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OREGON INSURANCE DIVISION BULLETIN INS 2014-1

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

DATE: November 14, 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.

References to "mandates" in this bulletin include the Oregon Mental Health Parity Statute, ORS 743A.168 (Oregon MHP) and MHPAEA mandates as implemented under the Affordable Care Act. If only one mandate is discussed, the bulletin specifies which mandate.

B. Background

The division has taken into account a number of recent developments in preparing this bulletin. These developments include activities in Oregon and throughout the country:

- Adoption of final MHPAEA regulations, providing clarity on the parity requirements of federal law and the interaction of the federal MHPAEA with state mental health requirements.
- Publication of Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), replacing the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" (DSM-IV).

- Changes in coverage required under the Affordable Care Act;
- Court decisions in Oregon under Oregon MHP—including *A.F. v. Providence*, a class action lawsuit—and similar decisions in other states;
- IRO decisions that have repeatedly overturned insurers' denials of coverage for treatment of mental health conditions;
- HERC review and recommendation to cover certain mental health treatments;
- Adoption of a number of bulletins and rules by other states that address mental health parity statutes similar to Oregon MHP. These states include California, Indiana, Washington, and New York.

A list of and citations for many of these developments is included in Appendix A to Bulletin INS 2014-2.

C. 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 an individualized determination of medical necessity under the terms of the policy.

- Although an insurer may determine that a treatment is not required to be covered because the treatment falls within a statutory or contract exclusion, the insurer may not categorically deny in all circumstances a treatment that in some circumstances is medically necessary for a mental health condition. An insurer may not apply a categorical exclusion (such as exclusions for developmental, social, or educational therapies) to a class of mental health conditions that results in the denial of medically necessary care or otherwise results in one of the mandates being effectively meaningless.

- Certain specific exclusions from mental health coverage are expressly allowed by the Oregon MHP. Any exclusion 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 a treatment denial was overturned on appeal, including decisions by an independent review organization (IRO). An insurer should review its appeals and IRO decisions for guidance on handling of future appeals and benefit determinations.

- Insurers should apply a determination of "medically necessary" and "experimental or investigational" to specific treatments covered by the mandates in a manner no more restrictive than applied to substantially all medical and surgical conditions. The definition of medical necessity must comply with all requirements of state and federal law, cannot be so stringent as written or as applied that it renders the mandates meaningless, and must be communicated and applied in a way that allows both the consumer and the division to readily identify in advance the services covered and the procedures necessary to obtain coverage.

- The division will work with individual carriers to address pending complaints related to mental health coverage.

D. Related Bulletins

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

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

INS 2012-1 addresses discrimination on the basis of gender identity or gender dysphoria. The guidance of INS 2012-1 is supplemented by the provisions of this bulletin to the extent that this bulletin provides additional guidance for the treatment of all mental health conditions including gender dysphoria.

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

II. Discussion

A. History of Provisions

The predecessor of Oregon MHP was first adopted in 1975, and the statute has undergone numerous changes since first enacted. However, the Oregon MHP has not been significantly amended since 2005, when the requirements of the existing mandate were extended to parity coverage of chemical dependency, including alcoholism, and mental or nervous conditions. Thus, the coverage requirement under ORS 743A.168 as it currently exists applies to all group plans issued or renewed after January 1, 2007 (the effective date of last major amendments to ORS MHP).

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 individual policies issued or renewed on or after January 1, 2014 that comply with all 2014 ACA market reforms ("ACA-compliant policies") through the ACA essential health benefits (EHB) requirement. Individual grandfathered and transitional plans are not subject to the Oregon MHP and coverage of the mandates is not required, because these plans are not required to provide essential health benefits. All group plans are subject to the mandates - including ACA-compliant, grandfathered and transitional plans.

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

B. Applicable Policy Types:

On its face, the Oregon MHP statute applies only to small and large groups. However, the benchmark plan sets the base requirements that all non-transitional and nongrandfathered individual and small group plans in Oregon must meet to be considered ACA-compliant. 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.

The MHPAEA applies to all large group health benefit plans that cover mental health benefits. The ACA incorporates the requirements of the MHPAEA and applies them to small group and individual policies. When combined with the requirement that ACA-compliant plans must have mental health and substance abuse coverage 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 MHPAEA applies to all plans that cover mental health benefits – individual, small group (except grandfathered and some 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 PacificSource 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.

C. 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 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 enumerated diagnostic codes that are exceptions. The excepted codes include codes related to mental retardation, learning disorders, paraphilias and some relationship-related codes, OAR 836-053-1404(1)(a). This rule was inclusive in that it identified 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.

