Compliance Actions Under State and Federal Mental Health and Substance Use Disorder Coverage and Parity Laws

Joint Annual Report to the General Assembly

Produced by:

Illinois Department of Insurance

Illinois Department of Healthcare and Family Services

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To the Honorable Members of the General Assembly:

Section 370c.1(h)(3) of the Illinois Insurance Code requires the Department of Insurance, in conjunction with the Department of Healthcare and Family Services, to submit an annual report to the General Assembly regarding the agencies' respective activities in enforcement of Sections 356z.23, 370c, and 370c.1 of the Illinois Insurance Code, as well as the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any federal regulations or guidance relating to the compliance and oversight of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and 42 U.S.C. 18031(j). *See* 215 ILCS 5/370c.1(h)(3).

In accordance with Section 370c.1(h)(3) of the Illinois Insurance Code, we are pleased to submit the January 2022 edition of the Joint Annual Report to the General Assembly on Compliance Actions Under State and Federal Mental Health and Substance Use Disorder Coverage and Parity Laws. The report contains significant information from a national and Illinois perspective regarding the current condition of regulated entities' compliance with these important laws.

Respectfully,

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Director of Insurance

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Contents

Methodology to Ensure Compliance

Illinois Department of Insurance

DOI utilizes market conduct examinations to verify a health insurance issuer's compliance with mental health and substance use disorder (MH/SUD) coverage and parity laws contained in Sections 356z.14, 356z.23, 370c, and 370c.1 of the Illinois Insurance Code and DOI regulations, which are interpreted consistently with the Paul Wellstone and Pete Demenici Mental Health Parity and Addiction Equity Act of 2008. The scope of the examinations includes, but is not limited to, activities as they pertain to parity in MH/SUD benefits within the company's health insurance business.

1. The objective of the examinations is to evaluate if the company designed, implemented, and managed MH/SUD benefits no less favorably than medical/surgical benefits. The specific review processes for the examination include, but are not limited to, the following:
2. Review the procedures and guidelines related to utilization review to ensure that such guidelines and utilization review processes on MH/SUD services are no more stringently applied that those applied to medical/surgical services.
3. Evaluate a sample of MH/SUD claims during the examination to compare services to medical/surgical and to ensure denials were appropriate based on medical necessity criteria.
4. Evaluate the universe of appeals during the examination to determine if the appeal decisions were based on appropriate clinical criteria and policies.
5. Evaluate the medical necessity criteria, policies, and procedures to ensure the company was not imposing more restrictive requirements and determination for MH/SUD treatments and services than on medical/surgical treatment and services.
6. Determine that the MH/SUD benefits provided in the classification identified by 45 CFR § 146.136(c)(2)(ii)(A) are paid in parity with benefits in the same medical/surgical classifications.
7. Evaluate financial requirements and quantitative treatment limitations (QTL) to ensure that any such requirements and limitations were consistently applied through MH/SUD and medical/surgical benefits, and that any financial 4 requirements and QTLs imposed meet the two-thirds threshold of "substantially all" requirements outlined in 45 CFR § 146.136(c)(3)(i).
8. Evaluate non-quantitative treatment limitations (NQTL) to ensure that such limitations were consistently applied through MH/SUD and medical/surgical benefits and that the company was not being more restrictive as outlined in 45 CFR § 146.136(c)(4)(i)-(ii).
9. Evaluate pre-certification/prior-authorization, step therapy policies, and procedural requirements for MH/SUD treatments to ensure that any such requirements were no more restrictive than the comparable medical/surgical policies and procedural requirements.
10. Determine that the policies and procedure for the selection, tier placement, and quantity limitations of MH/SUD treatment drugs on the formulary were no less favorable to the insured than policies and procedures used for the selection, placement, and limitations of medical/surgical drugs.

Outside of market conduct examinations, since 2018, the DOI has required every company to submit information in an MHSUD Supporting Documents Template for every major medical, HMO, or HMO Point-of-Service policy that the company files for approval, both on and off the ACA Health Insurance Marketplace. This template is designed to assist the DOI, when deciding whether to approve a policy to be sold in Illinois, and in performing an initial, high-level review of the policy for compliance with regulations under the federal Mental Health Parity and Addiction Equity Act. In particular, it instructs companies to explain how their policy complies with parity requirements relating to aggregate lifetime and annual dollar limits, financial requirements, QTLs, NQTLs, and the ability of healthcare providers and insured individuals to access a company's medical necessity criteria. Although this template was first put into use after the time periods reviewed in the market conduct exams discussed below, the DOI's future exams will be able to compare a company's responses on this template to its actual conduct during the applicable policy periods.

