Georgetown University Health Policy Institute
CENTER ON HEALTH INSURANCE REFORMS

OCTOBER 2022

A Review of State Efforts to Enforce Mental Health Parity: Lessons for Policymakers and Regulators

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Robert Wood Johnson Foundation

Support for this report was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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Executive Summary

The Mental Health Parity and Addiction Equity Act (MHPAEA) aims to remove insurance-related obstacles to mental health and substance use disorder treatment. However, federal and state regulators have found that enforcing the complex law is challenging. While insurers' quantitative barriers to treatment such as cost-sharing or visit limits can be relatively straightforward for regulators to assess, certain "non-quantitative" treatment limits, such as the use of prior authorization, provider reimbursement, and formulary design are much more difficult. Analyses of insurers' compliance with MHPAEA have found widespread problems, from a failure to submit adequate information to regulators to clear noncompliance. These problems raise questions about the ability of plan enrollees to access critical mental health and substance use services.

State insurance departments serve as the front line for MHPAEA enforcement for state-regulated individual and group-market insurance. In order to understand the challenges they face and identify potential improvements, the authors reviewed relevant laws, regulations, and guidance at the federal level and in five states: Arizona, Nebraska, Pennsylvania, Virginia, and Washington. Authors also conducted structured interviews with officials responsible for MHPAEA enforcement in these five states.

Research Findings

States' Evaluation of Insurers' Policies "As Written" and "In Operation" Varies Widely

State respondents are using the annual form review process to evaluate insurers' treatment limits "as written" in their plan documents, but the level of scrutiny at this stage varies widely. They also stressed that it is important to assess how policies work "in operation," in order to understand whether plan enrollees can access care and have it paid for under the plan's rules. Four out of five states in our study conduct some kind of market conduct review. These can range from surveys and requests for data from insurers to full-scale, on-site market conduct exams.

States Face Barriers to Effective Oversight and Enforcement

Limits of Traditional State Enforcement Processes: While form review presents an opportunity to spot parity violations before they impact consumers and identify areas in need of further investigation, the process is not always conducive to robust oversight due to tight, often legislatively mandated deadlines and the "time consuming" and "detailed" nature of evaluating non-quantitative treatment limits. State respondents also called market conduct exams a "really heavy lift" requiring significant resources and time.

Strains on State Resources Pose Obstacle to Detailed Review: Parity enforcement requires comparative analyses, a time- and resource-intensive task in which regulators must evaluate the processes, evidentiary standards, and other factors underlying each plan's treatment limits for mental health, substance use disorder, and other medical services. Obtaining information from insurers to perform these reviews is a challenge. Several states described insurers providing a "data dump," submitting voluminous paperwork, lengthy claims manuals, or "fluff."

Provider Network Restrictions Often Pose Obstacles for Patients, but Can be Difficult for States to Evaluate: Analyzing an insurer's provider network for parity involves "look[ing] at how they got the providers into their network," including credentialing requirements, the reimbursement methodology (as opposed to simply the reimbursement rate), and approaches to provider rate negotiations. Assessing each of these factors for parity can be difficult.

Role of Vendors Hinders Effective Enforcement: Insurers' use of third-party vendors, such as a managed behavioral health organization or a pharmacy benefit manager, can make enforcing the law more difficult. While states can and do hold insurers responsible for the actions of their vendors, the addition of a third party can complicate an already complicated enforcement exercise.

Identifying Non-compliant Insurers Hindered by Lack of Consumer, Provider Awareness: Insurance regulators rely on consumer and provider complaints to identify problematic practices. Respondents observed that consumers and providers alike are often unaware of their rights under MHPAEA and how to document and report problems.

State Enforcement Depends on Federal Support

Federal funding and guidance are critical to effective state oversight. Study states have used federal dollars to conduct market conduct actions, engage experts to develop procedures for reviewing a broader range of treatment limits, bring in clinical staff to help review formularies, build in-house expertise, and educate providers about parity requirements. Federal regulators have issued considerable guidance on treatment limitation enforcement, but states said more is needed. For example, states noted the need for further guidance on what constitutes a sufficient comparative analysis to demonstrate compliance with MHPAEA.

Discussion and Recommendations

This study identified several opportunities for state regulators to conduct more efficient and effective MHPAEA enforcement.

Maximizing Limited Opportunities in Form Review

Regulators can streamline the annual form review process by having insurers submit their MHPAEA comparative analyses with their forms and by leveraging information from market conduct and complaints teams, performing targeted reviews for trends that have been identified across the market, and checking that insurer-specific problems found in a market conduct exam have been corrected in the policy forms filed with the department.

