Status Report on Examinations of Insurers' Reimbursement of Mental Health Providers

As required by 2017 Senate Bill 860

Senate Bill 860 (2017) status report

Executive Summary

SB 860 required DCBS to conduct examination of insurers in four areas:

- The historical trends of each insurer's maximum allowable reimbursement rates for time-based outpatient office visit procedural codes and whether each insurer's in-network behavioral mental health providers have been paid reimbursement that is equivalent to the reimbursement for the insurer's in-network medical providers and mental health providers with prescribing privileges.

- Whether each insurer imposes utilization management procedures for behavioral mental health providers that are more restrictive than the utilization management procedures for medical providers as indicated by the time-based outpatient office visit procedural codes applied to providers in each category, including a review of whether an insurer restricts the use of longer office visits for behavioral mental health providers more than for medical providers.

- Whether each insurer pays equivalent reimbursement for time-based procedural codes for both in-network behavioral mental health providers and in-network medical providers, including the reimbursement of incremental increases in the length of an office visit.

- Whether the methodologies used by each insurer to determine the insurer's reimbursement rate schedule are equivalent for in-network behavioral health providers and in-network medical providers.

Section 2 of SB 860 requires DCBS to report to the interim committees of the Legislative Assembly related to health the status of the department's examination in accordance with section 1 no later than Sept. 1, 2019.

The preliminary findings below are those developed from initial analysis of five of the 11 insurers to be examined. More trend analysis and validation work remains, this progress report provides a glimpse of the kind of trends that are emerging from the data. A complete picture will emerge once DCBS and its vendor completes review of the remaining six insurers and a deeper dive of data can shed light on the underlying reasons behind the initial findings. Certainly, DCBS believes it would be inappropriate to draw conclusions about the state of mental health parity from this status document.

Preliminary Findings:

- In terms of setting reimbursements, with few exceptions, each of the subset of insurers examined started setting rates by applying the Centers for Medicare and Medicaid Services prescribed Resource-Based Relative Value Scale (RBRVS) method of

reimbursement. However, the insurers and third-party administrator's part of the initial findings tended to deviate from this accepted standard in more than one area.

- First, the initial findings examined the difference between reimbursement for physical health providers and behavioral health providers with prescribing privileges in the area of evaluation and management office visits. At least two of the five insurers or third-party administrators in the initial findings appear to be reimbursing these two groups of providers at different rates. Two other insurers or third-party administrators, however, did not appear to vary reimbursement for evaluation and management office visits.

- Next, in terms of the duration of office visits, the initial findings appear to show that in some circumstances, as the length of the outpatient office visit increases, medical provider rates increase to a much greater degree than the rates for in-network behavioral mental health providers and in-network mental health providers with prescribing privileges. At least one insurer or third-party administrator did not reimburse for the shortest of office visits for evaluation and management services, while other insurers or third party administrators did not appear to allow reimbursements for long office visits.

- Also, the initial findings also show a disconnect in some instances between the rate of increase over time for reimbursements between physical health providers and behavioral health providers with prescribing privileges. The data from the preliminary examination report to DCBS seems to indicate that that from year to year, in-network outpatient medical provider rates increase to a much greater degree than the rates for in-network outpatient behavioral mental health providers and in-network outpatient mental health providers with prescribing privileges. However, in other instances, insurers or third-party administrators appear to be consistently increasing reimbursements in step with medical providers.

- Finally, some insurers' or third-party administrators' utilization management procedures for behavioral mental health providers and mental health providers with prescribing privileges appear to be different than those for medical providers. For example, in the area of authorizing long-duration office visits,[1] at least one carrier or third-party administrator appeared to require prior approval before treatment could begin.[2] Another carrier or third-party administrator required prior authorization for a particular reimbursable service.[3]

[1] Denoted under CPT code 90837.
[2] Data available to DCBS. One carrier ended the practice in 2016.
[3] Family psychotherapist services, CPT codes 90846 and 90847.

