

**Parity Task Force: Summary of First Stakeholder Meeting**  
**April 25, 2016**  
**Noon-1 pm, Eisenhower Executive Office Building**

**Opening Remarks**

Carole Johnson of the White House Domestic Policy Council opened the meeting with some brief comments. She described the focus of the Parity Task Force on increasing awareness about parity and ensuring people know their rights as well as improving compliance by gathering information on tools, strategies, and best practices. She pointed out that the Presidential Memo establishing the Task Force named federal officials as members, but also called for aggressive outreach with stakeholders. Attendees were advised to submit written comments to [parity@hhs.gov](mailto:parity@hhs.gov). The floor was then opened for discussion.

Three main themes in parity implementation emerged from this listening session:

- Lack of knowledge and understanding of parity protections among consumers;
- Difficulty pursuing claims denials and appeals with failure of plans to disclose requirement information; and
- Lack of transparency and standardization in monitoring and enforcement and on-going concerns regarding lack of compliance with non-quantitative treatment limit (NQTL) rules.

**Lack of Awareness and Understanding of Parity Rights Among Consumers, Families, and Providers**

An attendee reported that in a recent survey of stakeholders indicated that consumers and providers often did not know about parity or how to file a complaint.

A few attendees recommended establishing a single portal or website for assistance with complaints; this page could re-direct users to the appropriate entity, depending on the type of coverage the consumer had.

A stakeholder pointed to the Occupational Safety and Health Administration (OSHA) website as a good model. It includes video tutorials showing patients how to file a complaint, step-by-step.

There was a recommendation that this webpage should also have educational materials for consumers, such as downloadable posters and handouts to help consumers file complaints.

Another attendee pointed out that the Maryland insurance department has developed one-pagers for consumers on parity rights and how to file an appeal.

This stakeholder also said that community forums can be helpful for educating consumers and families on their rights and how to file appeals.

Another speaker recommended that the summary plan description issued by health insurance plans should be required to include a statement outlining the consumer's parity rights.

There was discussion of other resources for consumers, families, and consumer advocates, including the National Alliance on Mental Illness (NAMI) helpline.

### **Difficulty Pursuing Appeals with Plans/Issuers Not Meeting Disclosure Requirements**

One speaker referenced hundreds of appeals in which health plans and insurance issuers failed to disclose required information. This attendee asserted that this lack of information made it impossible to assess parity compliance.

Another speaker noted that even when an extremely detailed appeal is submitted, it is uncommon for the issuers to respond in detail. This person asserted that there needs to be more guidance on exactly what information needs to be disclosed by insurers in response to appeals.

Another speaker said that the New York Attorney General found perfunctory reviews by health plans and insurance issuers of appeals for denied mental health and substance use disorder claims.

University of Maryland law students in their Drug Policy Clinic provide direct assistance with individual appeals.

It was pointed out that when issues arise with employer-sponsored plans governed by ERISA, Department of Labor (DOL) benefit advisors could help. An attendee noted that they should not have to seek help from these benefit advisors, since plans should be disclosing the required information without additional pressure from regulators.

### **Enforcement Issues and Best Practices**

Several speakers noted the need for standardization and transparency in monitoring and enforcement. They pointed out that while there might still be problems with quantitative treatment limits, parity issues with non-quantitative treatment limits are more likely to persist since they are harder to detect.

Attendees also urged that monitoring must be ongoing, for example, through a more formal monitoring system that collects attestations from insurers that parity requirements have been met with documentation to that effect, instead of carrying out enforcement with a "one-and-done" approach.

#### **Standardization**

Several speakers indicated that state insurance regulators would benefit from additional assistance with understanding the parity requirements and how to enforce them. It was pointed out that training and technical assistance is provided by HHS for state insurance departments.

An attendee said that state regulators are asking issuers different questions regarding parity compliance. This speaker suggested that state agencies might benefit from a template or recommendations on a standard set of questions they should ask issuers.

The National Association of Insurance Commissioners (NAIC) is developing a parity assessment tool, and they just finished developing a model law on network adequacy.

It was pointed out that DOL has a 12-page checklist on the website, which is used by their investigators.

### Transparency

One speaker asserted that de-identified information from enforcement activities should be disclosed, so all parties know what the rules and requirements are. Another attendee stated that insurance issuers are likely to support this recommendation to release de-identified information on the outcome of enforcement activities.