Enhancing Market Surveillance

States can conduct baseline MHPAEA exams on all insurers licensed to market plans in their state, but because annual and mid-year plan changes could raise compliance issues well before a scheduled exam, regulators need a way to assess treatment limits more frequently than every few years, and in more targeted ways. States can use a number of tools to identify emerging issues or trends that can help regulators conduct more narrowly focused and frequent exams, including market scans, calls for insurers to submit data, and the NAIC's market conduct statements, as well as consumer and provider complaints and data collected under state-required reports.

Additional Federal Resources

Clear federal guidance on what constitutes an adequate non-quantitative treatment limit comparative analysis and more examples of violations of such limits would be helpful to state enforcement efforts. States would also benefit from more funding for enforcement initiatives.

Introduction

The United States is in a behavioral health crisis. In 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that 52.9 million adults had a mental illness and 40.3 million people aged 12 and up had a substance use disorder. The COVID-19 pandemic appears to have exacerbated the problem; in a survey conducted in June and July of 2021, 48% of young adults aged 18 to 25 reported symptoms of anxiety, depression, or both. Drug overdose deaths have risen steadily in the last few years, reaching over 105,000 deaths between December 2020 and December 2021. Recent data show that people of color are more likely to struggle with mental health and substance use disorders than White individuals: during the first year of the

COVID-19 pandemic, Black and Hispanic adults reported mental health symptoms at a higher rate than White adults, and American Indian and Alaska Native communities experienced the highest overdose mortality rate, exceeding White Americans' overdose mortality rate by 30.8%.

As more individuals and families need behavioral healthcare, they face significant barriers to treatment. Behavioral health workforce shortages, the high cost of services, and persistent stigma surrounding mental health and substance use result in many people forgoing needed care, especially low-income and rural populations. While expanding health insurance coverage is essential to improving access to behavioral health services, coverage does not always ensure access to mental health and substance use disorder treatment if health plans impose limits on these services. Some of those limits are not easily measured or quantified, but can impose excessive barriers to care. For example, health plans may be less likely to grant prior authorization for inpatient behavioral health treatment than for inpatient medical services, leading to delays in obtaining care and limits on the level and duration of care. Further, health plans often pay behavioral health providers significantly lower payment rates than they do for other medical providers, dissuading them from joining plan networks and making it harder for enrollees to find in-network providers and timely appointments. As a result, enrollees are more likely to use an out-of-network provider for behavioral healthcare—and therefore pay higher out-of-pocket costs—than for other medical care.

In 2008, Congress enacted the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), a federal law that aims to remove insurance-related obstacles to mental health and substance use disorder treatment. However, federal and state regulators have found that enforcing the complex law is challenging – so much so that a 2022 report by the United States Department of Labor (DOL) found that none of the 30 plans and insurers evaluated could show that they were complying with key requirements of MHPAEA. In response to these enforcement challenges, the Biden administration has proposed strengthening federal and state oversight, and the U.S. House of Representatives recently voted to provide financial assistance to states for MHPAEA enforcement.

This issue brief explores state efforts to enforce MHPAEA, with a focus on treatment limits[1] that can often be challenging for regulators to assess, but that can pose significant challenges for patients seeking behavioral healthcare.

Background

The Mental Health Parity and Addiction Equity Act

MHPAEA prohibits large employer (defined in most states as employers with more than 50 employees) group plans from imposing stricter limits on mental health and substance use disorder benefits than they do on other medical benefits (referred to in MHPAEA as other medical/surgical benefits). MHPAEA does not require large group plans to provide mental health and substance use disorder benefits; instead, it requires large group plans that have chosen to cover these services to provide the benefits at parity with other medical benefits. The Affordable Care Act (ACA) expanded the reach of MHPAEA to also apply to individual and small employer group plans and requires them to provide mental health and substance use disorder benefits.

MHPAEA requires parity between mental health and substance use disorder and other medical benefits for three different types of cost containment strategies typically deployed by insurers and health plans, each of which can impose a barrier to accessing affordable, timely care:

[1] These treatment limits, which can include medical management tactics and requirements for providers, are known as "non-quantitative treatment limitations," or "NQTLs" in MHPAEA; for simplicity, we use the term "treatment limits" throughout this brief to refer to NQTLs and "quantitative treatment limits" to refer to coverage limits on the number of services or days of treatment.

