SETON HALL | LAW
Center for Health &
Pharmaceutical Law & Policy

Access to Behavioral Health Services in Marketplace Plans in New Jersey

The Puzzle of Parity

John V. Jacobi, J.D.
Tara Adams Ragone, J.D.

July 2016

Table of Contents

Acknowledgments iv
Executive Summary v
I. Introduction 1
II. Overview of the Relevant Law 3
A. Focus on Mental and Behavioral Health Parity 4
B. Focus on Transparency and Disclosure 12
III. Sentinel Project Findings in New Jersey 16
A. Summary of Behavioral Health Access Issues Raised in Interviews 16
1. Network Adequacy 16
a. Provider & Advocate Perspectives on Network Adequacy 16
b. Carrier & Regulator Perspectives on Network Adequacy 19
2. Utilization Management 20
a. Provider & Advocate Perspectives on Utilization Management 20
b. Carrier & Regulator Perspectives on Utilization Management 22
B. Sentinel Project Surveys of New Jersey Plans and Plan Filings 24
1. Survey of Federal Marketplace Silver Plans in New Jersey in 2015 24
a. Summaries of Benefits and Coverage 24
b. Formularies 27
i. Access to Drugs Based on Formulary Design 29
ii. Access to Drugs As a Result of Utilization Management Techniques 32
iii. Access to Drugs Based on Cost-Sharing & Adverse Tiering 33
iv. Focus on Tobacco Cessation Medication Coverage 366
v. Summary of Findings and Need for Further Research 38
c. Network Directories: Focus on Methadone Treatment Facilities 39
d. Transparency and Consumer Accessibility Concerns 42
i. Transparency in Network Directories 43
ii. Transparency in Drug Formularies 44

2. Survey of Carrier Filings to New Jersey Department of Banking & Insurance 477

a. Overview of DOBI's Regulatory Oversight of Marketplace Plans 47

b. Analyzing Templates for Annual Filings to DOBI 50

c. Observations from Review of 2015 Regulatory Filings 54

IV. Our Discussions Outside of New Jersey 61

A. Parity Enforcement in Other States 622

1. Complaint-Driven Enforcement: New York 622

2. Focus on Disclosure 62

a. Massachusetts 63

b. Connecticut 655

c. California 666

d. Maryland 68

3. Seeking Judicial Enforcement of Parity 699

B. Efforts to Address Network Adequacy in Other States 711

C. Additional Efforts to Improve Access to Behavioral Health Services 72

V. Next Steps 766

Appendix A: Individuals Interviewed or Consulted by the Sentinel Project during Preparation of Report 788

Appendix B: Tables 822

Table A: 58 Behavioral Health and Substance Use Disorder Medications Selected for Formulary Survey 84

Table B: Characteristics of Drug Coverage by Carrier in Formulary Survey 86

Table C-1: Carrier A – Drugs Not on Formulary or in High Cost-Sharing Tier 92

Table C-2: Carrier B - Drugs Not on Formulary or in High Cost-Sharing Tier 93

Table C-3: Carrier C - Drugs Not on Formulary or in High Cost-Sharing Tier 94

Table C-4: Carrier D - Drugs Not on Formulary or in High Cost-Sharing Tier 95

Table D: 2015 Smoking Cessation Coverage in Federal Marketplace Plans in New Jersey 96

Table E: Carrier Definitions of Formulary Tiers in 2015 Federal Marketplace Plans in New Jersey 99

Table F: Health Care Facility Expenses Reported in 2014 New Jersey HMO Annual Supplement Reports 100

Table G: Ambulatory Encounters Reported in 2014 New Jersey HMO Annual Supplement Reports 102

Table H: Commercial Member Complaints Reported in 2014 New Jersey HMO Annual Supplement Reports 103

Table I: Stage 1 Internal Utilization Management Appeals by Category Reported in 2014 New Jersey HMO Annual Supplement Reports 104

Table J: Stage 2 Internal Utilization Management Appeals by Category Reported in 2014 New Jersey HMO Annual Supplement Reports 105

Table K: External Utilization Management Appeals by Disposition and Category Reported in 2014 New Jersey HMO Annual Supplement Reports 106

Table L: Utilization Management Requests and Denials Reported in 2014 New Jersey HMO Annual Supplement Reports..... 107

Table M: Utilization of Inpatient Services Reported in 2014 New Jersey HMO Annual Supplement Reports 108

Acknowledgments

This project benefitted from the cooperation of a wide range of experts, including health care providers, consumer representatives, trade organization leaders, health plans, regulators, advocates, academics, and patients in New Jersey and beyond. We have included a list of many of those who unselfishly provided insight and information in Appendix A. We gratefully acknowledge those listed for their generous and open assistance in this endeavor, and we apologize for any unintentional omissions.

Current and former Seton Hall Law students Simisola Durosomo, Matthew Goss, Donna Hanrahan, Nicholas Pellegrino, Jessica Seiden, Lindsay Sheely, and Kate Slavin provided valuable research assistance during the various phases of this work. Donna Hanrahan and Lindsay Sheely, in particular, devoted substantial time to the project over an extended period of time. The continuity of their involvement, combined with their thoughtful analysis and attention to detail, appreciably enriched our work. We would also like to extend a special thank you to our former colleague, Kate Greenwood, whose vision and legal acumen helped shape the direction of the different phases of this project.

Finally, the authors thank the Robert Wood Johnson Foundation for funding the Sentinel Project. Senior Program Officer, Deborah Bae, has facilitated fruitful collaborations and consistently provided keen insights and sage guidance. Any errors remain the responsibility of the authors.

Executive Summary

The Sentinel Project at Seton Hall Law School set out to assess access to care through the Affordable Care Act (ACA) in New Jersey. The Project's goals are to evaluate whether the ACA's promising market reforms are fully implemented in the State and throughout the nation, and to understand how gaps in implementation may be filled. In this Report, we focus on access to behavioral health (BH) care in healthcare coverage available through the federal Marketplace, or Exchange, in New Jersey. BH services, which include mental health (MH) and substance use disorder (SUD) services, are among the ten essential health benefits (EHBs) identified by the ACA that must be provided in qualified health plans (QHPs) available in the Marketplace. Through focused interviews, we identified a number of potential barriers to BH care in the State, including network adequacy and utilization management (UM) techniques. These barriers, however, are subject to the requirements of the ACA's market reforms, which include its anti-discrimination provisions and the requirements of the federal Mental Health Parity and Addiction Equity Act (MHPAEA). Robust monitoring and enforcement of anti-discrimination and parity requirements, therefore, hold great promise for improving access to BH services. Regulators, carriers, providers, advocates, and patients alike, however, are wrestling with how best to implement these requirements. Parity, in particular, has been a decidedly vexing challenge for stakeholders. It is critical to solve the puzzle of parity to ensure beneficiaries can access the BH benefits that the ACA secures as essential. This Report is dependent on information gathered over a two-year period. We have updated many aspects of our work up to the time of publication, but we recognize that some circumstances may have changed in this dynamic area as the Report was compiled.