Illinois Department of Healthcare and Family Services

The Illinois Medicaid Managed Care Program (HealthChoice Illinois) delivers fully integrated healthcare, inclusive of behavioral health services, to Illinois Medical Assistance Program customers. To provide a base for ensuring compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), HFS includes specific language regarding MHPAEA compliance in all HealthChoice Illinois contracts. HFS utilizes two primary mechanisms to monitor each health plan's compliance with its contract: 1) internal quality and contract management activities and 2) compliance reviews conducted by HFS' external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

Mental Health Parity Workgroup

The Mental Health Parity Workgroup (Workgroup), established pursuant to 215 ILCS 5/370c.1(j), is comprised of eleven (11) members representing behavioral health parity experts, advocates, insurers, and providers. The Workgroup receives technical support from the DOI and HFS, and meets minimally on a semi-annual basis, with supplemental meetings scheduled as determined necessary by the members.

The purpose of the Workgroup is to provide recommendations to the General Assembly on health plan data reporting requirements that separately break out data on mental, emotional, nervous, or substance use disorder or condition benefits and data on other medical benefits, including physical health and related health services. The Workgroup also is tasked to create reporting instructions and formatting for insurance issuers to report detailed information on their claims practices as it relates to non-quantitative treatment limitations when comparing medical/surgical vs. MH/SUD benefits. The Workgroup broke down the complex information into three phases for data collection:

Phase	NQTLs Analyzed	Submission Date
Phase I	• Medical necessity • Prior authorization	July 1, 2021
Phase II	• Coverage limits • Utilization management	July 1, 2022
Phase III	• Provider network reimbursement	July 1, 2023 (tentative)

Compliance Activities in 2022

Market Conduct Examinations: Illinois Department of Insurance

DOI completed one market conduct examination evaluating compliance with MH/SUD coverage and parity laws for Celtic Insurance Company.

Each market conduct examination in which DOI has found violations of law has resulted in a stipulation and consent order requiring the company to correct all activities where violations were found, pay a civil forfeiture, and provide proof of compliance to the DOI. The orders and the final reports are posted publicly on the DOI website. The following is a summary of findings by company for the recent round of examinations:

- Created a barrier to treatment by imposing prior authorization for all substance use disorder claims.
- Failed to utilize American Society of Addiction Medicine (ASAM) medical necessity criteria for substance use disorder benefit determinations.
- Failed to sufficiently complete Non-Quantitative Treatment Limitation (NQTL) comparative analysis to prove adherence to Illinois and federal laws.
- Created consumer access barriers (prior authorization) to ADHD medications, anti-depressants, antipsychotics, flumazenil (treats drug overdose), Vivitrol (helps prevent relapse into drug or alcohol abuse), Lucemyra (alleviates opioid withdraw symptoms), buprenorphine/ naloxone tablets, buprenorphine tablets for pregnancy, and Fetzima/Trintellix/Viibryd (antidepressants).
- Created a quantity limitation barrier to Anti-Anxiety, Antipsychotic, Risperidone TBDP (schizophrenia treatment), Smoking Cessation Medications, Evzio (overdose treatment), Latuda (schizophrenia treatment), probuphine and sublocade (addiction treatment medications similar to buprenorphine), buprenorphine/naloxone/suboxone films, and HIV/AID medications.
- Placed certain commonly prescribed medications on non-preferred medication tiers or non-formulary, ADHD medication, antidepressant medications, and substance abuse medications-Antabuse, Zyban, and Suboxone films.
- Created a barrier to treatment for consumers by denying step therapy exception requests.

Parity Audits: Illinois Department of Healthcare and Family Services

Quarterly Business Reviews

HFS staff meet with the health plans independently for monthly operations meetings and quarterly business reviews (QBRs) focused on monitoring health plan performance. QBRs include monitoring of areas related to Mental Health Parity and Addiction Equity Act (MHPAEA) compliance, including: the percent of prior authorization requests denied and top denial reasons, broken down by behavioral health and non-behavioral health benefits.

Managed Care Provider Resolution Portal and Parity Tracking

Per Illinois statute (215 ILCS 5/370c(d)(2)), HFS is required to evaluate all consumer or provider complaints related to mental health (MH) or substance use disorder (SUD) coverage for possible parity violations. Effective January 1, 2022, HFS Bureau of Managed Care (BMC) updated its Managed Care Provider Resolution Portal to include the ability to identify complaints that include an indication of potential parity violations and to track the outcome of those complaints.