1. Financial requirements, such as copayments, co-insurance, and out-of-pocket limits;
2. Quantitative treatment limits, such as limits on the number of visits or days of treatment covered under a plan; and
3. Non-quantitative treatment limits (NQTLs), such as medical management standards, prior authorization, and provider compensation. (See Figure 1.)

In 2016, a federally organized parity task force found that since the enactment of MHPAEA, disparities between mental health and substance use disorder and other medical services in terms of the financial requirements and quantitative treatment limits placed upon them had been significantly reduced. However, the task force found continued disparities in how non-quantitative treatment limits are imposed on mental health and substance use disorders, and that more guidance was necessary to improve insurers' compliance with this key component of MHPAEA.

Enforcing MHPAEA

To enable insurance regulators to assess whether an insurer is applying financial requirements and quantitative treatment limits for mental health and substance use disorder at parity with medical benefits, federal MHPAEA regulations established the "substantially all/predominant test." This is essentially a mathematical formula that requires little subjective interpretation, making it easier for regulators to assess an insurer's compliance than it is for more subjective limits insurers may impose, such as medical necessity determinations.

The MHPAEA compliance standard for non-quantitative treatment limits is less prescriptive: a plan is not allowed to impose such a limit on a mental health and substance use disorder benefit unless, under the terms of the plan "**as written and in operation**," any processes, evidentiary standards, or other factors used in applying the NQTL are "**comparable to and applied no more stringently**" to mental health and substance use disorder benefits than those used for other medical benefits. Put simply, it cannot be more difficult for an individual to get care for their mental health or substance use disorder than it would be to get care for another medical condition.

Figure 1: Non-Exhaustive List of Non-Quantitative Treatment Limits

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Prior authorization or ongoing authorization requirements;
- Concurrent review standards for continued care, such as additional hospital days or therapy sessions;
- Formulary design for prescription drugs;
- Network tier design, when applicable;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan or insurer methods for determining usual, customary, and reasonable charges;
- Fail-first policies or step therapy protocols;
- Exclusions of specific treatments for certain conditions;
- Restrictions on applicable provider billing codes;
- Standards for granting access to out-of-network providers;
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

To implement MHPAEA, the federal government has released multiple sets of Frequently Asked Questions[2] clarifying various elements of the law, as well as guidance on how to identify red flags related to non-quantitative treatment limits in insurer submissions. DOL has also developed a "self-compliance tool" to help health plans, insurers, and regulators assess whether an insurer is complying with MHPAEA, including several illustrative examples of treatment limits and a suggested questionnaire for health plans and insurers to complete to demonstrate compliance. The tool establishes a four-step analysis for each treatment limit to determine if it meets the requirements under the law. DOL released the first version of this tool in 2018 and it was most recently updated in 2020. DOL will update this tool every two years. However, the DOL self-compliance tool is only intended to serve as guidance on best practices, and until relatively recently, health plans were not required to analyze their treatment limits in the manner articulated in the tool.

To improve oversight of non-quantitative treatment limits, the Consolidated Appropriations Act of 2021 (CAA) established an explicit requirement for insurers and health plans to document and analyze any non-quantitative treatment limit they use to demonstrate that it complies with MHPAEA. Insurers and employer group health plans are required to maintain these "comparative analyses" on file and make them available to the DOL and state regulators upon request. The DOL is also required to submit a report to Congress summarizing their review of comparative analyses for health plans that they suspect may be violating MHPAEA based on complaints or other information. (See Figure 2.)

However, in the first year of requesting comparative analyses from 156 plans and insurers using their new authority under the CAA, DOL found that "none of the comparative analyses… contained sufficient information upon initial receipt." DOL's subsequent analysis found that all the submissions failed to comply in some way with MHPAEA's requirements. The two most common compliance problems were plan limits on autism spectrum treatment services and burdensome billing requirements for certain licensed behavioral health providers. DOL has indicated that they will issue further guidance to improve future submissions.

Figure 2: What is a Comparative Analysis?

A comparative analysis is a written analysis for each non-quantitative treatment limit showing that the processes, strategies, evidentiary standards, and other factors used to establish that treatment limit for mental health and substance use disorder benefits are comparable to and applied no more stringently than those used for the treatment limit applied to other medical benefits. For example, when looking at provider reimbursement, a comparative analysis would require an insurer to demonstrate that the factors the insurer used to set the fee schedules for their mental health and substance use disorder providers are comparable to the factors used for other medical providers, such as the education level of the provider, geographic location, or complexity of service.