Phase I. Focused Interviews with Consumer Advocates, Providers, Carriers, and Regulators

In the first phase of this project, we engaged in focused interviews in 2014 and 2015 of consumer advocates, providers, carriers, and regulators regarding access to BH care in Marketplace plans in New Jersey. In addition, we hosted a conference in 2015 at which plan representatives, providers, and consumer advocates discussed their perspectives on plans' success in connecting consumers to appropriate BH care. These conversations helped us identify potential concerns regarding BH access that helped shape subsequent phases of research.

Network Adequacy: Through our interviews, we were able to identify several prominent perceived concerns regarding network adequacy for BH. We heard concerns from advocates that plan networks contained an inadequate number of appropriate BH providers, which meant that patients had to wait extended periods of time or travel long distances for appointments – or simply go without care. Advocates also raised concerns that consumers had difficulty accessing a provider of a specific gender, who speaks a common language, or who can address cultural sensitivities. Some expressed concern that in-network provider offices did not have flexible hours for patients who work or are not accessible by public transportation. We consistently heard about the dearth of pediatric psychiatrists in Marketplace networks, as well as the lack of psychiatrists in Marketplace networks in general. Additionally, advocates raised concerns that individual and small group markets do not include adequate numbers of qualified

providers of applied behavioral analysis (ABA) therapy for patients with autism, which is a mandated covered benefit in New Jersey's individual and small group markets. Another area of concern involved the availability of in-network services for SUD treatment. The problem of so-called phantom networks also arose in our discussions. Advocates claimed that there were not only an inadequate number of providers in-network, but carriers' published network directories often contained inaccurate information, which made it harder for patients to identify an appropriate, in-network provider. In response, regulators and carriers both emphasized that network adequacy challenges are not new. The industry long has been attuned to the need to provide adequate networks of providers, well before the ACA. Regulators and carriers also cited recent policies to improve network adequacy. Some carriers questioned whether New Jersey has a low supply of BH providers. Principally, however, they pointed to the reluctance of some BH professionals to be part of networks. They also expressed frustration because providers within their networks often do not provide updated contact information.

Utilization Management: Advocates identified UM as a tool that can result in beneficiaries inappropriately being denied access to covered BH services. SUD providers, for example, reported that the frequency and intensity of UM reviews have ramped up for some services. We have heard that UM reviews are becoming more taxing. Providers raised concerns about various UM strategies that are applied to BH prescriptions, such as imposing prior authorization (PA) or fail first requirements on prescriptions for patients who have been stable on psychotropic medications for long periods of time. There generally was a perception among BH providers and advocates that BH services are subject to more frequent and more demanding UM processes than medical/surgical services. Carriers told us that generally they are moving away from using UM to manage outpatient BH services, unless the services were "nonstandard." Overall, carriers, regulators, providers, and advocates alike mentioned the need for more guidance regarding how the parity analysis should be structured and applied to UM.

Phase II. Survey of Plan Documents and Plan and Marketplace Web Sites

In the second phase of this project, we took a closer look at 16 silver plans that were offered through the federal Marketplace in New Jersey in 2015 to get a better sense of the plan designs and information about plans that were publicly available to regulators and consumers. In surveying the information available in the healthcare.gov search return as well as in the Summaries of Benefits and Coverage (SBCs), formularies, and network directories for each plan surveyed, we attempted to evaluate a number of plan design features for compliance with the ACA's anti-discrimination principles and MH parity laws. We found that although important plan information was available to consumers and regulators regarding their access to BH services and providers, disclosure was inadequate to permit consumers to evaluate whether plans complied with parity or anti-discrimination principles.

Summaries of Benefits & Coverage: SBCs serve a valuable purpose for helping consumers learn more about health care coverage options, including coverage of BH services. For example, they itemize cost-sharing for outpatient and inpatient mental/BH and SUD treatment. But they do not provide the transparency necessary to monitor for compliance with parity and anti-discrimination requirements. The itemized cost-sharing in SBCs, for one, does not map the parity classifications and is not a proxy for the quantitative parity calculation. The SBCs also do not provide sufficient information to assess

nonquantitative treatment limitations (NQTLS) for parity compliance. SBCs, for example, do not include any information regarding how plans are applying NQTLs, which is a critical aspect of the parity requirement. They also do not include any information to assess plan reliance on a number of NQTLs, such as the standards for provider admission to participate in a network, including reimbursement rates, or plan methods for determining usual, customary, and reasonable charges.

Inclusion of BH and SUD Drugs in Formularies: We examined the formularies for the same 16 silver plans to see whether and how they covered 58 BH and SUD medications commonly prescribed for bipolar disorder, schizophrenia, alcohol and drug dependence, and smoking cessation drugs. One carrier excluded 25% of the 28 drugs commonly prescribed to treat schizophrenia, while another excluded 50% of the 10 bipolar disorder medications and 40% percent of the 15 drug cessation drugs surveyed. Although no carrier excluded all drugs to treat a condition, focused analysis of formularies that exclude significant percentages of medications to treat BH conditions is important to ensure that plan design is non-discriminatory and in compliance with MH parity requirements. There were a number of examples of formularies either excluding a formulation of a name brand drug that had no available therapeutic alternative or excluding both the name and generic versions of a drug. We also found that there were instances in which an active ingredient was covered in one form but not the form preferred by providers. There were several instances of plans not covering extended release or single-tablet treatments, which the Centers for Medicare and Medicaid Services (CMS) has cautioned could constitute impermissible discrimination against individuals with chronic diseases. We also noticed that for some carriers, several of the drugs excluded from a plan's formulary or placed in high tiers had therapeutic equivalents that were on the formularies. Further research is necessary to determine the clinical significance of these distinctions in formularies and how they may affect BH access.

