OREGON INSURANCE DIVISION BULLETIN INS 2014-1

TO: All Health Insurers, Health Care Service Contractors and Other Interested Persons

DATE: September 11, 2014

SUBJECT: Mental Health Parity

I. Introduction

A. Purpose of Bulletin

This bulletin provides guidance to insurers about the expectations of the Oregon Insurance Division (division) for insurers in implementing state and federal mental health mandates. The specific mandates addressed in this bulletin are:

1. ORS 743A.168 (Oregon MHP) and implementing rules at OAR 836-053-1404 and 836-053-1405;

2. The Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act, 29 U.S.C. 1185a (MHPAEA) and implementing regulations at 45 CFR §§146.136 and 147.160; and

3. The federal Affordable Care Act (ACA), its federal regulations, and related Oregon legislation at ORS 731.097 and 743.822 and rules at OAR 836-053-0008 and 836-053-0009.

B. Summary

The division expects insurers to comply with the following guidelines:

- An insurer must determine coverage of services and treatment of mental health and chemical dependency conditions in the same manner as the insurer makes a determination of services and treatment for other medical conditions. For any mental health condition, the decision must be based on whether the treatment is medically necessary under the terms of the policy and appropriate for the individual. Although an insurer may determine a treatment is not required because the treatment falls within a statutory exemption, the insurer may not categorically deny a treatment that is an accepted standard of care in some instances.

- An insurer may not apply a categorical exclusion to a class of mental health conditions (such as exclusions for developmental, social, or educational therapies) that results in the mandate being effectively meaningless.

- Only limited, specific exclusions from mental health coverage are allowed by the mental health mandate statutes. Any exclusion allowed must be applied and evaluated on a case by case basis.

- The division will monitor adverse benefit determinations to determine whether an insurer continues to deny treatment on the same basis for which treatment denial was overturned by an independent review organization (IRO) without demonstrating how the denial differs from previous denials on the same basis that have been overturned in the external review process.

- Insurers should apply a determination of "medically necessary" and "experimental or investigational" to specific treatments covered by the mental health mandates in the same manner as the insurer does for a medical condition. The definition of medical necessity must comply with requirements of state and federal law, may not be so stringent as to render the mental health mandates meaningless, and should be applied in a transparent and consistent way.

- This bulletin applies immediately consistent with the discussion below.

C. Related Bulletins

INS 2014-2 provides more specific guidance for coverage of the treatment of autism spectrum disorders and specifically, applied behavioral analysis therapy.

INS 2013-2 Senate Bill 91 (2011) Standard Plans is withdrawn.

INS 2003-3 is withdrawn and replaced by this bulletin.

II. Discussion

A. Effective Dates

The Oregon MHP was first adopted in 1987 and has undergone numerous changes since first enacted. However, the Oregon MHP has not been significantly amended since 2005.

The Oregon MHP is part of the benchmark plan establishing Oregon's essential health benefits plan under OAR 836-053-0008. Nothing in this bulletin interpreting the Oregon MHP establishes a new benefit under the ACA.

Federal mental health parity was first adopted in 1996, and like Oregon MHP has undergone significant changes since first enacted. However, the federal mental health parity law has not been significantly amended since 2008, when MHPAEA was enacted. The final MHPAEA rule applies to plan years (in the individual market, policy years) beginning on or after July 1, 2014.

The coverage requirements of the Oregon MHP apply to ACA-compliant individual policies issued or renewed on or after s January 1, 2014. Individual grandfathered and transitional plans are not subject to the Oregon MHP and coverage is not required because they are not required to

provide essential health benefits. All group plans are subject to the mandate - including ACA-compliant, grandfathered and transitional plans. Therefore, at a minimum, the coverage requirement applies to group plans issued or renewed after 2007 (effective date of last major amendments to ORS 743A.168).

Because the state and federal mental health mandates are not new requirements, effective immediately, the division expects insurers to comply with the laws and provide the mandated coverage in accordance with the guidance in this bulletin.

B. Coverage Requirements

Under State Law:

ORS 743A.168 sets forth the requirements for treatment of "mental or nervous conditions." That statute states in part:

> A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions.