State Enforcement of MHPAEA

While DOL is generally responsible for overseeing MHPAEA compliance for self-funded employer-sponsored plans, state insurance departments are responsible for monitoring group and individual plans sold by insurers in their states, including those sold on the ACA marketplaces. Many state insurance departments have leveraged two key mechanisms they use to monitor insurers – "form review" and "market conduct exams" – to assess insurers' compliance with MHPAEA. (See Figure 3).

A 2019 report by the United States Government Accountability Office found that state insurance departments' enforcement of MHPAEA's requirements for parity of plans' financial requirements and quantitative treatment limits

[2] See sets 5, 7, 17, 18, 29, 31, 34, 38, 39, 43, and 45

Figure 3: Regulatory Mechanisms Used by State DOIs

Form review is the annual process by which state departments of insurance require insurers to submit plan documents and other forms to demonstrate that each plan they intend to sell in the state is complying with all relevant federal and state laws. In many states, insurance regulators review these forms and have the power to reject any plan that fails to comply.

State departments of insurance initiate **market conduct examinations** of insurers either on a periodic basis or in response to complaints and other indicators of potential violations. Regulators take a close look at a variety of data like information on claims processing and prior authorization requests, and then conduct interviews of the insurer's staff to determine if the insurer has been complying with federal and state laws. Examinations can either generally assess an insurers' market conduct, like compliance with all state and federal insurance laws, or target a specific area, like compliance with MHPAEA. These examinations can take years to complete and many states require insurers to pay for certain kinds of examinations.

has been generally effective. However, they have had a more difficult time monitoring insurers' compliance with MHPAEA's requirements for non-quantitative treatment limits, such as how frequently they impose prior authorization requirements or how they reimburse behavioral health providers in comparison to other medical providers. The report observes that it is difficult for regulators to identify whether plans are imposing non-quantitative treatment limits at parity with other medical services based on plan documents alone. Some state regulators have called for better tools and guidance from their federal partners.

In addition to updating the DOL self-compliance tool, the federal government has responded to states' calls for additional guidance by issuing new sets of FAQs.[3] They have also supported state enforcement efforts through grants that insurance departments can use to hire clinicians to help with MHPAEA review, develop templates for insurers' submissions to demonstrate compliance, and to launch targeted MHPAEA examinations. Further, the CAA now requires insurers to perform comparative analyses for every non-quantitative treatment limit that they use and make them available to state regulators upon request. These analyses have the potential to be yet another resource to improve state enforcement efforts.

Study Approach

In order to understand state approaches to enforcing MHPAEA's requirements for non-quantitative treatment limits, the authors reviewed federal and state laws, regulations, and sub-regulatory guidance governing MHPAEA compliance and enforcement in five states: Arizona, Nebraska, Pennsylvania, Virginia, and Washington. We chose these states to reflect geographic diversity and because they are members of a National Association of Insurance Commissioners (NAIC) working group on MHPAEA. Authors also conducted interviews with state officials who are responsible for MHPAEA enforcement in these five states in May 2022. Each conversation was structured to supplement legal research and to gain insight into enforcement strategies, compliance tools, common challenges, and resource needs related to state MHPAEA implementation and enforcement.

[3] See sets 5, 7, 17, 18, 29, 31, 34, 38, 39, 43, and 45

Research Findings

States Use Different Tools to Evaluate Insurers' Policies "As Written" and "In Operation"

States assess treatment limits for parity in two main ways. First, many states review and analyze insurer policies during the form review process of inspecting insurers' contracts and other policy forms to gauge MHPAEA compliance "as written." Second, states use a variety of tools, including calls for data from insurers and market conduct examinations, to evaluate MHPAEA compliance "in operation."

Enforcement of Insurers' Written Policies Through Form Review

State respondents are using the annual form review process to evaluate insurers' treatment limits "as written," but the level of scrutiny at this stage varies widely. One state only asks insurers to attest to their compliance with MHPAEA's requirements for treatment limits, and some states review policy forms only for more obvious violations like explicit benefit exclusions. Other states require insurers to submit additional information during form review to demonstrate that they meet MHPAEA's standards. In Pennsylvania, for example, insurers were asked to submit three examples of non-quantitative treatment limits along with comparative analyses to illustrate that the limits comply with MHPAEA. However, in the first year of implementing this new requirement, regulators reported that no more than half of the insurers in their small group and individual markets provided sufficient documentation in their treatment limit analyses. In order to give insurers an opportunity to develop an adequately documented comparative analysis, Pennsylvania's regulators allowed insurers to submit just one treatment limit analysis for the upcoming plan year, and anticipates building back up to three in future years. Pennsylvania provides a self-assessment tool for insurers to demonstrate MHPAEA compliance for treatment limits, but does not require insurers to use this tool. Nebraska, starting in 2023, will require documentation of treatment limit parity with form filings, either by using the state's self-assessment tool or by providing the information in a different format.