Access to Drugs Based on Utilization Management Techniques: Even where formularies included a given drug, we identified a number of UM techniques that the carriers were using to regulate access to these BH formulary medications in Marketplace plans in New Jersey. The tools carriers use to manage utilization of benefits – and *how* they use them –are NQTLs that directly impact access to covered benefits and thus must be evaluated to ensure they do not violate the ACA's anti-discrimination or parity provisions. All five carriers imposed UM requirements on some of the BH drugs that they included in their formularies, including PA, quantity limits (QLs), step therapy (*i.e.,* "fail first" requirements), or specialty tiering, albeit to varying degrees. For example, three of the carriers required PA and QLs for a higher percentage of drug cessation drugs than the other drugs surveyed, and a fourth required PA for a higher percentage of drug cessation drugs. Another carrier frequently required PA for long-acting drugs. Because these various UM techniques can operate as direct barriers to these covered medications, it is important to ensure that there is a valid basis for these requirements. Further research is necessary to evaluate the carriers' rationale for employing these UM techniques in varying ways for different types of drugs to ensure their formulary designs are not discriminatory or in violation of parity requirements.

Access to Drugs Based on Cost-Sharing & Adverse Tiering: A substantial number of tiers in the plans we surveyed had high cost-sharing. 41 of the 64 (64.1%) tiers in the sixteen plans surveyed would incur a cost-sharing of 30% or greater. Significant numbers of the 53 drugs we surveyed for schizophrenia, bipolar, or drug cessation treatment either were excluded from the formulary or were in one of these 41 tiers with high cost-sharing, including many generic drugs. Nothing from the face of the formularies

suggested that the surveyed plans were placing drugs in tiers based on whether they were used to treat behavioral or physical health conditions. Further analysis is needed to assess whether in practice BH drugs disproportionately are classified in tiers with higher cost-sharing. Even if there is no discriminatory plan design or parity violation, these findings raise concerns about consumers' ability to afford their coinsurances.

Tobacco Cessation Medication Coverage: The five tobacco cessation drugs that we included in our formulary survey all are FDA-approved smoking cessation products. At least two carriers offering plans in the federal Marketplace in New Jersey in 2015 appeared to be in violation of a guidance requiring the coverage of all FDA-approved tobacco cessation interventions as preventive services without cost-sharing. Other carriers may also have been in violation of the guidance for imposing PA and other UM requirements on the coverage of these drugs that may not have been permissible.

Network Adequacy for Methadone Treatment: Our findings raise significant questions regarding the adequacy of the carriers' networks with respect to methadone maintenance therapy, one of three drugs approved by the FDA for use in medication-assisted treatment (MAT) of opioid dependence. Although the federal government has not specifically required plans to cover methadone treatment to satisfy EHB requirements, methadone is on the formulary for each of the five carriers offering plans through the Marketplace in New Jersey. But patients in need of methadone to treat addiction must go to one of 29 outpatient opioid treatment program (OTP) certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and licensed by New Jersey's Office of Licensure (OOL). Our review revealed that three carriers included one OTP in their networks, which could require consumers to drive hundreds of miles round-trip on a daily basis to access the closest in-network provider. The remaining two carriers did not include any OTPs. Neither scenario seems reasonable nor adequate.

Transparency: Throughout our research, lack of transparency arose as a primary concern that may hinder patient access to care. It is an arduous – and potentially impossible - process for consumers to identify, understand, compartmentalize, and compare the information they need to assess plan options and evaluate if plans are providing access to BH services in parity with medical services and in compliance with anti-discrimination requirements. Transparency and functionality of SBCs, formularies, and network directories remain problematic. As part of its efforts to increase the accuracy and transparency of provider directories and drug formularies, CMS is requiring plans to make their up-to-date and accurate provider directories and formularies publicly available on their web sites in a machine-readable file format specified by the U.S. Department of Health and Human Services. Having access to machine-readable data should make it easier for advocates, consumers, and researchers to compare provider networks and drug formularies, which could help identify possible discriminatory plan designs or parity violations. But these standardized formats will not reveal the standards used to develop networks or formularies nor how these standards are applied, which are essential components of a comprehensive parity analysis.

Phase III. Survey of Carrier Regulatory Filings to New Jersey Department of Banking & Insurance

In the third phase of this project, we surveyed carrier filings to the New Jersey Department of Banking & Insurance (DOBI) to assess what information regulators evaluate and what they do to monitor plans for compliance with the ACA's anti-discrimination principles and MH parity requirements. States have primary responsibility for regulating insurance and are responsible for enforcing the ACA's market provisions, which include the parity requirements. In addition, CMS asks DOBI to confirm that plans seeking to be offered through the federal Marketplace satisfy a number of QHP requirements including MH parity and network adequacy. DOBI does not presently require any special filing from plans to demonstrate compliance with parity.

Template Form Analysis: We examined the templates for the reports that DOBI requires Health Maintenance Organizations (HMOs), Organized Delivery Systems (ODSs), and Selective Contracting Arrangements (SCAs) to file each year to get a better understanding of the kinds of information available to regulators. Our findings suggest that State regulators are not able to assess parity and otherwise effectively monitor ACA compliance based on the reports carriers presently file with DOBI. While HMO annual supplement reports gather a rich collection of data about plan design, there are a number of potential structural and substantive flaws with these reports, such as inconsistently collecting separate data on BH and SUD services. The ODS and SCA template forms generally collect even less information than the HMO annual supplements. DOBI also should consider which entities to require to file these reports. Only HMOs presently are required to file the more comprehensive reports. That means only three of the five insurers offering plans in the federal Marketplace in New Jersey in 2015 were required to file these reports, and only for their HMO lines of business, which represent a shrinking share of their market. Given the need to monitor and enforce compliance with the ACA and parity laws, it would seem all managed care plans should be required to file reports that include meaningful, comprehensive data to facilitate efficient monitoring and enforcement. It also would be helpful to consider how reports could incorporate elements that would facilitate the parity analysis, including having carriers report data in the parity categories, provide the methodology for the quantitative parity analysis, identify NQTLs, and elicit narratives regarding the selection of standards for NQTLs and how they are being applied. DOBI has authority under the applicable New Jersey regulations to prescribe the format of these reports.

