State Parity Legislative and Regulatory Compliance Workgroup

October 14, 2020

Agenda

- State Updates
  - Pending Bills
  - Final NYS Regulations Requiring Parity Compliance Programs
  - California SB 855 Enacted!
- Required Parity Compliance Disclosures & Recent Amicus Briefs
- Federal Stimulus Update

Kentucky

Bill Request (BR) 61

- **Status:** Prefiled Sept. 17, 2020
- **Author:** Moser (R) -- Republican legislature
- **Summary:**
  - Based off of model bill
  - Applies to commercial health plans
  - Builds Federal Parity Requirements into state law
  - Requires detailed reporting on treatment limitations compliance with Federal Parity Act.

https://apps.legislature.ky.gov/record/21RS/prefiled/BR61.html

Michigan

SB 1157

- **Status:** Introduced September 30, 2020
- **Author:** Irwin (D) – Republican legislature
- **Summary:**
  - Contains limited provisions from model bill
  - Requires Director of Insurance to implement Federal Parity Act by:
    - Proactively ensuring compliance
    - Evaluating all consumer/provider complaints relating to MH/SUD coverage for parity violations
    - Perform parity-market conduct examinations
    - Require insurers submit comparative analyses during form review process demonstrating parity compliance for non-quantitative treatment limitations (NQTLs)
  - Does NOT contain detailed reporting requirements for NQTLs

http://www.legislature.mi.gov/(S(q5y5dtm02fpe1n2uakggva4o))/mileg.aspx?page=GetObject&objectname=2020-SB-1157

Missouri

HB 61

- **Status:** Introduced August 10, 2020 (2020 First Extraordinary Session, ended Sept. 2)
- **Author:** Razer (D) – Republican legislature
- **Summary:**
  - Updates existing law to align with Federal Parity Act (has been introduced previously)
  - Missouri Dept. of Insurance says lacks power to enforce Federal Parity Act.

https://www.house.mo.gov/Bill.aspx?bill=HB61&year=2020&code=S1

Pennsylvania

HB 1696

- **Status:** Passed House (202-0-1), Passed Senate Banking & Insurance and Senate Appropriations Committees
- **Author:** Murt (R), with bipartisan cosponsors – Republican legislature
- **Summary:**
  - Insurer must file annual attestation that it has conducted analyses on Federal Parity Act compliance
  - Parity compliance analyses must be available for review.
  - Parity compliance analyses must contain all the information required in the model parity bill.
- HB 1696 is a version of the model bill's reporting requirements that doesn't require annual parity reporting to insurance department, but rather requires attestation that the analyses have been conducted and must be made available to the department upon request.

https://www.legis.state.pa.us/cfdocs/billinfo/billinfo.cfm?syear=2019&sind=0&body=H&type=B&bn=1696

New York

Final Rule on Requiring Parity Compliance Programs

- Dept. of Financial Services finalized rule requiring insurers to put in place parity compliance program. Requires:
  - Establishing formal compliance program with a designed individual heading
  - Written policies/procedures
  - Methodologies for identification and remediation of improper practices
  - Conduct “comparative analysis” on NQTLs
  - Actuarial certification of compliant financial requirements and QTLs
  - Annual certification that compliance program meets rules requirements
  - Training and education of personnel

- Very minor changes made from proposed rule.
- Somewhat disappointing because there were opportunities to strengthen. However, still a significant step forward.

https://www.dfs.ny.gov/system/files/documents/2020/10/rf218_11nycrr230_text.pdf

California

SB 855

- **Enacted!**
- Groundbreaking new law takes effect January 1, 2021
- Advances MH/SUD parity using a somewhat different mechanism
- Does not go directly through the Federal Parity Act, but rather complements it
- Directly addresses the issues identified in the *Wit v. United Behavioral Health* ruling from the U.S. District Court in the N. District of California