One state using form review as a component of its treatment limit parity analysis indicated this up-front review of insurer policies has allowed regulators to "ma[k]e huge strides" in their oversight efforts. Another state noted that form review lets them "look for red flags," which may lead the insurance department to ask for additional information, and that form filings are a good medium for a targeted front-end review, such as evaluating a commonly omitted benefit and requesting comparative analyses for that coverage exclusion. A state that collects CAA-mandated comparative analyses through the form review process highlighted the value of the DOL's self-compliance tool, which incorporates updates in MHPAEA oversight and produces uniformity.

Enforcement of Insurers' Practices Through Market Conduct Actions

State respondents stressed that it is also important to assess how policies work in practice. As one state official put it, "[t]he cyclical review process isn't a cure for everything that's wrong," emphasizing there is value in "see[ing] what's happening in application." Insurers may point to a set of guidelines they use to impose treatment limits, but "they have to tell [regulators] how they apply those guidelines."

To review treatment limit parity "in operation," four out of five states in our study conduct some kind of market conduct review. These enforcement efforts include surveys and requests for data from insurers to better understand their policies and procedures around claims denials, complaints, appeals, and use of out-of-network services. Insurance regulators also may require full-scale, on-site market conduct exams. Less time- and resource-intensive enforcement initiatives such as a call for data can inform more in-depth exams, which typically take well over a year to complete. Washington, for example, has completed "market scans" to collect information such as claims denial rates, provider credentialing, formulary

development processes, out-of-network benefit use, and other data to assess insurer business practices. One such scan asked insurers to complete a compliance guide prepared by the Kennedy Forum, a non-profit mental health advocacy organization. The Kennedy Forum compliance guide, which largely tracks with the DOL's self-compliance tool, requires explanations for the factors and evidentiary standards used to design and apply the treatment limits as well as comparative analyses of the treatment limits both as written and in operation. Virginia requires its larger insurers to annually report paid and denied claims (including the reason for the denial), complaints, appeals, and processed external reviews. One state regulator described how their approach, which does not rely on market conduct exams to obtain data, allows the state to "try to do it more conversationally as opposed to 'open up your file cabinets and let us go through them.'" However, other states also highlighted the value of full-scale market conduct exams for doing "deep dive[s]" into MHPAEA compliance and a "more thorough . . . review" of policies in operation. Pennsylvania, for example, has found MHPAEA violations significant enough to levy fines against insurers in at least three recent market conduct exams.

Market conduct actions are often driven by consumer and provider complaints, issues identified during form review, or information picked up from market analyses. One source of market analysis information is the market conduct annual statement (MCAS) submitted to the National Association of Insurance Commissioners (NAIC). Health insurers in most states are required to report market conduct data annually to the NAIC using the MCAS template, which includes three parity-specific data points: prior authorizations requested, approved, and denied for mental health and substance use disorder benefits. It currently does not ask that any other data, including claims denials, be broken down by mental health and substance use disorders versus other medical services. Multiple states noted that data collected annually from insurers helps to identify "outliers," such as insurers with a disproportionate percentage of denied mental health claims.

States Face Resource, Data, and Other Barriers to Effective Oversight and Enforcement

Despite the variety of tools states use to evaluate parity for treatment limits, the breadth and complexity of the restrictions plans may impose on access to mental health and substance use disorder services pose challenges to effective enforcement.

Limits of Traditional State Enforcement Processes

State respondents highlighted the limits of the tools currently used to assess parity of treatment limits as written and in operation.

While form review presents an opportunity to spot parity violations before they impact consumers and identify areas in need of further investigation, the format of the annual process is not always conducive to robust oversight. One state that requires only that insurers attest that they are in compliance with MHPAEA and does not conduct an independent assessment during the form review process argued that a parity analysis is "virtually impossible" due to the tight, often legislatively mandated timeline of form review and the "time-consuming" and "detailed" nature of evaluating treatment limits. Another state, which only reviews consumer-facing policy forms during form review, described how "[t]here's just not a whole lot written in consumer policies that will get to the [insurers']…compliance," underscoring that insurers are incentivized to put the "minimum amount" in these forms. Even states that rely on the form review process to collect comparative analyses or supporting documentation conceded its limits. In addition to the short form review timeline, they reported that a lack of staff capacity and access to insurers' internal policies, such as policies regarding claims handling and provider credentialing, limit the utility of form review for parity oversight.