2015 Filing Analysis: Although New Jersey's regulatory filings have shortcomings that limit the extent to which regulators may effectively rely on them to monitor plan behavior for compliance with the ACA's non-discrimination provisions and MH parity, the information collected can provide some indication of market behavior. For example, our review of the 2015 regulatory filings by New Jersey carriers offering plans through the Marketplace raised some flags that warrant additional scrutiny. For one, the percentages of HMO business that involved BH and SUD services numbers were so incredibly low that either there was very little spending on BH and SUD services, which raises concerns about access to these EHBs, or the reports fail to reflect the spending on these services, which suggests the need to reform how carriers report to DOBI. In contrast, however, BH/SUD UM requests often represented higher percentages of overall UM requests, and the percentage of denials of UM requests was higher for BH/SUD than for

general medical for some carriers. Careful scrutiny is needed to ensure UM policies are not being applied in a more stringent manner to BH/SUD services. Similarly, there were instances of higher rates of denials of inpatient MH and SUD admissions when compared with inpatient med/surg admissions, which requires scrutiny as well to explore whether the reasons for the denials were justified or signal impermissible discrimination or violations of parity. In addition, both the HMO annual supplement reports and ODS Annual Reports raised questions about network adequacy. Given the limitations in the information available, these observations do not establish violations, but they raise questions that warrant further inquiry.

Phase IV. Efforts in Other States to Achieve Behavioral Health Access

In the fourth phase of this project, we spoke with a number of advocates, regulators, and some insurers outside of New Jersey to learn how they are monitoring and enforcing the ACA's market conduct rules and parity requirements. All agreed that the task is challenging but critical, and they are experimenting with a variety of methods to meet the challenge. This section of the Report highlights some of the approaches taken in states like New York, Massachusetts, California, Connecticut, and Maryland, among others, to address BH access issues, including requiring annual filings by insurers on their experience with BH coverage, periodic audits of insurers' coverage of BH care, complaint-driven investigations of carriers, standardized benefit plans, secret shopper surveys, increased transparency, and partnerships with advocacy groups to help connect consumers to appropriate care. These discussions offer a valuable learning opportunity for New Jersey as it considers how to move forward.

Next Steps

The ACA and MHPAEA provide important, powerful tools that offer the promise of increasing access to BH care to millions of consumers. Many of these tools, however, are not self-executing. It is critical to monitor the statutes' implementation and make adjustments where necessary to support their success.

A closer look at implementation in New Jersey suggests that existing regulatory structures may not be sufficient to identify and address implementation shortfalls or challenges. The information necessary to assess parity compliance, for example, is not readily available to consumers, providers, advocates, researchers, or even regulators. Regulatory resources also may not be sufficient to permit the granular analysis needed to assess parity compliance or otherwise monitor ACA compliance. Despite some of the most specific network adequacy regulations in the nation, claims of phantom networks persist in New Jersey, suggesting that enhanced enforcement may be needed.

This Report benefited from the input and cooperation of regulators, insurers, providers, and advocacy groups. All of the parties we consulted are dedicated to making appropriate access to BH services a reality. In particular, insurance representatives were open and interested in exploring problems and working toward solutions. Regulators expressed interest and willingness to work to improve the

system. Consumer groups recognized the need to work collaboratively to identify problems, form solutions, and give credit when appropriate for joint success.

The Sentinel Project will build on the information contained in this Report to convene a program in September 2016 to examine possible paths forward toward access, transparency, and parity. Gathering wisdom from regulators from other states, from national BH parity organizations, and from New Jersey's stakeholders will allow for the formation of solutions responsive to New Jersey's needs in the context of a national dialogue. It is our goal that this dialogue will help New Jersey realize the promise of the ACA and afford meaningful and appropriate BH access to its citizens.

Access to Behavioral Health Services in Marketplace Plans in New Jersey: The Puzzle of Parity

John V. Jacobi, J.D. and Tara Adams Ragone, J.D.

I. Introduction

A central goal of the Affordable Care Act ("ACA") is to improve access to appropriate, high-quality health care. It dramatically has increased access to health insurance. Insurance coverage is necessary to achieve health care access, but alone it is insufficient to connect patients to care. Recognizing this, the ACA created the essential health benefits (EHB) requirement, which requires most plans to cover the care consumers need. This requirement expanded insurance coverage of such services as mental health (MH), substance use disorder (SUD), and habilitative care that previously had been covered unevenly by insurance plans. The ACA's reforms thoughtfully address systemic issues of insurance coverage. Nevertheless, the ACA's aspirations require execution on the ground by health insurers, state regulators, health care providers, and consumers.

The Sentinel Project of Seton Hall Law School aims to ensure faithful implementation of the ACA's reforms in New Jersey to ensure that consumers are gaining access to care. In particular, the Sentinel Project is examining the extent to which the aspirations of the ACA meshed with access to needed care at the time services were required.

In a previous Report,[1] the Sentinel Project described several areas of law and practice that could be determinative in achieving the success of the ACA, including contractual terms instantiating the extent of coverage; methods for determining the "medical necessity" of particular treatments; plans' formation of networks of providers to whom insureds would have access; and methods to decision-making that could run contrary to nondiscrimination requirements of the ACA and other laws, including requirements of the federal Mental Health Parity and Addiction Equity Act (MHPAEA).

In phase one of this project, Sentinel Project researchers engaged in focused interviews with consumer advocates, providers, carriers, and regulators. Our preliminary findings led us to focus on behavioral health (BH) services as an area of interest. We provided outreach to consumers, with an offer to assist them in disputes with their plans. In addition, we hosted a conference at which plan

[1] *See* JOHN V. JACOBI, TARA ADAMS RAGONE, & KATE GREENWOOD, CENTER FOR HEALTH & PHARMACEUTICAL LAW & POLICY, SETON HALL LAW SCHOOL, THE SENTINEL PROJECT: THE ACA'S MARKETPLACE REFORMS AND ACCESS TO CARE (Sept. 2014), *available at* http://law.shu.edu/Health-Law/upload/RWJF-Sentinel-Project-Report-09102014.pdf.

representatives, providers, and consumer representatives discussed their perspectives on plans' success in connecting consumers to appropriate BH care.

The interviews and conference surfaced a number of potential barriers to access to BH care, including inadequate networks of BH providers, and utilization management (UM) techniques that may inappropriately deny access to covered services. Anti-discrimination and MH parity laws offer the promise of checking the extent to which these barriers limit access to appropriate BH care. But many whom we interviewed expressed confusion regarding how these laws work in practice.

In the second phase of this project, we conducted independent research of plan documents and web sites to assess market response to the ACA's requirements. In surveying the Summary of Benefits and Coverage (SBCs) and, formularies, and network directories for a sample of sixteen silver plans available in the federal Marketplace in New Jersey in 2015, we concluded that although important plan information is available to consumers and regulators, current disclosure is inadequate to permit meaningful monitoring and oversight of plan compliance with ACA market reforms and MH parity requirements.

In the third phase of this project, we surveyed regulatory filings to New Jersey Department of Banking & Insurance (DOBI) to assess what information regulators evaluate and what they do to monitor plans for compliance with legal requirements such as the ACA's anti-discrimination principles and the federal MH parity requirements.

