, expecting consumers and providers to police parity laws simply won't work.

This is for three main reasons. First, consumers who are going through a mental health or addiction crises are very often unable to advocate for themselves and navigate a complicated process of assembling documentation and making complaints. Second, because the details of parity laws can be complex, neither consumers nor providers are well positioned to understand the details of what the parity law requires. Third, and most importantly, neither consumers nor providers have the information necessary to make a comparison between a plan's specific underlying processes, strategies, evidentiary standards, and other factors used to apply an NQTL to mental health and addiction benefits and to other types of medical benefits.

Indeed, these issues are why the Illinois General Assembly amended the state's parity law in 2015 as part of the Heroin Crisis Act to add the following requirement (emphasis added):

> *The Department [IDOI]* ***shall enforce*** *the requirements of State and federal parity law, which includes ensuring compliance by individual and group policies; detecting violations of the law by individual and group policies* ***proactively monitoring discriminatory practices****; accepting, evaluating, and responding to complaints regarding such violations; and ensuring violations are appropriately remedied and deterred.*[7]

The word "proactively" is particularly instructive. Its plain-English definition -- "By taking action to control a situation rather than just responding to it after it has happened."[8] -- makes clear that the Department of Insurance has a responsibility under Illinois law to enforce state and federal parity laws without sitting back and waiting for complaints. It is The Kennedy Forum's expectation that the Department will live up to its statutory responsibilities under the Heroin Crisis Act.

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[6] Final report of The President's Commission on Combating Drug Addiction and the Opioid Crisis, November 1, 2017, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.
[7] 215 ILCS 5/370c.
[8] Oxford Dictionary, https://en.oxforddictionaries.com/definition/proactively.

Analyses Health Plans Must Already Do Under Federal Law

Based on these survey results and from the recent findings of the Milliman report, it is essential that health plans closely examine barriers to mental health and addiction coverage and ensure that coverage limitations are comparable and no more stringently implied on mental health and addiction care than on other types of medical care. This requires a detailed comparison between coverage limitations on mental health and addiction care and limitations on other types of medical care. **Without a comparison, there is simply no possible way to know whether state and federal parity laws are being complied with.**

It is particularly essential for plans and regulators to conduct detailed comparative analyses of non-quantitative treatment limitations (NQTLs) in place on the mental health and addiction side and the medical side.[9] **Health plans have no legitimate reason not to conduct detailed NQTL comparative analyses, as they are already required by federal law.** In fact, the federal rule on NQTLs is very specific on how these limitations must comply with the federal parity law. It states:

> *A group health plan (or health insurance coverage) may not impose a non-quantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) 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.*[10]

To demonstrate compliance with this rule, The Kennedy Forum, American Psychiatric Association, and Parity Implementation Coalition believe a six-step approach to the NQTL analysis across classifications[11] is required (see Appendix for illustration of the different steps).[12] This six-part guide can be used both by health plans in constructing their NQTL analyses and by

[9] NQTLs are anything that can't be measured numerically but can limit care such as prior authorization requirements, "fail-first" requirements, standards for providers joining a network, geographic restrictions, formulary design for prescription drugs, network tier design, and many others. While NQTLs are inherent part of health plans, NQTLs that are applied more stringently to mental health and addiction coverage are illegal.

[10] Federal Register, *Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*, Vol. 78: No: 219, November 13, 2013.

[11] The six classifications across which parity analyses must be done are inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, prescription drugs, and emergency. For Medicaid MCOs and health maintenance organizations (HMOs), there are four categories because no in-network / out-of-network distinction exists.

[12] The Kennedy Forum, American Psychiatric Association, and Parity Implementation Coalition, *The 'Six-Step' Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements*, September 2017, https://www.paritytrack.org/wp-content/uploads/2017/09/six_step_issue_brief.pdf.

regulators to support audits that focus on the design an application of NQTLs as well as for use as part of the certification and form review processes prior to plan certification. The Kennedy Forum recognizes that compliance with state and federal requirements relating to NQTLs is a relatively new and rapidly developing area. Consequently, we are actively engaged with health plans around the country on how to conduct NQTL analyses that demonstrate compliance with federal law.