The division has defined "mental or nervous conditions" by rule to mean:

> All disorders listed in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" except for:
> (i) Diagnostic codes 317, 318.0, 318.1, 318.2, 319; Mental Retardation;
> (ii) Diagnostic codes 315.00, 315.1, 315.2, 315.9; Learning Disorders;
> (iii) Diagnostic codes 302.4, 302.81, 302.89, 302.2, 302.83, 302.84, 302.82, 302.9; Paraphilias; and
> (iv) Diagnostic codes V15.81 through V71.09; "V" codes. This exception does not extend to children 5 years of age or younger for diagnostic codes V61.20; Parent-Child Relational Problem through V61.21; Neglect, Physical Abuse, or Sexual Abuse of Child, and V62.82; Bereavement.

OAR 836-053-1404(1)(a). This rule is inclusive in that it identifies all conditions in DSM-IV-TR as subject to the Oregon MHP mandate, with three narrow and specific exceptions – certain diagnostic codes related to mental retardation, learning disorders and paraphilias, and some "V" codes for children older than five years. With these exceptions, every diagnosis in DSM-IV-TR is a mental health or nervous condition and subject to Oregon MHP and this bulletin.

The division has adopted a rule to update the references in this rule to include the parallel references in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). For diagnoses made before the effective date of the rule using DSM-5, the insurer should evaluate whether the diagnosis is a "mental or nervous condition" using a standard crosswalk between DSM-5 diagnostic codes and DSM-IV-TR diagnostic codes.

Applying this definition to the statutory mandate, any disorder included in the DSM-IV-TR diagnostic codes (or their DSM-5 equivalents), apart from the specific DSM-IV-TR exclusions, is subject to the mandate. For example, depression, anxiety, autism and gender dysphoria are subject to the mandate. If a mental or nervous condition is encompassed by the mandate, an insurer must provide coverage for appropriate and medically necessary treatments for the condition.

Under Federal Law:

MHPAEA is not a mandate to require coverage, but rather it is a requirement that when mental health coverage is included in a health plan or policy, the coverage must be in parity with coverage of all other medical conditions. The federal mandate arises from applying the parity requirement of MHPAEA to policies that have mental health coverage, including but not limited to coverage mandated by ORS 743A.168 or the ACA. Thus, all ACA-compliant individual policies and all group policies must provide mental health coverage that is in parity (using MHPAEA tests) with the medical benefits provided by the policy or plan.

Final regulations implementing MHPAEA were published in the Federal Register on November 13, 2013. See 45 CFR §§ 146.136 and 147.160. Under these regulations[i], an insurer may not apply any financial requirement or quantitative treatment limits to mental health benefits *in any classification* that is more restrictive than the *predominant* financial requirement or quantitative treatment limitation of that type applied to *substantially all* medical benefits in the same *classification*.

The "substantially all" and "predominant" tests are determined separately for each type of financial requirement or quantitative treatment limitation. A type of financial requirement or quantitative treatment limitation is considered to apply to *substantially all* medical benefits in a classification of benefits if it applies to at least 2/3 of all medical benefits in that classification. If a financial requirement or quantitative treatment limitation *does not apply* to at least 2/3 of all medical benefits in a classification, then the financial requirement or quantitative treatment limitation of that type *cannot be applied* to mental health benefits in that classification.

If a type of financial requirement or quantitative treatment limitation applies to at least 2/3 of all medical benefits in a classification, the predominant level is the level that applies to more than ½ of the medical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

A plan may not impose a non-quantitative treatment limit (NQTL) on mental health benefits unless the processes, strategies, and evidentiary standards used in applying the NQTL to mental health or substance abuse benefits in the classification are comparable to, and are applied no more stringently than those used in applying the NQTLs to medical benefits in the classification.

Examples of NQTLs include the following:

- Medical management standards that limit or exclude benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective;
- Exclusions based on failure to complete a course of treatment; and
- Coverage restrictions based on geographical location, facility type and provider specialty, and other criteria that limit the scope or duration of benefits for services.

Oregon MHP has both a mandate for coverage and a parity requirement, while MHPAEA has only a parity requirement. The division considers any health benefit plan that complies with the MHPAEA regulations to have satisfied the parity requirements of Oregon MHP.