State respondents also called attention to the limits of market conduct actions, particularly full-scale examinations. One state called exams a "really heavy lift," citing the money, resources, and time required to conduct them. A state that has not used market conduct exams to enforce treatment limitation parity, or MHPAEA

in general, pointed to a lack of resources. This limitation stems from that state's inability to seek reimbursement from insurers for the full cost of exams—a practice of many state insurance departments—due to recent changes to state law. Another limitation is that market conduct exams are often reactive to consumer complaints, rather than "try[ing] to stop carrier compliance issues prior to the policies being issued to consumers."

Strains on State Resources Pose Obstacle to Detailed Review

Parity enforcement requires comparative analyses, a time- and resource-intensive task in which regulators must evaluate the processes, evidentiary standards, and other factors underlying each plan's treatment limits for both mental health and substance use disorder and other medical services. And, as one state put it, "[p]retty much anything can be a [non-quantitative treatment limit]." Obtaining enough information to perform these reviews is a challenge for regulators. State data sources, such as all-payer claims databases (APCD), may have limited mental health and substance use disorder claims due to privacy limits on substance use disorder-related claims. Further, states have had trouble retaining staff with an in-depth understanding of MHPAEA issues, limiting their ability to leverage APCDs and other data sources.

The format of insurers' data reporting exacerbates resource limits—several states described insurers providing a "data dump," submitting voluminous paperwork, lengthy claims manuals, or "fluff." As one state noted, "if you ask them a question about their prior authorization processes, they are just going to load you down with paper." Multiple states emphasized the importance of getting insurers to do more of the legwork, such as describing steps taken to impose a treatment limitation or providing relevant page numbers in their manuals for the limitation in question.

Provider Network Restrictions Often Pose Obstacles for Patients, but Can be Difficult for States to Evaluate

State respondents reported that insurers' provider network restrictions and provider reimbursement policies can be difficult to evaluate for parity. Mental health and substance use disorder patients frequently resort to out-of-network providers, suggesting that many plans have insufficient mental health and substance use disorder providers to meet enrollees' treatment needs. Insurer practices for building provider networks involve several practices subject to federal parity requirements, including credentialing standards and provider reimbursement.

A plan's demonstration that it complies with the state's network adequacy standards is insufficient to determine whether or not it meets MHPAEA parity standards. As one state regulator put it, a plan may have "been able to get a sufficient number and type of providers. But the MHPAEA piece is, did you violate MHPAEA on the way there?" This state pointed out that analyzing the provider network for parity involves "look[ing] at how they got the providers into their network," including credentialing requirements, the reimbursement methodology (as opposed to simply the reimbursement rate), and approaches to provider rate negotiations. Assessing each of these factors for parity can be difficult. Low provider reimbursements, for example, contribute to insufficient behavioral health provider networks. But to evaluate parity between mental health and substance use disorder and other medical provider fee schedules, regulators have to look at "the way those fee schedules are derived," asking companies to "walk backwards and demonstrate how they got to those numbers."

A provider's decision to participate in a network is impacted not only by an insurer's credentialing policies and reimbursement, but also by medical management practices like prior authorization that can increase the paperwork mental health and substance use disorder providers must deal with when treating a patient. One state lamented that "[t]here isn't a lot [of guidance] out there in terms of what the companies are supposed to be doing" to demonstrate parity of provider networks. Another state regulator noted that although it collects network data that would, in theory, allow it to assess a plan's compliance with MHPAEA, the department lacks the resources to analyze the data for that purpose.

Role of Vendors Hinders Effective Enforcement

While insurers are ultimately responsible for MHPAEA compliance, their use of third-party vendors can make the regulators' jobs enforcing

the law more difficult. If a third party, such as a managed behavioral health organization or a pharmacy benefit manager, provides any part of the behavioral health benefits, it enables some insurers to point to the vendor as the responsible party if there's a problem with MHPAEA requirements. While states can and do hold insurers responsible for the actions of their vendors, the addition of a third party can complicate an already complicated enforcement exercise. Further, these third-party vendors are often not privy to the administration of other medical benefits, frustrating the parity analysis, which is grounded in comparison of requirements that apply across benefits. This dynamic is exacerbated by sub-contractors. One state, citing the "chain of different vendors" performing tasks for insurers, described the enforcement process as "whack-a-mole," requiring regulators to "chase how a claim gets processed," while a different state noted that now-terminated vendor contracts make it difficult to gather information during market conduct exams that encompass past-year policies.