In the fourth phase of this project, we reached out to researchers in other states who described alternative methods of understanding the fit between the promise of BH coverage and its realization. These methods include annual filings by insurers on their experience with BH coverage, periodic audits of insurance coverage of BH care, and complaint-driven investigations of consumer incidents.

In this Report, we provide analysis that follows from these four phases. The Sentinel Project's offer to represent New Jersey consumers with disputes over BH coverage with their health plans had very few takers. This was an example of a "dog that didn't bark;"[2] that is, it could indicate that consumers were not experiencing difficulties, or it could indicate a confounding factor in understanding the extent to which problems exist. The lack of individual consumer complaints was to an extent counterbalanced by the detailed discussions of providers and advocates that tended to suggest that consumers do experience gaps in coverage, but, due to a variety of circumstances detailed in this Report, are poorly equipped to pursue individual appeals. We learned from talking with other states that where states invested resources to probe compliance with parity and anti-discrimination requirements, often they unearthed problematic behavior that was serving as a barrier to care. This highlights to us the need for conscientious monitoring and enforcement of the laws that are designed to protect meaningful access to essential health benefits like BH services.

This Report benefited from the input and cooperation of regulators, insurers, providers, and advocacy groups. One major conclusion is that all of the parties we consulted are dedicated to making appropriate access to BH services a reality. In particular, insurance representatives were open and interested in exploring problems and working toward solutions. Regulators expressed interest and

[2] *See* Arthur Conan Doyle, *Silver Blaze*, in MEMOIRS OF SHERLOCK HOLMES (2014).

willingness to work to improve the system. Consumer groups recognized the need to work collaboratively to identify problems, form solutions, and give credit when appropriate for joint success.

The Sentinel Project will build on the information contained in this Report to convene a program in fall 2016 to examine possible paths forward toward access, transparency, and parity. Gathering wisdom from regulators from other states, from national BH parity organizations, and from New Jersey's stakeholders will allow for the formation of solutions responsive to New Jersey's needs in the context of a national dialogue. It is our goal that this dialogue will help New Jersey realize the promise of the ACA and afford meaningful and appropriate BH access to its citizens.

II. Overview of the Relevant Law

As discussed in more detail in the Sentinel Project's first Report,[3] the ACA contains a number of provisions aimed at expanding consumer access to meaningful health insurance. For example, it expands access to coverage in the individual and group markets in each state by prohibiting insurers from denying coverage based on preexisting conditions; requiring insurers to write and renew insurance for all applicants regardless of health status; and limiting how much premiums may vary based on factors like a consumer's age.[4] It is the first federal law to directly and expressly prohibit discrimination in health insurance on the basis of health status by barring individual and small group insurers from establishing rules for eligibility or charging higher premiums based on a number of health status-related factors, including, but not limited to, health status; medical condition (including both physical and mental illnesses); claims experience; or disability.[5]

The ACA also seeks to ensure that consumers have access to a comprehensive array of covered health care services by requiring most individual and small group plans to include a slate of ten EHBs.[6] This list of essential services includes "[m]ental health and substance use disorder services, including BH treatment,"[7] a category that often was not comprehensively covered before the ACA. Most individual and group health plans also are required to provide preventive health services to beneficiaries with no cost-sharing when those services are provided by a network provider.[8]

---

[3] *See* JACOBI, RAGONE, & GREENWOOD, THE SENTINEL PROJECT, *supra* note 1; *see also* JOHN V. JACOBI, TARA ADAMS RAGONE, & KATE GREENWOOD, HEALTH INSURER MARKET BEHAVIOR AFTER THE AFFORDABLE CARE ACT: ASSESSING THE NEED FOR MONITORING, TARGETED ENFORCEMENT, AND REGULATORY REFORM, 120 PENN. STATE L. REV. 109 (Summer 2015) (publishing much of the work outlined in the Report with some updates and revisions).

[4] *See* 42 U.S.C. §§ 300gg-1, 300gg-2, 300gg(a), 300gg-3. New Jersey law imposed guaranteed issue and guaranteed renewal requirements on individual and small group plans prior to the ACA. *See* N.J.S.A. §§ 17B:27A-6(a) & 17B:27A-19(b).

[5] *See* 42 U.S.C. §§ 300gg-4. *See also* JACOBI, RAGONE, & GREENWOOD, THE SENTINEL PROJECT, *supra* note 1, at 64-68 (reviewing provisions of New Jersey that address discrimination in health care access and coverage).

[6] *See* 42 U.S.C. § 18022. *See also* JACOBI, RAGONE, & GREENWOOD, THE SENTINEL PROJECT, *supra* note 1, at 12-13, 66 (summarizing New Jersey's standardized benefit plans and mandated benefits in its individual and small group markets).

[7] 42 U.S.C. § 18022(b)(1)7(E).

[8] *See id.* § 300gg-13.

The ACA also extended the Mental Health Parity and Addiction Equity Act (MHPAEA) to all health insurance plans in the individual market.[9] Moreover, plans in the individual and small group markets must comply with federal MH parity requirements to satisfy EHB requirements.[10] An insurer also will not be deemed to satisfy EHB requirements "if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions," although this provision does not "prevent an issuer from appropriately utilizing reasonable medical management techniques."[11] Nor may an insurer "employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions."[12]

Notwithstanding the value of these important reforms, our first Report highlighted a number of areas to monitor as insurers implement the ACA's market reforms because plan behavior in these areas will have a direct impact on consumer access to meaningful insurance coverage.[13] First, it is important to evaluate how plans define services that are excluded from plan contracts. Second, it is critical to ensure that plan medical necessity determinations, or UM, appropriately exercise discretion to deny only inappropriate care and to continue to authorize medically appropriate care. Third, plan networks must be adequate so that insured individuals can access appropriate providers without unreasonable delay or burden. Fourth, it is essential to guard against discriminatory plan design and administration, whether intentional or inadvertent.

With our focus on BH access, it has become clear that MH parity is an essential lens through which to examine this range of issues that affects meaningful access, including, but not limited to, network adequacy and UM. Yet much is still not understood about what parity requires, how best to implement its mandates, or how to monitor for compliance. For that reason, an overview of federal MH parity requirements is appropriate before delving into plan design and implementation of the ACA in New Jersey.