https://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=201920200SB855

THE KENNEDY FORUM
thekennedyforum.org

California SB 855

Provisions in Detail

1. Findings
   - Not law, but helped with making clear why bill was important and may well help with implementation. Described generally accepted standards of care identified in Wit.
2. Ban on Discretionary Clauses
   - Insurers insert discretionary clauses into policies. Gives them *wide latitude to interpret the terms of their own policies*.
   - Courts frequently use different standard of review – whether the insurer abused its discretion – rather than *de novo* review (equal weighting of the evidence). Very hard standard to overcome.
   - NAIC has model bill to prohibit. Roughly half of states have done through statute or regulation. Has status by state. https://content.naic.org/sites/default/files/inline-files/MDL-042.pdf
   - NAIC states purpose as "to assure that health insurance benefits and disability income protection coverage are contractually guaranteed, and to avoid the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due."
   - Good description on why discretionary clauses so bad: https://www.debofsky.com/articles/why-discretionary-clauses-must-be-prohibited/

California SB 855

3. Expansion of CA Mental Health Parity Act
   - Predates Federal Parity Act and requires all medically necessary treatment of 9 severe mental illnesses be covered
   - SB 855 expands to cover all MH/SUD in current editions of DSM / ICD
4. Includes definition of ”medically necessary treatment”
   - Based on AMA / APA (Psychiatric) definition of medical necessity
   - Prevents plans from creating their own definitions
5. Prohibits limiting coverage to short-term or acute treatment
   - Made clear cannot refuse to cover ongoing care for chronic conditions
6. Strengthens out-of-network coverage when in-network services are not available within CA geographic and timely access standards
   - CA has fairly strong timely access rules that require out-of-network coverage at in-network cost-sharing if in-network services not available
   - Patients often on their own in finding / arranging out-of-network coverage

California SB 855

7. May not limit benefits or coverage because insurer believes a public program could or should pay for services
   - Insurers sometimes refuse to cover care because they claim a government entities should cover instead (e.g. Medicaid, school districts)
8. **Requires all medical necessity determinations to be based on generally accepted standards of care and defines valid sources to establish these standards**
   - Codifies the standards set forth in *Wit v. UBH* with valid sources for establishing
9. Insurers must use medical necessity criteria for MH/SUD from relevant non-profit clinical specialty association (e.g. ASAM criteria, LOCUS, CALOCUS)
   - CA and NYS have now put in place strong rules on criteria
10. Requires staff education on utilization review criteria and puts in place interrater reliability testing requirements with 90% pass rate
    - Criteria only as good as implementation
11. Puts in place enhanced penalties for insurers regulated by the CA Dept. of Insurance

Required Parity Disclosures

Federal Law Requires Disclosure

- **Disclosure Key to Enforcing Parity Compliance**
  - Federal regulations require disclosure of plans' parity compliance analyses, including criteria for medical necessity determinations (both MH/SUD and med/surg) and reason for denial (https://www.federalregister.gov/d/2013-27086/p-460)
  - Congress reaffirmed in 21st Century Cures Act and USDOL has made requirements very clear and has a sample disclosure form for individuals to use:
    - https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf
  - Yet, insurers frequently drag their feet on disclosing required materials
  - Insurers cannot get around disclosure by asserting that information is proprietary or has commercial value
  - Lack of disclosure puts consumers in an impossible position – can't fight denials or assert parity violations with needed specificity

Required Parity Disclosures

USDOL form details what must be provided upon request:

- the plan language about limitations and the M/S and MH/SUD benefits to which they apply;
- the factors used in the development of the limitations, which may include but are not limited to, excessive utilization, and safety and effectiveness of treatment;
- the sources used to identify the factors identified, including any processes, strategies, or evidentiary standards (including safety and efficacy in treatment);
- the methods and analysis used in the development of the limitations; and
- any evidence and documentation to establish that the limitation is applied no more stringently, as written and *in operation*, to MH/SUD benefits than to M/S benefits.