When a provider submits a complaint through the portal, there is an option for indicating if the complaint is related to MH/SUD Parity. Complaints flagged as a potential parity violation are routed to staff within the HFS Bureau of Behavioral Health (BBH), for additional review and scrutiny to determine if the complaint is related to MH Parity and if there is evidence of a possible parity violation. Once a Complaint has been received by BBH staff, they have 30 days to review and respond with a determination. Data regarding the number of complaints identified as possible parity issues and the outcomes of the determinations are tracked and reported monthly. Since the January 1, 2022 effective date, there have been only two complaints flagged potential parity violation. Upon further review, both were determined to not be parity issues.

Parity Audit: Phase I Mental Health Parity (MHP) Monitoring

HFS finalized a workplan with Health Services Advisory Group, Inc. (HSAG), in January 2022 to conduct an MHP analysis of all HealthChoice Illinois health plans ("health plans"). HSAG developed a protocol and tools in alignment with guidance outlined in the toolkit provided by the Centers for Medicare & Medicaid Services (CMS): *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.

The MHP analysis consisted of the following:

- Review of the health plans' Phase I MHP Parity Analysis Template and comparative analyses, which were submitted to HFS on July 1, 2021.
- An attestation of continued compliance with MHP requirements and documentation of any related policy or procedural changes since the July 1, 2021, submission.
- Review of the health plans' utilization management (UM) documents and information.
- Review of the availability of prior authorization (PA) and clinical practice guideline (CPG) information on each health plan's website.
- Analysis of medical and surgical (M/S) and mental, emotional, nervous, or substance use disorder or condition (MH/SUD) PA denial data, which are self-reported to HFS.
- File review of adverse benefit determination (ABD) records encompassing both M/S and MH/SUD denials.

For each health plan, HSAG made a determination as to whether the health plan demonstrated how it designs and applies NQTLs, both as written and in operation, for MH/SUD benefits as compared to how it designs and applies NQTLs, as written and in operation, for M/S benefits.

Overall, HSAG determined that the health plans demonstrated parity between M/S and MH/SUD services. Documentation and implementation of the health plans' processes demonstrated compliance with State and federal MHP requirements and standards.

- Non-parity between M/S and MH/SUD denial rates: There was one health plan (County Care), that demonstrated non-parity when self-reported denial data were analyzed; however, results are limited to data analysis and does not reflect a review of appropriateness of decisions.

Each health plan achieved parity overall on the ABD record reviews. The overall average for health plan compliance with scored elements of M/S and MH/SUD ABD records was 85 percent. There were two findings consistent across all six health plans:

- Readability: All six health plans had an opportunity for improvement related to readability levels for denial letters. All health plans should review the systems and processes responsible for letter creation and ensure that all relevant information is written in easily understandable language.
- Notice sent within required time frame: All six health plans had an opportunity for improvement related to compliance with timely notifications of ABD. All health plans should ensure and demonstrate that decisions and communications are processed in a timely manner, including decisions made by delegates (as applicable).

Educational Actions Taken in 2022

Illinois Department of Insurance

In 2022, with an eye towards an education campaign for 2023, Get Covered Illinois procured a vendor for an education campaign to ensure, that Illinois consumers statewide are informed and educated about their consumer rights under mental health laws. The campaigns goals are to increase awareness with mental health parity rights, explain to consumers how to seek relief if their rights are violated and to reinforce the importance of maintaining health coverage and guaranteeing support under the law.

Illinois Department of Healthcare and Family Services

In February 2022, HFS provided all HealthChoice Illinois health plans with a readability protocol, which provided guidance to achieve compliance with sixth grade reading levels. Based on the timing of the MHP analysis and the issuance of the readability protocol, it was determined that the department would continue to monitor the level of compliance and HSAG will plan to perform follow-up reviews for readability during Phase II review activities. HFS provided health plans with the instructions and templates for submitting Phase II NQTL MHP documentation, which includes reporting of M/S and MH/SUD NQTL utilization management (i.e., concurrent, and retrospective reviews), exclusions criteria, out-of-network coverage standards, and geographic restrictions. All health plans returned the required MHP documentation by July 1, 2022.

In September 2022, HFS issued an Ad Hoc report request, that health plans review the Phase I MHP analysis report and respond with any agreements, disputes, and corrective actions being taken to address an identified deficiency with response by September 23, 2022. All health plans submitted responses and corrective actions addressing identified deficiencies.

The 2021 Mental Health Parity Analysis Summary Report is viewable on the HFS website at:
https://www2.illinois.gov/hfs/SiteCollectionDocuments/IL202122MentalHealthParitySummaryReportF1.pdf