A. Focus on Mental and Behavioral Health Parity

As noted above, to satisfy the EHB requirements, individual and small group plans must comply with the regulations implementing the MHPAEA.[14] The parity regulations require that plans sold in the

[9] *See* 42 U.S.C. §§ 300gg-26; § 18031(j).
[10] *See* 45 C.F.R. §§ 147.150(a), 156.115(a)(3), 146.136; 147.160(a).
[11] *Id.* § 156.125(a), (c).
[12] *Id.* § 147.104(e); *see also id.* § 156.225; 42 U.S.C. § 18031(c)(1)(A).
[13] *See* JACOBI, RAGONE, & GREENWOOD, THE SENTINEL PROJECT, *supra* note 1.
[14] *See* 45 C.F.R. §§ 147.150(a), 156.115(a)(3), 146.136; 147.160(a). *See also* JACOBI, RAGONE, & GREENWOOD, THE SENTINEL PROJECT, *supra* note 1, at 64-68 (discussing New Jersey's MH parity requirements); *See, e.g.,* Colleen L. Barry, Howard H. Goldman, & Haiden A. Huskamp, *Federal Parity In The Evolving Mental Health And Addiction Care Landscape*, HEALTH AFFAIRS, 35, no. 6, at 1009-16 (June 016), *available at*

Marketplace "may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification."[15] Figuring out how to apply this standard requires substantial unpacking.

"Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums."[16] Treatment limitations, in turn, "include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment."[17] Treatment limits may be quantitative or nonquantitative in nature.

As their name suggests, quantitative treatment limitations (QTLs) "are expressed numerically (such as 50 outpatient visits per year)."

Nonquantitative treatment limitations (NQTLs), in contrast, are not expressed numerically and are somewhat harder to define. The U.S. Department of Health and Human Services (HHS) defines them as treatment limits that "otherwise limit the scope or duration of benefits for treatment under a plan or coverage."[18] To help flesh out this definition, the regulations also provide the following nonexhaustive list of NQTLs:

> (A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
>
> (B) Formulary design for prescription drugs;
>
> (C) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
>
> (D) Standards for provider admission to participate in a network, including reimbursement rates;
>
> (E) Plan methods for determining usual, customary, and reasonable charges;
>
> (F) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

http://content.healthaffairs.org/content/35/6/1009.abstract?rss=1 (reviewing history and evolution of federal parity requirements).

[15] 45 C.F.R. §§ 146.136(c)(2)(i); 147.160(a).

[16] *Id.* §§ 146.136(a); 147.160(a).

[17] *Id.* §§ 146.136(a); 147.160(a).

[18] *Id.* §§ 146.136(a); 147.160(a).

> (G) Exclusions based on failure to complete a course of treatment; and
> (H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.[19]

When the parity standard refers to classifications, it is referring to six categories of benefits: (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. The parity comparison is performed within each classification. Benefits may not be categorized outside of these six classifications.[20] Although the final parity regulations did not prescribe how covered intermediate services, such as residential treatment, partial hospitalization, and intensive outpatient programs (IOP), must be categorized, they emphasized that they must be assigned to one of the six classifications in a manner that is consistent with how comparable medical/surgical (med/surg) intermediate services are classified.[21] For example, if a plan assigns skilled nursing facilities or rehabilitation hospitals to an inpatient classification, then it must also classify covered treatment of MH or SUDs in residential treatment facilities as inpatient services. Similarly, if home health care services are classified as outpatient benefits, "then any covered intensive outpatient mental health or substance use disorder services or partial hospitalization must be considered outpatient benefits as well."[22]

In addition to assessing parity within each classification, determining "[w]hether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation."[23] Thus, the parity analysis is performed for each different financial requirement, QTL, or NQTL, such as different deductibles, copayments, coinsurance, out-of-pocket maximums, visit limits, medical necessity criteria, or step therapy protocol, within each classification. If a plan applies different levels of financial requirements or QTLs to different coverage units in a classification of med/surg benefits, such as for individual versus family coverage, it must separately determine the predominant level that applies to substantially all med/surg benefits in the classification for each coverage unit.[24]

Federal law has developed different tests for assessing parity compliance depending on whether we are evaluating financial requirements and QTLs, on the one hand, or NQTLs, on the other.

---

[19] *Id.* §§ 146.136(c)(4)(ii); 147.160(a).

[20] U.S. Dep'ts of Treasury, Labor, & Health & Human Servcs., Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program; Final Rule, 78 Fed. Reg. 68,240, 68,243 (Nov. 13, 2013) [hereinafter Final Parity Rule Preamble, 78 Fed. Reg. at *].

[21] *Id.* at 68,246-47.

[22] *Id.* at 68,247.

[23] 45 C.F.R. §§ 146.136(c)(1)(ii); 147.160(a).

[24] *Id.* §§ 146.136(c)(3)(ii); 147.160(a).

HHS developed a mathematical test, which it refers to as the quantitative parity analysis, to determine what level of a financial requirement or QTL, if any, is the most restrictive level that may be applied to MH or SUD benefits within a classification.[25] When evaluating a type of financial requirement or QTL, it will be considered to apply:

> to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification. . . . If a type of financial requirement or [QTL] does not apply to at least two-thirds of all medical/surgical benefits in a given classification, then that type may not be applied to mental health or substance use disorder benefits in that classification."[26]

Therefore, if a copay does not apply to at least two-thirds of inpatient, in-network med/surg benefits, then a plan may not apply a copay to inpatient, in-network MH or SUD benefits. Plans are to use a "reasonable method"[27] to determine "the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative treatment limitation)" when determining what portion of med/surg benefits in a classification of benefits is subject to a financial requirement or QTL.[28] Recent guidance clarified that it is not a reasonable method for a carrier to base this analysis on the carrier's overall book of business.[29] Carriers offering individual market and insured small group plans "should use data at the 'plan' level (as opposed to the 'product' level) to perform the substantially all and predominant analyses, as such terms are defined in 45 CFR 144.103."[30]

When a type of financial requirement or QTL applies to at least two-thirds of all med/surg benefits in a classification, the plan may apply no more than the predominant level that applies to med/surg benefits to MH or SUD treatment benefits in the same classification. "[L]evel refers to the magnitude of the type of financial requirement or treatment limitation."[31] Copayments of $20 and $30 for an office visit, for example, are financial requirements of the same type but different levels. Different coinsurance percentages represent different levels of coinsurance. "[T]he level of the financial requirement or [QTL] that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial

[25] *See* Final Parity Rule Preamble, *supra* note 20, 78 Fed. Reg. at 68,240, 68,241.

[26] 45 C.F.R. §§ 146.136(c)(3)(A); 147.160(a).