Senate Bill 860 (2017) status report

Introduction

Senate Bill 860 (2017) provides the Oregon Department of Consumer and Business Services (DCBS) an opportunity to delve into an area of compliance that is both complicated and needs more attention from all corners of government. We appreciate this opportunity to provide a status report on the work that has been done in accordance with SB 860, and outline the next steps to carry out the examination mandate. In Oregon, all Affordable Care Act-compliant individual policies and all group policies must provide mental health coverage that meets federal and state mental health parity requirements. Oregon mental health benefit requirements are part of the benchmark plan establishing Oregon's essential health benefits plan under Oregon Administrative Rule 836-053-0012.

1. Mental Health Parity and Addiction Equity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008[4] (MHPAEA) is the federal law that prohibits group health plans and health insurers providing mental health or substance use disorder benefits from imposing more limits on those benefits than on medical/surgical benefits.

Coverage requirements or limitations under MHPAEA include:

- No use of annual or lifetime dollar limits on mental health benefits that are less than any such limits imposed on medical or surgical benefits.
- Financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to mental health or substance use disorder benefits must be no more restrictive than the predominant financial requirements or treatment limitations applicable to substantially all medical or surgical benefits.
- Mental health or substance use disorder benefits may not be subject to any separate cost-sharing requirements or treatment limitations.
- If the plan provides benefits for out-of-network medical or surgical services, it must also provide for out-of-network mental health or substance use disorder benefits.
- Standards for medical necessity determinations and reason for any denial of benefits for mental health or substance use disorder benefits must be disclosed upon request.

MHPAEA addresses both quantitative and nonquantitative treatment limitations. Quantitative treatment limitations are numerical, such as visit limits and day limits. On the other hand,

[4] Codified at 29 U.S.C. § 1185a.

nonquantitative treatment limitations include matters such as medical management policies, use of step therapy in prescription drug benefits, and prior authorization before reimbursing for certain treatments.

Plans may not impose a nonquantitative treatment limitation on mental health or substance use disorder benefits unless any processes, strategies, evidentiary standards, or other factors used in applying the treatment limit are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical or surgical benefits in the same classification.

a. Mental health parity in Oregon

i. Senate Bill 1[5]

The predecessor of Oregon mental health parity was first adopted in 1975, and the statute has undergone several changes since first enacted. The Oregon mental health parity law was amended in 2005 with Senate Bill 1, when the requirements of the existing mandate were extended to parity coverage of chemical dependency, including alcoholism, and mental and nervous conditions. House Bill 3091 (2017) further clarified the scope of services to be covered for people experiencing a behavioral health crisis in an emergency setting and defined the type of provider authorized to conduct a behavioral health assessment. In 2019, the law was modified again to clarify the requirements applicable to individual and group health benefit plans.[6]

ii. Bulletins on mental health parity

In November 2014, the division issued Bulletin 2014-1 to provide insurers with guidance about expectations for compliance with state and federal mental health mandates. Bulletin 2014-1 provides background and historical information related to these benefits, guidelines for applicability of the guidelines within the bulletin, and current coverage requirements. The expectations for compliance summarized in the bulletin address coverage determinations, exclusions, and coverage denials, as well as decisions related to medical necessity or experimental and investigational treatment. In this bulletin, the Department of Consumer and Business Services recommended that insurers review their appeals and independent review organization decisions for guidance on handling of future appeals and benefit determinations.

DCBS issued Bulletin 2014-2 as a companion bulletin to Bulletin 2014-1. This bulletin provides guidance to insurers about expectations regarding health benefit plan coverage of autism

[5] 2005 Or Laws ch 705; codified at ORS 743A.168
[6] 2019 Or Laws ch 285 (Enrolled Senate Bill 250).

spectrum disorder (ASD) and other pervasive developmental disorders (PDD), including the treatment known as applied behavior analysis (ABA). It explains that since these conditions are mental health conditions subject to all of the mental health laws described in Bulletin 2014-1, it applies to ASD and PDD. Bulletin 2014-2 outlines additional considerations specific to these diagnoses and ABA.