In connection with this bulletin, the division is adopting a temporary rule to update the references in OAR 836-053-1404(1)(a) to include the parallel references in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Under this rule either DSM-IV or DSM 5 is referenced to define mental or nervous conditions, depending on which edition of the Manual provided the criteria for diagnosis. 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 Oregon MHP mandate, any disorder included in the DSM-IV-TR or DSM -5 diagnostic codes, as applicable, apart from the specific 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 medically necessary treatments for the condition. Recent judicial opinions have indicated that if a plan excludes a therapy regardless of whether it is medically necessary, the blanket exclusion violates the mental health parity requirements if the therapy may be medically necessary to treat a mental disorder,

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. Also, any transitional or grandfathered plans that provide mental health coverage must apply the MHPAEA tests to assure parity.

Final regulations implementing MHPAEA were published in the Federal Register on November 13, 2013.[1] This bulletin provides a high-level summary of the MHPAEA regulations, but insurers are responsible for implementing the regulations in detail, whether or not summarized here.

Under these regulations, 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*. As specified in the regulations, the six classifications of benefits to be used are: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

[1] 45 CFR 146.136 and 147.160.

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.

In evaluating a quantitative treatment limitation, the comparison is always between a mental health benefit and substantially all medical or surgical benefits in that classification, not to only one medical or surgical benefit, even if that medical surgical benefit is analogous to the mental health benefit in question. 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 same 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.

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.

- ORS 743A.168(4)(a) expressly allows exclusions for:

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

Although these limitations or exclusions are allowed under state law, insurers must be mindful of the restrictions on these exclusions or limitations under the MHPAEA or other mandates. In some instances, such as the 45-day standard for long-term residential mental health programs in ORS 743A.168(4)(a)(B), the limitation can be saved if interpreted as a floor rather than as a maximum number of treatments the insurer must cover. If applied as a limitation, it must be analyzed as required by MHPAEA. If a categorical limitation or exclusion effectively denies all coverage for a treatment for a mental health condition, the limitation or exclusion would not be permitted because no similar exclusion bars coverage for the treatment of any other medical condition. In other instances, the insurer must examine a quantitative limitation in light of the recently adopted federal MHPAEA rules. For example the 45 day standard for long-term residential mental health programs in 743A.168(4)(a) is a quantitative treatment limitation prohibited by MHPAEA unless substantially all medical treatments in the same classification are subject to the same or more restrictive limitations. Similarly, the 30-visit limits for speech therapy, occupational therapy and physical therapy in Oregon's Essential Health Benefits package are quantitative treatment limitations prohibited by MHPAEA when the therapy is to treat a mental health condition.

In addition to the requirements of Oregon's MHP and the federal MHPAEA , 45 CFR 156.125(a) provides 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.[2]

Some policies include broad-based treatment exclusions that are based on categories such as "academic or social skills training," "educational," or "sexual dysfunction." Recent judicial opinions, however, have disallowed such broad exclusions, where they undercut mandates. If the exclusion operates to nullify a mandate, the exclusion is too broad and must be restricted. 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 in a way that prevents the insured from receiving medically necessary treatment.

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," a carrier may not exclude all medically necessary treatment for a mental or nervous disorder by classifying the treatment as "educational or correctional" rather than medical. The exclusions allowed are limited to specific circumstances (e.g., "provided by a school or halfway house" and "received as part of an educational or training program"). To expand the exemption by categorizing an entire form of treatment as "educational" regardless of where or how it is provided exceeds the scope of the statutory exemption.

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

[2] 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,[3] and 45 CFR §146.136(c)(4) applies the same provision to mental health benefits specifically.

Independent Review Organizations:

Insureds may employ 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 reviews the results of IRO decisions including those decisions regarding mental health treatments. When an IRO finds that a treatment is medically necessary, the division will look at an insurer's subsequent denials to determine 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 the company's previous denials overturned by external review. Although IRO determinations are not binding beyond the individual case and are not available to other insurers, the division considers patterns of IRO decisions significant evidence in determining whether to examine more closely any pattern of denials related to a mental health treatment.

Guidelines and Transparency:

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

- Insurers should review definitions of "medically necessary" and "experimental or investigational" that are 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 in violation of ORS 743A.168 and MHPAEA.
- 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) so that the insurer can consider the medical necessity of the treatment and respond in writing with a coverage decision. A denial must include information about the appeal process and opportunity for external review and conform to state and federal statutory and regulatory requirements.
- 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).
- In evaluating medical necessity for any treatment requested for a mental health condition, the insurer must evaluate the request using general standards but also when possible with peer-reviewed scientific studies of clinical effectiveness and with specialty standards established by national or international medical, clinical or research 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

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[3] *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.

insurer should refer to the guideline in making an individualized determination of medical necessity. 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.

III. Enforcement

An insurer's denial of coverage on a basis prohibited by this bulletin may subject the insurer to enforcement measures for violation of the Oregon Insurance Code.

This bulletin is dated the 14th of November, 2014, at Salem, Oregon.

Laura N. Cali, FCAS, MAAA
Insurance Commissioner