[27] *Id.* §§ 146.136(c)(3)(i)(E); 147.160(a).

[28] *Id.* §§ 146.136(c)(3)(C); 147.160(a).

[29] *See* U.S. DEP'TS OF LABOR, HEALTH & HUMAN SERVCS., & TREASURY, "FAQs about Affordable Care Act Implementation Part 31, Mental Health Parity Implementation, and Women's Health and Cancer Rights Act Implementation," Q.8, at 11 (Apr. 20, 2016), *available at* https://www.dol.gov/ebsa/faqs/faq-aca31.html [hereinafter MH Parity FAQs Part 31].

[30] *Id.* In the absence of adequate data at the plan level, the issuer may use product level data to inform expected spending projections in the relevant benefit classification as long as it can "demonstrate the validity of the projection method based on the best available data." *Id.*

[31] "[L]evel refers to the magnitude of the type of financial requirement or treatment limitation." 45 C.F.R §§ 146.136(c)(1)(iii); 147.160(a).

requirement or quantitative treatment limitation."[32] If no single level applies to more than fifty percent of med/surg benefits in the classification, the plan "may combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the classification."[33]

In addition to ensuring parity compliance for different types of financial or QTLs within classifications, plans also may not impose separate cumulative financial requirements or cumulative QTLs "for mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification."[34] Thus, while a plan may have a combined $500 deductible for med/surg, MH, and SUD benefits, it may not have a separate $250 deductible that applies to MH benefits and a comparable $250 deductible that applies to med/surg benefits.[35]

Because the United States Departments of Treasury, Labor (DOL), and HHS decided in the final parity rule that NQTLs are not susceptible of mathematical evaluation,[36] they adopted a different parity standard for NQTLs that is less precise:

> [A plan] may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written *and in operation*, any processes, strategies, evidentiary standards, or other factors used *in applying* the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, *and are applied no more stringently than*, the processes, strategies, evidentiary standards, or other factors used *in applying* the limitation with respect to medical/surgical benefits in the classification.[37]

Comparability requires that "the processes, strategies, evidentiary standards and other factors cannot be specifically designed to restrict access to mental health or substance use disorder benefits." [38]

The preamble emphasized that the NQTL standard applies to any plan standard that "operates to limit the scope or duration of treatment with respect to mental health or substance use disorder benefits," even if that NQTL is not itemized in the illustrative list in the parity regulation.[39] For example, it identified

[32] *Id.* §§ 146.136(c)(3)(B)(1); 147.160(a).
[33] *Id.* §§ 146.136(c)(3)(B)(2); 147.160(a).
[34] *Id.* §§ 146.136(c)(3)(V)(A); 147.160(a).
[35] *Id.* §§ 146.136(c)(3)(V)(B); 147.160(a).
[36] Final Parity Rule Preamble, *supra* note 20, 78 Fed. Reg. at 68,245.
[37] 45 C.F.R. §§ 146.136(c)(4)(i) (emphasis added); 147.160(a).
[38] Final Parity Rule Preamble, *supra* note 20, 78 Fed. Reg. at 68,246.
[39] *Id.*

additional plan standards that must be applied in a manner that complies with the NQTL standards, "such as in- and out-of-network geographic limitations, limitations on inpatient services for situations where the participant is a threat to self or others, exclusions for court-ordered and involuntary holds, experimental treatment limitations, service coding, exclusions for services provided by clinical social workers, and network adequacy . . . ."[40]

The interim final rules had included an exception to the NQTL requirements that allowed for variation "to the extent that recognized clinically appropriate standards of care may permit a difference."[41] The final parity rule did not include this exception, however, after commenters raised concerns that it would be subject to abuse and could swallow the rule.[42] The Departments noted in the preamble, however, that plans retain "the flexibility contained in the NQTL requirements to take into account clinically appropriate standards of care when determining whether and to what extent medical management techniques and other NQTLs apply to med/surg benefits and MH and SUD benefits, as long as the processes, strategies, evidentiary standards, and other factors used in applying a NQTL to MH and SUD benefits are comparable to, and applied no more stringently than, those with respect to med/surg benefits."[43]

Thus, plans do not have to use the same NQTLS for MH and SUD benefits and med/surg benefits as long as "the processes, strategies, evidentiary standards, and other factors used by the plan or issuer to determine whether and to what extent a benefit is subject to a NQTL are comparable to and applied no more stringently for mental health or substance use disorder benefits than for medical/surgical benefits."[44] That these standards may result in disparate results does not, on its own, establish a parity violation.[45] The Departments warned, however, "that it is unlikely that a reasonable application of the NQTL requirement would result in all mental health or substance use disorder benefits being subject to a NQTL in the same classification in which less than all medical/surgical benefits are subject to the NQTL."[46]

The rule provides a number of examples to illustrate how the NQTL standard applies to a variety of plan designs and to emphasize what the italicized words above mean - that plans must comply with this standard both in their written policies and standards *and* also in how they apply them.[47] For example, PA is a type of NQTL. It is not sufficient for a plan to have a policy of requiring PA that a treatment is medically necessary for all inpatient med/surg, MH, and SUD benefits. The parity rule requires plans to demonstrate that this NQTL is applied no more stringently to MH and SUD benefits than it is to med/surg benefits. So even if PA is required for all benefits in this classification, if in practice, inpatient benefits for med/surg conditions are routinely approved for seven days, whereas inpatient MH and SUD benefits routinely are

[40] *Id.*
[41] *Id.* at 68,245.
[42] *Id.*
[43] *Id.*
[44] *Id.* at 68,241.
[45] *See id.* at 68,245.
[46] *Id.*
[47] 45 C.F.R. §§ 146.136(c)(4)(iii); 147.160(a).

approved for only one day, before a treatment plan must be submitted by the patient's attending provider and approved by the plan, the plan is not in compliance with the parity rule.[48]

If, however, a plan establishes evidentiary standards to use in determining whether a treatment is medically appropriate based on recommendations "by panels of experts with appropriate training and experience in the fields of medicine involved," and "[t]he evidentiary standards are applied in a manner that is based on clinically appropriate standards of care for a condition," then the plan complies with parity "because the processes for developing the evidentiary standards used to determine medical appropriateness and the application of these standards to mental health and substance use disorder benefits are comparable to and are applied no more stringently than for medical/surgical benefits."[49] This is true even if application of these standards results in different benefits coverage for MH or SUDs than for a particular med/surg condition.[50]

The preamble states that although not required to, plans may use standards, "such as the behavioral health accreditation standards set forth by the National Committee for Quality Assurance or the standards for implementing parity in managed care set forth by URAC, . . . as references and best practices in implementing NQTLs, if they are applied in a manner that complies with the[parity] final regulations."[51]

---

[48] *Id.* §§ 146.136(c)(4)(iii) (example 1); 147.160(a).