Bulletin 2012-1 addresses discrimination on the basis of gender identity or gender dysphoria. The guidance of Bulletin 2012-1 is supplemented by Bulletin 2014-1 because it provides additional guidance for the treatment of all mental health conditions, including gender dysphoria.

2. Senate Bill 860 (2017)[7]

SB 860 required DCBS to conduct examination of insurers in four areas:

- The historical trends of each insurer's maximum allowable reimbursement rates for time-based outpatient office visit procedural codes and whether each insurer's in-network behavioral mental health providers have been paid reimbursement that is equivalent to the reimbursement for the insurer's in-network medical providers and mental health providers with prescribing privileges.

- Whether each insurer imposes utilization management procedures for behavioral mental health providers that are more restrictive than the utilization management procedures for medical providers as indicated by the time-based outpatient office visit procedural codes applied to providers in each category, including a review of whether an insurer restricts the use of longer office visits for behavioral mental health providers more than for medical providers.

- Whether each insurer pays equivalent reimbursement for time-based procedural codes for both in-network behavioral mental health providers and in-network medical providers, including the reimbursement of incremental increases in the length of an office visit.

- Whether the methodologies used by each insurer to determine the insurer's reimbursement rate schedule are equivalent for in-network behavioral health providers and in-network medical providers.

Section 2 of SB 860 requires DCBS to report to the interim committees of the Legislative Assembly related to health the status of the department's examination in accordance with section 1 no later than Sept. 1, 2019. The report must include information about adopted rules or any other actions taken by DCBS as a result of this examination.

[7] 2017 Or Laws ch 694 §§1-2 (temporary provisions codified after ORS 743B.462.)

3. DCBS implementation of SB 860

a. Implementation history:

During deliberations on passage of SB 860, DCBS recognized the amount of work hours and expertise needed to complete the examination contemplated by the bill. As a result, DCBS used the expenditure limitation granted in SB 860 to bring in additional examination resources. After a competitive bidding process, DCBS chose to contract with Risk & Regulatory Consulting (RRC) in October 2018. RRC is an insurance consultant with whom DCBS has previously collaborated in resolving insurance carrier solvency issues. DCBS communicated its decision in October 2018 and finalized the work order contract on Dec. 20, 2018.

In collaboration with RRC, DCBS issued an extensive data call to 11 insurers on Jan. 7, 2019. DCBS received all insurer responses to the data call and subsequent inquiries by June 21, 2019.[8]

DCBS and RRC collectively answered 52 unique questions as a function of providing weekly answers to questions posed by insurers after receiving the data call. While the initial due date for the data call was set for Feb. 15, 2019, DCBS and RRC expected the insurers to have additional questions but received none beyond June 21, 2019.

b. Time period to be examined

DCBS narrowed the time period of the examination to cover from Jan. 1, 2015, through Dec. 31, 2018. It is the department's view that the last three years of data contain the most relevant and actionable data for DCBS regulation of individual and group plans for several reasons. The Oregon mental health parity law went into effect in 2007 for fully-insured commercial group insurance, but did not apply to the individual market at that time. The final rules of the federal parity law (MHPAEA) applied to plan years beginning on or after July 1, 2014, which extended to both the small group and individual markets. As discussed above, Oregon issued Bulletin No. 2014-1 in November 2014 to provide guidance for insurers in implementing state and federal mental health mandates. Obtaining data from 2015 through 2018 provides an accurate assessment of how well the guidance was implemented.

c. Scope of the lines of business

The data call includes fully-insured individual, small group, and large group health benefit plans issued in Oregon, as well as student health benefit plans and associations.

[8] Under the authority provided in Oregon's insurance code, insurers must respond completely and accurately to inquiries or face regulatory action under applicable portions of the insurance code. *See* ORS 731.296 (director's inquiries).

d. Evaluation of outsourced managed care company

The current data call takes into consideration insurers' use of third-party administrators for utilization management services. Regardless of who is administering the benefits, the processes, strategies, standards, and methodologies relied upon to establish rates or limitations for mental health providers with or without prescribing privileges must be comparable to and in parity with physical medical providers' reimbursement.