### Non-quantitative Treatment Limits

Several attendees asserted that more guidance to insurers on how to calculate and compare NQTLs is needed.

Others asserted that the differences between management strategies used by insurers for behavioral health (i.e., mental health and substance use disorder treatment) and medical/surgical services need to be explored further, and the implications for parity enforcement more fully considered. As an example, this person pointed to the use of diagnosis related groups (DRGs) for medical/surgical reimbursement, but not for behavioral health services.

Another speaker noted that it is difficult to determine the criteria that plans are using for behavioral health and medical/surgical benefits. Another attendee indicated it is difficult to compare the criteria across behavioral health and medical/surgical benefits

One speaker asserted that precise definitional clarity would be useful for the following terms: evidentiary standards, processes, strategies

### Medical Necessity

Medical necessity criteria were mentioned more often than any other NQTL. Concerns were raised that several important mental health and substance use disorder services might not meet medical necessity criteria. For example, one speaker asserted that it is problematic that private plans are not covering non-medical services that might be covered by Medicaid, such as early intervention services. Attendees claimed that the restrictiveness of medical necessity criteria for behavioral health care is greater than for medical/surgical services.

### Network Adequacy

Another NQTL that several attendees raised as problematic is how plans and issuers determine their provider networks. They conceded that parity violations on this topic are difficult to assess. However, they also pointed out that many provider directories are out-of-date and include providers who are retired or no longer in network for other reasons. Maryland passed a law to require that health insurers' information regarding their provider networks must be current.

With regard to network adequacy, a NAMI survey and analysis of their helpline usage shows that consumers are having problems accessing care, in both private insurance and Medicaid which may be related to network adequacy.

### Additional Monitoring and Enforcement Recommendations

An attendee described several actions that the Maryland insurance department has taken including a survey of insurers about compliance with parity and instituting fines for insurers for lack of compliance. Even though the fine amounts were relatively low, this attendee asserted that they increased awareness of the issue.

A speaker recommended instituting whistleblower protection for families and providers, since some parties might be concerned about retaliation by issuers. For example, residential substance use disorder facilities might be wary of being dropped from issuer networks if they file appeals or register complaints. This person pointed to OSHA as a model for this.

An attendee asserted that providers know which insurers are denying an inordinate amount of behavioral health claims, and this person recommended collecting this information from providers.

### Issues with Specific Treatment and Screening Services

Several speakers asserted that coverage of medication-assisted treatment for opioid use disorder is often not in compliance with parity.

An attendee also pointed out that residential treatment is often not covered for behavioral health, whereas sub-acute inpatient care is generally covered for medical/surgical services, such as hospice care. This speaker also stated that intensive outpatient treatment cannot always be substituted for residential care since it does not provide sufficient treatment intensity for some patients with serious behavioral health issues.

Another speaker asserted that screening should be covered in compliance with parity.

An attendee asserted that there continue to be lots of parity violations in coverage of substance use disorder care in general, and particularly for substance use disorder care provided via tele-health technologies.

Another attendee referred to two examples of recent cases in which patients in residential programs that typically ran for 28 days were only covered for about two weeks. According to this speaker, insurers appear to only have conducted a perfunctory review of the facts of each

case before denying coverage. This commenter asserted that there seems to be a bias against covering certain behavioral health services, particularly residential detox.

### **Federal Employees' Health Benefit Program**

One speaker noted that Federal Employees' Health Benefit Program (FEHBP) has established MHPAEA as a requirement in the Office of Personnel Management carrier letters. However, this person asserted that some FEHBP plans are not in compliance with the parity law, and denial rates for mental health and substance use disorder services may be rising. This attendee claimed that fewer than two in three patients in one plan received the necessary prior authorization for inpatient substance use disorder rehab and some FEHBP plans have broad exclusions for residential treatment.

### **Essential Health Benefit Benchmark Plans**

An attendee claimed that some of the 2017 essential health benefit benchmark plans have clear parity violations. This person states that some plans have blanket exclusions on residential treatment, eating disorders, and allow methadone for pain only (not maintenance treatment for addiction). This speaker was not aware of how or if qualified health plans are addressing any potential parity issues in those benchmark plans.