C. Applicable Policy Types:

On its face, the Oregon MHP statute applies only to small and large groups. However, the benchmark plan sets the base requirement for all individual and small group plans in Oregon that are ACA-compliant (i.e., non-transitional and nongrandfathered plans). Therefore, the Oregon MHP requirement applies to all ACA-compliant individual and small group health benefit plans. For those plans that are not ACA-compliant, i.e., grandfathered or transitional plans, Oregon MHP mandate applies only to small and large group plans. ORS 743A.168 (1).

The language of MHPAEA applies to all large group health benefit plans that cover mental health benefits. When combined with the requirement that ACA-compliant plans be based on the Oregon benchmark, MHPAEA applies to all health benefit plans that cover mental health benefits, except grandfathered and transitional small group plans.

Thus, the guidelines of this bulletin apply as follows:

- Oregon MHP by its terms applies to group insurance.
- Federal MHP applies to all plans that cover mental health benefits – individual, small group (except grandfathered and transitional small group plans) and large group. It requires parity of treatment; i.e., if mental health is covered, it must be treated at parity with other medical conditions.
- ACA-compliant health benefit plans issued or renewed on or after January 1, 2014 must cover mental health because those plans must cover all EHBs including mental health coverage.
- Oregon's benchmark plan includes mental health coverage because the Pacific Source small group plan was governed by the Oregon MHP statute. Oregon's benchmark plan applies to all ACA-compliant plans after January 1, 2014. This includes individual and small group plans both in and out of Cover Oregon.

D. Exclusions or Limitations

ORS 743A.168 specifies the permitted exemptions and treatment limitations related to the mandate.

- The deductibles and coinsurance for other medical conditions apply to mental health conditions, but under no circumstances may deductibles or coinsurance for mental health conditions exceed those for other medical conditions:

  (2) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health facilities or residential facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

- Treatment limitations are allowed only if similar to those imposed on other medical conditions:

  (3) The coverage may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses may be limited to treatment that is medically necessary as determined under the policy for other medical conditions.

- Certain types of treatment are excluded from the mandate:

  (4)(a) Nothing in this section requires coverage for:

  Educational or correctional services or sheltered living provided by a school or halfway house;
  A long-term residential mental health program that lasts longer than 45 days;
  Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present; or
  A court-ordered sex offender treatment program.

Additionally, as discussed previously, the division's administrative rule specifies four diagnostic exemptions, tied to specific DSM-IV-TR Codes.

45 CFR 156.125(a) states that a health benefit plan fails to provide essential health benefits "if its benefit design, or *the implementation of its benefit design*, discriminates based on . . . present or predicted disability, degree of medical dependency, quality of life, or other health conditions." (Emphasis added.) 45 CFR 146.121 (which applies to individual health benefit plans pursuant to 45 CFR 147.110) prohibits an insurer from discriminating against an insured based on health factors. Health factors include health status, medical condition, and medical history. 45 CFR 146.121(a). Thus the implementation of a health plan's mental health benefit design may not

discriminate on the basis of mental health status, mental health condition, or mental health history.

45 CFR 156.110 states that a health benefit plan that includes a discriminatory benefit design in contravention of the standards described in 45 CFR 156.125 does not comply with the essential health benefits requirements of the Affordable Care Act. Accordingly, a health benefit plan that employs such a benefit design with respect to an essential health benefit like mental health treatment fails to provide essential health benefits.

An insurer may not require a special rider or endorsement or impose an additional premium for an insured to obtain mental health coverage. This would violate Oregon MHP and in most instances would violate MHPAEA as well. 45 CFR 156.110.[1]

Some insurers have included in policies broad-based treatment exclusions that are based on categories such as "academic or social skills training," "educational," or "sexual dysfunction." Recent opinions by courts and IROs, however, have indicated that such broad exclusions are not acceptable if the particular treatment requested is not examined on a case-by-case basis to determine whether the proposed treatment is appropriate and medically necessary. If the exclusion operates to nullify the mandate, the exclusion is too broad and not allowed. In other words, an insurer may not profess to include coverage required by the state and federal mental health mandates while at the same time applying a broad exclusion that prevents the insured from receiving medically necessary treatment.