Consumer and Provider Complaints can be an Effective Oversight Tool, but Many Lack Sufficient Awareness of Patient Rights Under MHPAEA

The lack of awareness among providers and patients regarding insurers' obligations under the parity law limits states' ability to enforce MHPAEA. States called out the need to educate these stakeholders so they can flag potential parity violations, and three states described initiatives to educate providers and/or consumers about MHPAEA requirements. As one regulator noted, there is not always a paper trail for treatment limits—"[a] lot of times [a provider] will have a phone conversation with the insurer, and never get a denial on the record." Provider education may help improve documentation, for example, by getting providers to ask for denials in writing. Also, given how complaints inform market conduct actions, improving state MHPAEA enforcement requires arming patients and providers with information so they can "spot something that smells fishy."

State Enforcement Depends on Federal Support

Respondents uniformly emphasized the importance of federal funding and federal guidance to effective state oversight of treatment limits.

Federal grant funding has been critical to state MHPAEA enforcement. Four of our five state respondents received grants from the Centers for Medicare and Medicaid Services (CMS) to help with MHPAEA enforcement.[4] Federal dollars have gone towards conducting market conduct actions, engaging experts to develop procedures for reviewing a broader range of treatment limits, bringing in clinical staff to help review formularies, building in-house expertise, and educating providers about parity requirements. Washington used federal grant money to conduct two market scans. In the first market scan, regulators collected information about insurer policies and market practices that outside consultants called "one of the most in-depth and comprehensive evaluations of parity to date." In the second market scan, the state had insurers complete a model data request and the Kennedy Forum six-step parity compliance guide. Between both market scans, Washington unearthed significant information about insurer practices, including out-of-network provider use, provider reimbursement, and claims denial rates. State regulators stressed that the full extent of Washington's efforts would not have been possible without federal funding. Another state, citing bandwidth issues, expressed that additional federal funds for the front-end review process—which they cannot bill insurers for, as many states do for market conduct exams—would expand the scope of their parity

[4] See, for example, Center for Consumer Information and Insurance Oversight, "Nebraska Health Insurance Enforcement and Consumer Protections Grant Award" (Oct. 31, 2016), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/ne-cpg; Center for Consumer Information and Insurance Oversight, "Virginia State Flexibility to Stabilize the Market Grant Award" (Aug. 20, 2018), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/va-flex; Washington State Office of the Insurance Commissioner, "Federal Government Awards Washington $284,000 to Study Improvements to Mental Health, Addiction Services" (press release, Aug. 20, 2018), https://www.insurance.wa.gov/news/federal-government-awards-washington-284000-study-improvements-mental-health-addiction.

oversight. A different state said that additional federal funds "might allow us to do more than we do currently given our limited staff."

Beyond funding, federal regulators have also issued considerable guidance on treatment limitation enforcement. One state, praising federal efforts to provide examples of treatment limit parity compliance, asserted "you can never have enough of them." The DOL self-compliance tool also helps states ask insurers the right questions to assess parity compliance, but it does not help states evaluate insurers' answers. One state noted that further guidance on "what constitutes a sufficient comparative analysis and compliance with MHPAEA" would help state parity enforcement. Another state noted a need for "really concrete standards from the DOL about what a sufficient analysis looks like." State regulators also noted that clear and specific federal guidance helps them when they receive insurers' objections to elements of state enforcement. In one state, officials detailed how insurers have "ke[pt] saying, the federal regulations don't specify that, so you can't specify that." This state said that federal regulators should "minutely define" compliance, including quantitative requirements, to bolster state enforcement in the face of insurer pushback.

Discussions and Recommendations

Mental health parity remains one of the principle policy levers for improving coverage of mental health and substance use disorder services, an integral component of increasing access to care. Federal and state policymakers have demonstrated a strong interest in responding to the behavioral health crisis, but to do so, it is critical to understand whether and how insurers are covering mental health and substance use disorder services and the barriers that remain for patients and providers. States play a key role in implementing and enforcing MHPAEA, and under the CAA state regulators have a new tool to obtain insurers' parity analyses for non-quantitative treatment limits. This new tool can help fill a known gap in state enforcement efforts, provided states can leverage the tool to assess how well insurers are complying with MHPAEA's standards for these treatment limits. This study identified several opportunities for state regulators to conduct more efficient and effective MHPAEA enforcement, as well as the barriers they face and the need for additional resources.