Regulators Must Proactively Monitor Discriminatory Practices

To help the Department of Insurance enforce state and federal parity laws for plans under its jurisdiction, The Kennedy Forum has asked the Department to prioritize five action steps:

1. Prior to plan certification, require insurers to submit to the Department the parity analyses they are already required to do under federal parity law and confirm that these analyses demonstrate compliance with state and federal parity laws, particularly with regard to NQTLs. The Kennedy Forum, American Psychiatric Association, and the Parity Implementation Coalition recommends that NQTL analysis should follow a six-step approach mentioned above to demonstrate than an NQTL is compliant.
2. Using the six-step approach, conduct market conduct examinations that look at selected NQTLs to ensure that an NQTL is comparable to and no more stringently applied, both as written and in operation. Suggested areas to focus on given the results of the recent provider survey are medical necessity criteria, step-therapy protocols, and barriers to joining insurers' networks.
3. Issue guidance to insurers about what the Department expects to see in their NQTL analyses. This guidance should include all information needed to demonstrate compliance with the federal NQTL rule, such as is laid out in the six-step approach.
4. Publicly release information on what questions the Department is asking and what information it is requesting relating to parity as part of its market conduct examinations.
5. Pursue parity implementation training for Department staff from leading parity experts, as identified by the U.S. Department of Labor, the U.S. Substance Abuse and Mental Health Services Administration, and U.S. Center for Consumer Information and Insurance Oversight.

If these steps are taken, The Kennedy Forum believes insurers subject to the Department of Insurance's jurisdiction would be forced to come into compliance and access to mental health and addiction coverage would increase, allowing more people to get the treatment they need.

For Medicaid, the Department of Healthcare and Family Services has jurisdiction to enforce state and federal parity laws. While the federal parity law applies to Medicaid MCOs, Illinois has gone even further and subjected traditional fee-for-service Medicaid to state parity laws. One vital place to help enforce parity laws is the state's contracts with Medicaid MCOs. While the state has taken a small step forward by including language in the latest version of the model contract that requires plans to "demonstrate" compliance with parity laws, The Kennedy Forum

urges the Department to include more specific language in contracts that spells out what information and analyses must be reported. This will ensure that the Department gets the information that it needs to verify that plans are in compliance with parity laws.

How Lawmakers Can Strengthen Parity Enforcement

Currently, it is very difficult to verify that plans are in compliance with the law or that the Department of Insurance and Department of Healthcare and Family Services are adequately enforcing the law. At the heart of the problem is a near complete lack of transparency. Health plans are not required under state law to provide information relating to parity, and the departments do not provide information about whether they are performing their vital functions.

To improve transparency and increase enforcement, Representative Lou Lang has introduced House Bill 68, Amendment 1. This bill would require reporting of information that would shine a light on health plans' parity compliance. It would ensure that the departments have the information that is necessary to determine whether plans are more stringently applying limitations on mental health and addiction coverage. Legislation with essentially identical transparency requirements was passed unanimously last spring in Tennessee.[13] This new law requires Tennessee's Medicaid MCOs to report data and information necessary to TennCare to ensure that its MCOs are in compliance.

Finally, legislators also have a critical role to play in overseeing the work of regulators. Members of the General Assembly should ask questions to ensure that Executive Branch agencies are fulfilling their responsibilities under state law.

Conclusion

Mental health and addiction parity laws are all about fairness and ending discrimination in health coverage against people who have illnesses of the brain. With proactive enforcement, we already have the tools at our disposal to ensure that people with mental health and addiction challenges receive the coverage to which they are entitled in order to afford the treatment they need. To effectively combat our ongoing mental health and addiction crises, we must make parity enforcement a priority. If we don't, too many people will be unable to access treatment, with the resulting higher costs to society representing a cost-shift from health plans to taxpayers.

[13] Tennessee General Assembly, Senate Bill 837, http://wapp.capitol.tn.gov/apps/BillInfo/Default.aspx?BillNumber=SB0837.

APPENDIX

Six-Step Approach to Non-Quantitative Treatment Limitation (NQTL) Parity Law Compliance