Federal parity lawsuit (N.R. v. Raytheon) was recently dismissed despite plaintiff being denied access to requested information

- Now on appeal to the First Circuit Court of Appeals
- Both group of parity advocates and USDOL itself filed Amicus briefs

Required Parity Disclosures

Advocates' Amicus:

"After denying mental health treatment for N.R., Raytheon Company and its health plan have refused to provide N.R. or his attorney any disclosures concerning its parity practices, despite the fact that such disclosure is required by law. Then, when N.R. filed suit to contest their adverse benefit determination, Raytheon Company and its health plan used their refusal to comply with disclosure requirements as a sword: asserting that the Raytheon health plan applies a uniform policy applicable to both mental health and medical/surgical benefits, but without disclosing the very information in their exclusive control that could verify or disprove their assertions. Rather than compel Raytheon and its health plan to produce the information, the District Court instead allowed their refusal to disclose to be weaponized, dismissing N.R.'s case based on his failure to provide sufficient detail in his allegations. Yet, it is precisely because of the lack of disclosure by Raytheon and its health plan that N.R. cannot satisfy this standard. The District Court's approach places plaintiffs in an untenable position where it will be impossible to obtain the information needed to meet the court's standard to plead a violation of the parity act. Discrimination in mental health coverage has increasingly moved to nonquantitative treatment limitations (NQTLs) that by their nature require information from plans in order to evaluate. If the District Court's opinion is allowed to stand, the progress towards ending discrimination will stop in its tracks and the promise of parity will be eviscerated."

Joined By:

- National Health Law Program (NHeLP), Autism Legal Resource Center, Center for Public Representation, Center for Health Law and Policy Innovation of Harvard Law School, Judge David L. Bazelon Center for Mental Health Law, Health Law Advocates, Disability Rights Education and Defense Fund (DREDF), National Autism Law Center (NALC), and The Kennedy Forum

Required Parity Disclosures

USDOL Amicus:

*"[T]*he Plan failed to provide this information to N.R.'s parents in connection with the claims process despite their request, a failure which detrimentally impacted N.R.'s ability to plead a parity claim with the factual detail necessary to satisfy the district court."

…

"The Plan and the Plan's claims administrator were the only entities in possession of the information about whether the Plan's limitation complied with this regulation, and they were obligated to provide it to N.R. upon request.…Affirming the dismissal would condone the Plan's 'unseemly argument' that N.R.'s claim 'was insufficiently supported when [the Plan's] own failure to maintain reasonable claims procedures as required by the ERISA regulations made obtaining further supporting [information] impossible.' Scibelli v. Prudential Ins. Co. of Am., 666 F.3d 32, 44 (1st Cir. 2012).

"This wholesale refusal may have undermined N.R.'s parents' ability to prosecute this claim. Yet after incorrectly dismissing the section 502(a)(1)(B) claim, the district court did not address the significance of the information request in light of the Department's regulation or its potential prejudice to N.R.'s MHPAEA claim. The Department tailored the regulations on disclosure in the MHPAEA context, in part, to respond to concerns about 'the lack of health plan transparency,' and the difficulty in 'understand[ing] whether a plan complies with the NQTL provisions without information showing that the processes, strategies, evidentiary standards, and other factors used in applying an NQTL to mental health or substance use disorder benefits and medical/surgical benefits are comparable, impairing plan participants' means of ensuring compliance with MHPAEA.' Preamble, Final Rules, 78 Fed. Reg. 68240-01, 68247-48 (Nov. 13, 2013). Accordingly, the Secretary respectfully requests that the Court vacate the dismissal of the section 502(a)(1)(B) claim and remand for further consideration of the extent to which the Plan's failure to provide this information prejudiced N.R.'s claim and what relief, if any, is warranted."

COVID-19 and Federal Stimulus

- House created new version of its HEROES Act and passed.
- Revised HEROES Act *increases* MH/SUD funding. Key provisions:
  - $3.5 billion for the Substance Abuse and Prevention Treatment Block Grant
  - $4 billion for the Mental Health Services Block Grant
  - $600 million for Certified Community Behavioral Health Clinics
  - $50 million for suicide prevention programs
  - $100 million for Project Aware (a school-based mental health program)
  - $10 million for the National Child Traumatic Stress Network
  - $250 million for emergency grants to states
  - Medicaid Reentry Act (allowing enrollment 30 days prior to release)
  - Increase Medicaid matching rate (FMAP by 7.8 percentage points)
  - $200 million for NIMH
- Chaotic fight between House, Senate, and President Trump
- Unclear what will happen. Trump has alternatively called off negotiations and demanded they move forward.