Mental Health Parity

LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

What is mental health parity?

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 prohibits health insurers that offer mental health or substance use disorder benefits from imposing less favorable benefit limitations on MH/SUD benefits than medical/surgical benefits.

NM Mental Health Access Act

Senate Bill 273 – Passed in 2023

- Requires compliance with and expands upon federal mental health parity law and requires:
  - Large group employer plans required to cover mental health and substance use benefits
  - Insurers to apply generally recognized standards of care in evaluating medical necessity of services in coverage decisions
  - Defines mental health or substance use disorder benefits to include talk therapy services, including services provided by licensed marriage and family therapists
  - Requires IBAC (public employee) plans to comply with mental health parity laws
  - Requires transparency in utilization management (prior authorization) practices for patients and providers
  - Prohibits prior authorization or referral requirements for acute care or acute episodes of chronic conditions
  - Prohibits arbitrary limitations on duration of stay and levels of care
  - Prohibits prior authorization and step-therapy protocols for generic, prescription substance use medications
  - Requires insurers to maintain adequate provider networks, which may include increasing reimbursement

NM Mental Health Access Act

Senate Bill 273 – Passed in 2023

- Requires OSI to audit insurers (and IBAC plans) for compliance with state and federal mental health parity and access law.
- Gave OSI resources to conduct compliance review

What is parity analysis?

Two pathways for analysis:

Quantitative Treatment Limitations:

Quantitative treatment limitations are numerical, such as visit limits and day limits.

Example: A plan's physical therapy benefit allows 30 visits to a physical therapist a year. The same plan's outpatient, talk-therapy benefit has a benefit limit of 10 covered visits a year. Does the plan demonstrate parity?

Non-Quantitative Treatment Limitations:

NQTLs include, but are not limited to: Medical management standards limiting or excluding benefits based on medical necessity, medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for concurrent review). Formulary design for prescription drugs. Network inclusion and credentialing standards.

Example: A plan applies the same policies to MH/SUD and M/S inpatient and outpatient services for when Prior Authorization is required. Does this plan demonstrate parity?

Trick Question!

NQTL analysis is not that easy – what sounds good on paper is not necessarily equitable in practice.

Example:

- Insurance company has a policy that it will reject authorization of intensive outpatient treatment services where the patient has released him or herself against the advice of a doctor from an inpatient stay. How might this impact patients of BH services differently than patients of MED/SURG services? Is this equitable?
- Insurance company has a policy that step-therapy is required for all suboxone prescriptions? How might this impact SUD patients differently than MED/SURG services? Is this standard equitable?

Devil is in the Details

Which of these limitations violate mental health parity law?

- Insurer requires preauthorization for all mental health and substance use disorder services

- Insurer's medical management program (precertification and concurrent review) delegates its review authority to attending physicians for med/surg services but conducts its own reviews for MH/SUD services.

- Insurer requires pre-notification for all mental health and substance use disorder inpatient services, intensive outpatient program treatment, and extended outpatient treatment visits beyond 45-50 minutes.

A lawyer's favorite answer…it depends…

Some limitations on BH services are okay…**IF** the insurance company can prove that these limitations it has are no more stringent in operation than those on medical/surgical benefits. Insurer proves equity by showing its work:

- Are policies/processes/procedures clearly disclosed, defined, and explained?
- Does the insurer provide the specific criteria (rationale, data, etc.) for when the limitation applies?
- Does the insurer define the factors of cost, patient safety, and clinical efficiency with reference to specific sources and evidentiary standards in development limitations and standards? (Or does it just…make them up?)

OSI Implementation of Mental Health Parity

OSI has contracted with two mental health parity experts/audit firms to develop data inquiries to insurers on mental health parity.

- Utilization management (standards for authorizing services)
    - Responses submitted
- Network adequacy and reimbursement standards
    - Responses due Oct. 16th

OSI Expectations

While this is the FIRST time OSI has conducted MHPAEA audits, this is NOT the first time MOST of our major medical insurers have had to report to regulators on their compliance with MHPAEA law and show their work.