Simply because a third-party administrator is managing benefits does not excuse the insurer from compliance with state and federal parity laws. Nor does the role of the third-party administrator relieve an insurer from its responsibility to remain compliant with the law. Federal parity law requires reviewing written material and outcomes.

e. Detection of atypical reimbursement methodologies

The current data call examines policies, procedures, and methodologies of setting reimbursement; the negotiation process; and utilization management, in addition to the actual reimbursement rates applied. Additionally, the data call examines the number of available mental health providers within each insurer's network across all plans. This figure will be compared to the number of available medical providers within each insurer's network across all plans. For any area that appears to result in less populated panels, this information will be included in the report for each insurer. It is important to note, a less populated panel of providers may or may not be indicative of a companywide or system-wide problem. The number of providers in an area can have an effect on the size of the network.[9]

f. Data call to carriers

To underscore the enormity of the project, the data call was submitted to 11 health insurers on Jan. 7, 2019, and required a written response to 24 questions and numeric responses to 15 categories of questions. Over the course of the analysis, RRC reviewed cost information specific to 35 different CPT[10] codes, across eight different provider types, among 22 health plans for 11 different health insurers. In total, RRC obtained and reviewed approximately 190,960 data points.

g. Data call management

[9] *See, e.g.,* Monte Reel, *The State With the Highest Suicide Rate Desperately Needs Shrinks*, Bloomberg Businessweek, available at https://www.bloomberg.com/news/features/2019-08-15/the-state-with-the-highest-suicide-rate-desperately-needs-shrinks?srnd=premium (last visited Aug. 23, 2019)

[10] "CPT" means Current Procedural Terminology codes and terminology under the American Medical Association's Current Procedural Terminology (CPT® 2018), Fourth Edition Revised, 2017, for billing by medical providers.

After submission of the data call to the insurers on Jan. 7, 2019, DCBS received 52 different questions from insurers by Feb. 5. In addition, DCBS received numerous requests for extensions that were managed to ensure sufficient time for RRC to complete its analysis and for DCBS to review RRC's work product.

4. **Preliminary findings**

The preliminary findings below are those developed by RRC from its initial analysis of five of the 11 insurers to be examined. While more trend analysis and validation work remains, this progress report provides a glimpse of the kind of trends that are emerging from the data. A complete picture will emerge once DCBS and its vendor completes review of the remaining six insurers and a deeper dive of data can shed light on the underlying reasons behind the initial findings. Although differences were observed between provider types in the reimbursement amounts each received, which is permitted, much of the examination work that remains will focus on the methods used and will guide the agency's response to each carrier. Certainly, DCBS believes it would be inappropriate to draw conclusions about the state of mental health parity from this status document.

The largest complication in presenting preliminary findings is that insurers carry out business with different processes and procedures, which is by itself not necessarily indicative of a companywide or a systemic problem in meeting mental health parity laws. The results also appeared to differ if an insurer contracted management of behavioral health services to a third-party administrator, which has different practices and procedures for ensuring compliance with mental health parity laws.

Additionally, a crucial distinction is that the initial findings compare physical health providers and behavioral health providers with prescribing privileges.[11,12] It is particularly appropriate to focus on prescribing privileges because the scope of allowed practice between providers with prescribing privileges is more alike than between providers that can or cannot prescribe medications. The comparison is more apt because of control factors such as education, experience, and credentialing.

In terms of setting reimbursements, with few exceptions, each of the subset of insurers examined started setting rates by applying the Centers for Medicare and Medicaid Services prescribed Resource-Based Relative Value Scale (RBRVS) method of reimbursement. However,

[11] Behavioral health practitioners with prescribing privileges include nurse practitioners (NPs), psychiatrists, and psychiatrist and mental health nurse practitioners (PMHNPs). SB 860 defined two of the three specialties.
[12] Behavioral health providers that do not have prescribing privileges include psychologists, licensed clinical social workers, and licensed professional counselors/licensed marriage family therapists.

the insurers and third-party administrator's part of the initial findings tended to deviate from this accepted standard in more than one area.