For example, a group policy that complies with the Oregon MHP must provide coverage for treatment of gender dysphoria, a condition included by rule in Oregon's definition of mental health or nervous condition. If gender reassignment surgery is determined to be medically necessary, the insurer may not rely on a categorical exclusion, such as an exclusion for treatment for sexual dysfunction, to deny coverage.

While ORS 743A.168 (4)(a), quoted above, specifically excludes "[e]ducational or correctional services or sheltered living provided by a school or halfway house" and "[p]sychoanalysis or psychotherapy received as part of an educational or training program," that does not imply that an insurer may impose a broad exclusion for a medically accepted treatment for a mental or nervous disorder as "educational" rather than medical.

E. Individualized Determinations

Medical Management:

ORS 743A.168 (8) and (9) allow and encourage the application of medical management and utilization review techniques for mental health coverage. Similarly, 45 CFR 156.125(c) allows a health benefit plan to use reasonable medical management techniques in the provision of

[1] Even if a benefit restriction applies uniformly to all similarly situated individuals, it must still satisfy the requirements of the ACA provisions relating to essential health benefits, including 42 U.S.C. 18022, 45 CFR 146.115, 146.12, and 146.125. 45 CFR 156.115.

essential health benefits,[2] and 45 CFR §146.136(c)(4) applies the same provision to mental health benefits specifically.

Independent Review Organizations

Insureds must have access to an IRO to review adverse decisions regarding medical necessity or experimental exclusion and similar matters of medical judgment. ORS 743.857 to 743.864 and OAR 836-053-1300 to 836-053-1365.

The division will examine results of IRO' decisions regarding mental health treatments. When an IRO finds that a treatment is appropriate and medically necessary, the division will look closely at an insurer's subsequent denials to ascertain whether the insurer is continuing to deny the same treatment on the same basis. The insurer should be prepared to explain how the denial differs from previous denials that have been overturned in the external review process. Although IRO determinations are not binding beyond the individual case, the division considers patterns of IRO decisions significant evidence in determining whether a mental health treatment should be covered.

Guidelines and Transparency:

The following guidelines refer to mental health coverage, but are not exclusive to mental health coverage provisions:

Insurers should review applicable definitions of "medically necessary" and "experimental or investigational" to be applied to treatments covered by the mental health mandates. These definitions must comply with other requirements and may not apply more stringent requirements to mental health treatments so as to render the mandates under ORS 743A.168 and MHPAEA meaningless.

An insurer must not avoid the appeals process by simply "providing information" to an insured verbally that a particular treatment is not covered. The insured should be encouraged to submit the proposed treatment (in the form of a prior authorization request if appropriate) and allow the insurer to consider the medical necessity and appropriateness of the treatment and to then respond in writing to the insured either allowing the treatment or denying it. A denial should of course include information about the appeal process and opportunity for external review.

In handling mental health conditions and their treatment, insurers should be very clear about what the policy or plan covers and include notices and disclaimers consistent with state and federal law and requirements (e.g., ERISA notice requirements).

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[2] *See* Question 1 FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation, December 22, 2010, United States Department of Labor. Available here: http://www.dol.gov/ebsa/faqs/faq-aca5.html. Reasonable medical management techniques are primarily designed to allow insurers to control costs and steer patients toward high value, efficient medical treatment.

In evaluating medical necessity for any treatment requested for a mental health condition, the insurer must evaluate the request using a medically accepted standard of care that is not only consistent with general standards but also when possible with peer-reviewed scientific studies of clinical effectiveness and with specialty standards established by national or international organizations that have studied or specialize in treatment for a particular condition.

For common or recurrent conditions, insurers should adopt and use medical necessity guidelines that it makes available to providers and insureds. When coverage is denied, the insurer should refer to the guideline. This is not to say that every case will be decided by the logic of a guideline, only that the framework for decision must be transparent to the provider and insured.

Insurers should issue internal memos, train staff and provide documentation to staff and providers clarifying the services provided for specific mental health conditions, the requirements for demonstrating medical necessity for these conditions and the process an insured must follow to appeal a denial.