- Centers for Medicare and Medicaid (CMS) has conducted audits of some of our insurers in other states
- Federal Department of Labor has conducted audits of some of our insurers' employer health plans
- Other states have conducted audits of our insurers' policies in their states

OSI expected insurers who had previously been subject to other agencies' audits and enforcement actions to show more initial MHPAEA compliance in their regulatory filings – be better at showing their work. That has not been the case.

Next Steps

OSI and auditors are giving insurers a chance to revise filings to come into compliance (in process)

If filings still show substantial noncompliance or continue to not be complete, OSI will take regulatory action, up to and including financial penalties

OSI is collaborating with CMS, DOL, other states and HSD in oversight of insurers' compliance with MHPAEA

OSI is working with providers to address issues in mental health parity identified in complaints

Begin review of NA NQTL Filings (preliminary data is mixed)

Coverage Affordability Initiatives and Research

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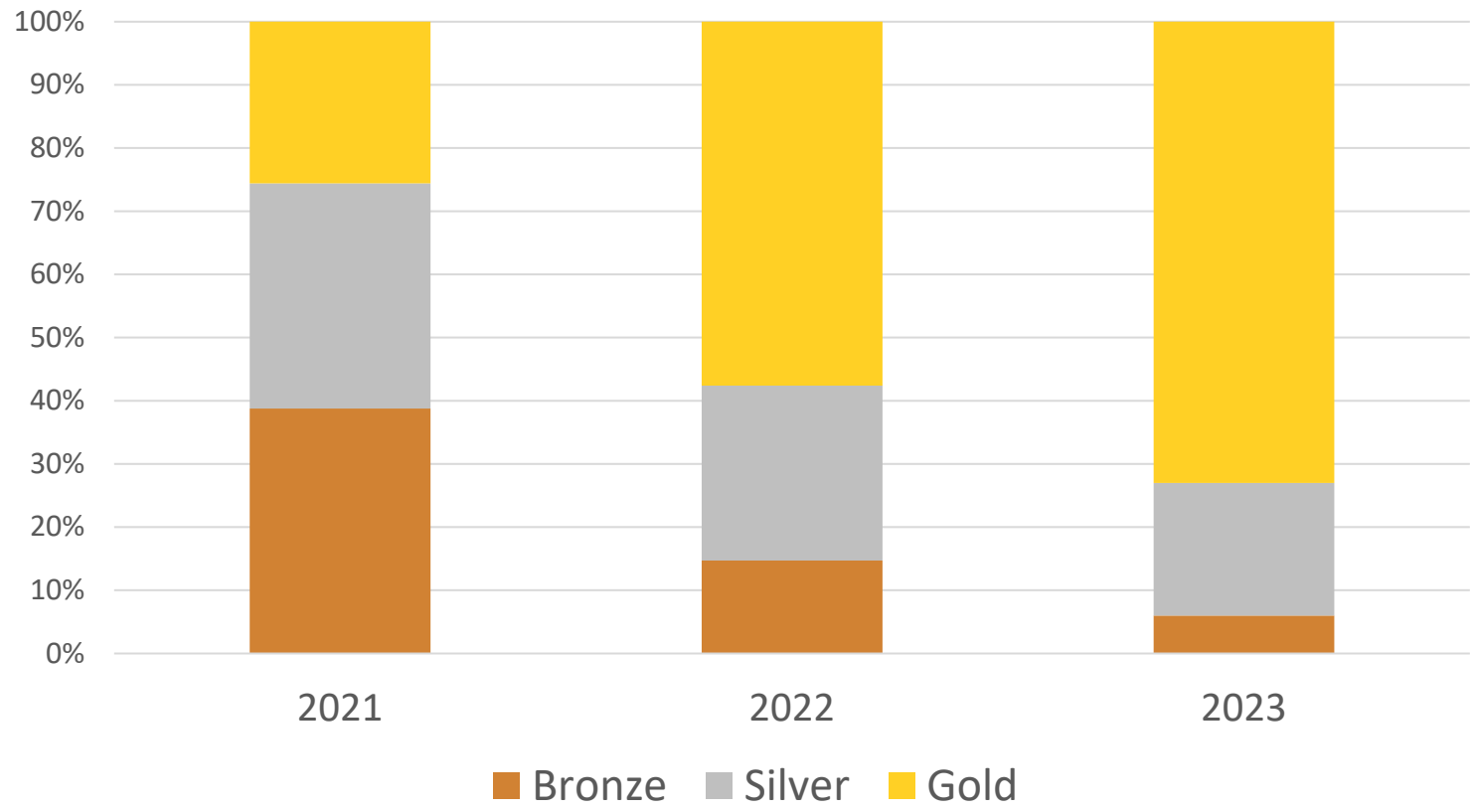
Health Insurance Marketplace Affordability Program (beWellnm)