First, the initial findings examined the difference between reimbursement for physical health providers and behavioral health providers with prescribing privileges in the area of evaluation and management office visits. At least two of the five insurers or third-party administrators in the initial findings appear to be reimbursing these two groups of providers at different rates. Two other insurers or third-party administrators, however, did not appear to vary reimbursement for evaluation and management office visits. Even where there appears to be this disparity, an important outstanding question for the subsequent examination work by DCBS is whether or not the inconsistencies are a result of the underlying methodologies used in determining the reimbursement rates. More work will be needed to understand the conditions that led to the differences in this particular reimbursement.

Next, in terms of the duration of office visits, the initial findings appear to show that in some circumstances, as the length of the outpatient office visit increases, medical provider rates increase to a much greater degree than the rates for in-network behavioral mental health providers and in-network mental health providers with prescribing privileges. At least one insurer or third-party administrator did not reimburse for the shortest of office visits for evaluation and management services, while other insurers or third party administrators did not appear to allow reimbursements for long office visits.

Also, the initial findings also show a disconnect in some instances between the rate of increase over time for reimbursements between physical health providers and behavioral health providers with prescribing privileges. The data from the preliminary examination report to DCBS seems to indicate that that from year to year, in-network outpatient medical provider rates increase to a much greater degree than the rates for in-network outpatient behavioral mental health providers and in-network outpatient mental health providers with prescribing privileges. However, in other instances, insurers or third-party administrators appear to be consistently increasing reimbursements in step with medical providers. More data and analysis will be needed to determine why DCBS sees this result.

Finally, some insurers' or third-party administrators' utilization management procedures for behavioral mental health providers and mental health providers with prescribing privileges appear to be different than those for medical providers. For example, in the area of authorizing long-duration office visits,[13] at least one carrier or third-party administrator appeared to require prior approval before treatment could begin.[14] Another carrier or third-

[13] Denoted under CPT code 90837.
[14] Data available to DCBS. One carrier ended the practice in 2016.

party administrator required prior authorization for a particular reimbursable service.[15] DCBS will need more information on whether differing standards of practice or the levels of care appropriate to patients presenting with a given conditions affects this data point.

5. Next steps

a. Complete and publish final, aggregated report on findings

The next step is to finish painting a full picture of how well insurers are meeting the terms of SB 860. As noted in this status report, DCBS needs to receive the remainder of the insurer-specific reports.

b. Additional policy guidance

Based on the findings of the final report, the division might find areas in which clear guidance does not exist and create guidance to fill those gaps. There are various levers that DCBS could exercise in moving public policy toward a specific result, including guidance in the form of bulletins, adoption of administrative rules, or requests for legislative action. In any case, DCBS would broadly engage with all stakeholders to find solutions.

c. Follow-up compliance inquiries

After an examination, it is common practice for DCBS to follow up at a later date to assess whether or not the insurer took steps to incorporate findings into their business practices, and to ensure compliance with the insurance code. The form of follow up is a written inquiry, and generally takes place within a year of the examination findings.

d. Potentially referring individual cases for enforcement

To the extent that the data and information reviewed demonstrates lack of compliance with the insurance code, enforcement against individual insurers may be warranted. Like any agency, DCBS must be able to show that, through a preponderance of the evidence, an entity or person violated a provision of law under DCBS authority. Penalties, orders, and the like are ultimately leverage for DCBS to make certain regulated entities are following the law.

In terms of due process, all cases DCBS undertakes proceed under the Administrative Procedures Act (APA).[16] This is the set of statutes that ensure all state agency actions are fair and consistent, and ensure a level of transparency. The APA also encourages all state agencies to use collaborative decision-making processes in contested cases.[17]

[15] Family psychotherapist services, CPT codes 90846 and 90847.
[16] ORS 183.411 to 183.471.
[17] ORS 183.501(2).