Maximizing Limited Opportunities in Form Review

An essential first step to assess a plan's compliance with MHPAEA is to integrate it into the annual form review process. However, states face significant time constraints when reviewing policies and plan documents prior to approving them for sale before the annual open enrollment period. Regulators can streamline their review by having insurers submit their CAA comparative analyses with their forms. Form review teams can also leverage information from market conduct and complaints teams, performing targeted reviews for trends that have been identified across the market, or checking that insurer-specific problems found in a market conduct exam have been corrected in the policy forms filed with the department.

Enhancing Market Surveillance

Market conduct exams are essential to reviewing insurer compliance with MHPAEA "in operation." However, market conduct exams are time and resource intensive. They typically take more than a year to conduct, and are inherently backwards-looking, with regulators reviewing insurer data and operations for multiple past years. States can conduct baseline MHPAEA exams on all insurers licensed to market plans in their state. But because annual and mid-year plan changes could raise compliance issues well before a scheduled exam, regulators need a way to assess treatment limits more frequently than every few years, and in more targeted ways. Market scans, calls for insurers to submit data, and the NAIC's market conduct statements may identify emerging issues

or trends that warrant closer review, whether for a particular benefit across all insurers—for example, coverage of applied behavioral analysis (ABA) for autism—or for issues with a particular insurer. Consumer and provider complaints, data collected from independent review organizations that handle external appeals, or data obtained under state reporting requirements, such as Virginia's requirement that insurers annually file data on paid and denied claims, could help regulators conduct more narrowly focused and frequent exams.

Additional Federal Resources

Additional guidance and resources from federal regulators would enhance state efforts. State respondents indicated that clear guidance on what constitutes an adequate non-quantitative treatment limit comparative analysis and more examples of violations of such limits would be helpful to their enforcement efforts. In states facing pushback from insurers, being able to cite clear federal standards would back up regulators' efforts to obtain adequate documentation and data, and help create uniformity across all states.

States would also benefit from funding for enforcement initiatives. Nearly all of our study states used federal funds to help with their enforcement, from conducting market scans to identify issues for further investigation to tapping clinical expertise for formulary evaluations. States described how federal resources made possible enforcement efforts they could not sustain with state resources and in-house expertise. Federal funding could also be used to raise public awareness of parity protections and to educate providers on their patients' rights.

Conclusion

Insurance companies have a number of tools to limit treatment and create barriers to accessing care for mental health and substance use disorders. MHPAEA targets those tools with requirements that are meant to ensure it cannot be more difficult to obtain care or see an in-network provider for a mental health or substance use disorder than it would be to access care for other medical conditions. Yet the evidence of unmet need and a growing behavioral health crisis in this county means it is urgent that more be done to ensure robust compliance with MHPAEA.

Health plans have erected barriers to receiving mental health and substance use disorder services that are preventing patients from accessing the in-network providers they need and obtaining necessary care. Yet our study finds that states – the primary source of consumer protection for millions of plan enrollees – face challenges to conducting robust enforcement. Assessing whether insurers' non-quantitative treatment limits comply with MHPAEA requires complex, data-heavy, and resource-intensive analyses that exceed the capacity of most state insurance regulators. The state regulators in our study have helped identify several state and federal policy changes that could improve enforcement efforts and ultimately help patients gain greater and more affordable access to the mental health and substance user disorder services they need. For states, these include maximizing the annual form review process by requiring insurers to submit their comparative analyses and conducting targeted reviews; conducting baseline MHPAEA exams on all insurers in-state; and using third-party data sources to conduct more narrowly focused and frequent exams. Federal regulators and policymakers can also provide additional guidance – particularly on what would constitute an adequate comparative analysis that states should require and insurers must provide – and resources to enhance state efforts and expertise. These recommended changes are not a panacea – enforcement of MHPAEA is likely to remain challenging for state and federal regulators. However, an investment in better tools and expanded capacity would bolster states' ability to effectively enforce the law.

MHPAEA stands as the primary mechanism to lower barriers to care for mental health and substance use disorder patients with private insurance coverage, by holding out the promise that coverage for their treatment would not be inferior to that of other medical care. That does not guarantee robust or even adequate coverage of behavioral health services, nor would it solve workforce shortages that limit access to care. But MHPAEA's promises are only as good as their enforcement.

Acknowledgements

The authors thank the Robert Wood Johnson Foundation for their generous support for this project. We are also grateful to Sabrina Corlette and Christina L. Goe for their thoughtful review and comments.

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