- Reduces premiums for qualifying individuals and families up to 400% of the federal poverty level
- Reduces out-of-pocket costs like co-pays and deductibles for qualifying individuals and families up to 300% of the federal poverty level
- Covers the first month’s premium for those moving from Medicaid to beWellnm coverage

beWellnm enrollment is growing

- Enrollment is up 27% year-over-year
- 34,526 in September 2022 compared to 43,869 in September 2023
- About 40% of enrollees selected a plan for $10 or less per month
- 2024 enrollment begins on November 1

Enrollees are shifting towards Gold plans



Coming in 2024: “Clear Cost” Plans

- The legislature authorized beWellnm’s Board of Directors to design and implement “standardized health plans”
- Starting in 2024, all marketplace insurers marketplace must offer these plans (in addition to their own plan designs)
- Clear Cost Plans are designed to:
  - Minimize the number of services subject to a deductible
  - Only use co-pays, not coinsurance
  - Organize benefits into simple “low/mid/high” cost categories

Small Business Health Insurance Premium Relief Initiative

- Reduces health insurance premiums for small businesses and their employees
- Lowers costs for nearly 6,000 businesses
- On October 1, OSI announced that the 10% premium reduction will continue in 2024

Coverage Expansion Plan

- OSI continues to develop the Coverage Expansion Plan for uninsured New Mexicans
- Presented a proposal in August
- We expect to have new details to share about implementation during the upcoming legislative session

Affordability and Access Studies

- Global Budgeting Reports (Health Management Associates)
- Cost and Access Surveys (UNM Center for Social Policy)
- Medicaid Forward (Urban Institute)
- Standardized Health Plans (Wakely Consulting)

Read the reports: https://www.osi.state.nm.us/osi-affordability-and-accessibility-research-projects

The Medicaid Forward Policy that the Urban Institute Modeled for OSI

Eligibility: New Mexico would give all non-elderly state residents the option of enrolling in Medicaid

Member Costs: Most newly-eligible enrollees would pay premiums/co-pays on a sliding scale, with no one paying more than 5% of household income on covered services

Federal/State Funds: The "Individuals above 133% FPL under Age 65" eligibility group would draw down federal match at the traditional FMAP (currently 72.59%); assistance for those who don't qualify for the match would be funded using only state dollars

Employer Contributions: Workers would have the option to enroll in Medicaid Forward; large employers would contribute half of the state's share of costs towards their workers who enroll in Medicaid Forward

Provider Payment Enhancements: The state would reimburse providers 17% higher than current Medicaid rates for Medicaid Forward and Traditional Medicaid enrollees

Summary of Results

- **Reduction in Uninsured:** 142,000 fewer uninsured New Mexicans (58.7% reduction)
- **Consumer Savings:** $1.2 billion reduction in household health spending (37.9% reduction)
- **Employer Savings:** $229 million reduction in employer costs (after accounting for wage increases)
- **Increased Wages:** $874 million increase in wages
- **State Costs:** On net, the state would save $3 million by implementing Medicaid Forward
- **Reimbursement:** Physician reimbursement would be 130-140% of Medicare for all Medicaid patients

Note: Based on high enrollment and high provider reimbursement scenario

Additional study needed

- HB 400 (2023) directs the Human Services Department to study critical questions
  - Impact on providers and how to maximize provider reimbursement
  - Impact on existing insurance markets
  - Operational needs for administration
  - Financial sustainability

Note: Based on high enrollment and high provider reimbursement scenario

Thank you!

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