[49] *Id.* §§ 146.136(c)(4)(iii) (example 4); 147.160(a).

[50] *Id.* §§ 146.136(c)(4)(iii) (example 4); 147.160(a). In a recent FAQ, the Departments seemed to bless the following NQTL analysis of a pre-authorization requirement after the ninth office visit to treat depression:

> [I]f the plan can demonstrate that it imposes pre-authorization requirements for both MH/SUD and medical/surgical benefits in the outpatient, in-network classification when the length of treatment for a condition exceeds the national average length of treatment by 10% or more, it has identified a factor on which the NQTL is based. Furthermore, to the extent the plan can document, via studies, schedules or similar documents that contain relevant information or data, that the national average length of outpatient treatment for depression is eight visits, it has identified an evidentiary standard used to evaluate the factor. Finally, by applying the eight visit standard to the case at hand, it demonstrates how the evidentiary standard is applied and the result.

MH Parity FAQs Part 31, *supra* note 29, at 13, Q.9. We cannot reconcile this analysis with example 4 in the final parity rule. As noted in the text, example 4 bases evidentiary standards on recommendations "by panels of experts with appropriate training and experience in the fields of medicine involved," and requires that "[t]he evidentiary standards are applied in a manner that is based on clinically appropriate standards of care for a condition." 45 C.F.R. §§ 146.136(c)(4)(iii) (example 4); 147.160(a). The more recent example in the FAQ, however, seems to accept evidence of what the national average length of treatment is as sufficient support for the NQTL factor. But the average length of treatment merely is what is being provided in fact; it does not necessarily reflect a clinically appropriate standard of care. Such a standard permits the status quo to continue, even if that status quo reflects inadequate care. The parity analysis should demand that factors for NQTLs are supported by clinical evidence.

[51] Final Parity Rule Preamble, *supra* note 20, 78 Fed. Reg. at 68,246.

In June 2016, the United States Department of Labor issued a publication focused on identifying a non-exhaustive list of "red flag" NQTL provisions that require "inquiry beyond the plan/policy terms in order to determine compliance with mental health parity requirements.[52] The guidance classified red flag provisions in five categories:

1. **Preauthorization and Pre-service Notification Requirements**, including blanket preauthorization requirements; treatment facility admission preauthorization for MH/SUD; medical necessity review authority delegated for med/surg but not MH/SUD; prescription drug preauthorization; and extensive pre-notification requirements.
2. **Fail-First Protocols**, including progress requirements and treatment attempt requirements.
3. **Probability of Improvement.**
4. **Written Treatment Plan Required**, including a general requirement for a written treatment plan or for such plan to be submitted within a certain time period or on a regular basis.
5. **Other**, including patient-non-compliance conditions, residential treatment limits, geographical limitations, and facility licensure requirements.[53]

The guidance states that plans should investigate these types of plan or policy provisions to be sure they are applied to med/surg benefits (and not just MH/SUD benefits) and that they are being applied to MH/SUD and med/surg benefits in compliance with parity requirements.[54] Although this guidance identifies examples of potentially impermissible NQTLs, it does not flesh out how plans should be applying the NQTL standards to these varying provisions.

The final parity regulations incorporate some special rules in the parity requirements. For example, plans may apply different levels of financial requirements to different tiers of prescription drug benefits subject to several requirements.[55] First, the variations must be based on "reasonable factors," such as cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.[56] Second, these "reasonable factors" must comply with the NQTL requirements.[57] Third, the variations must have been determined "without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits."[58]

Similarly, a plan "may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with [the

[52] U.S. DEP'T OF LABOR, Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance, at 1, 2 (undated), *available at* https://www.dol.gov/ebsa/pdf/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf.

[53] *See id.* at 2-3.

[54] *See id.* at 2.

[55] 45 C.F.R. §§ 146.136(c)(3)(iii)(A); 147.160(a).

[56] *Id.* §§ 146.136(c)(3)(iii)(A); 147.160(a).

[57] *Id.* §§ 146.136(c)(3)(iii)(A); 147.160(a).

[58] *Id.* §§ 146.136(c)(3)(iii)(A); 147.160(a).

NQTL rules]," such as accreditation, quality and performance measures (including customer feedback), relative reimbursement rates, and market standards, and "without regard to whether a provider provides services with respect to medical/surgical benefits or mental health or substance use disorder benefits."[59] The parity analysis is then performed in each subclassification such that "the plan or issuer may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification . . . ."[60]

Plans also may subdivide their outpatient services into two subclassifications, (1) office visits, such as physician visits; and (2) all other outpatient items and services, such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items.[61] The final parity rule rejected additional sub-classifications, such as for generalists and specialists.[62]

The final parity rule includes several additional examples to help illustrate how the parity analysis applies to different plan designs.[63]

B. Focus on Transparency and Disclosure

Transparency and disclosure can be vital tools for monitoring plan behavior for compliance with the ACA's non-discrimination and parity requirements. New Jersey law requires health maintenance organizations (HMOs) to make "written clinical criteria and protocols" on which UM determinations are made "readily available, upon request, to members and participating providers in the relevant practice areas."[64] There is an exception to this requirement, however, for "internal or proprietary quantitative thresholds for utilization management."[65] There is a similar requirement for non-HMO managed care plans, except that "[w]hen the request is related to specific treatment or services for which benefits are being sought, the information provided may be limited to all criteria and protocols by which the carrier performs UM relevant to only that treatment or services."[66]

[59] *Id.* §§ 146.136(c)(3)(iii)(B), (c)(iv) (example 5); 147.160(a).
[60] *Id.* §§ 146.136(c)(3)(iii)(B); 147.160(a).
[61] *Id.* §§ 146.136(c)(3)(iii)(C); 147.160(a).
[62] *Id.* §§ 146.136(c)(3)(iii)(C); 147.160(a).
[63] *Id.* §§ 146.136(c)(3)(iv), (c)(4)(ii); 147.160(a).
[64] N.J.A.C. § 11:24-8.1(b).
[65] *Id.*
[66] *Id.* § 11:24A-3.4(b)(2)(i). Note that this regulation may be in tension with federal regulations, discussed below, *see infra* note 77 & accompanying text, that require plans to disclose information regarding "medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan," at least in the context of appeals. 45 C.F.R. §§ 146.136(d)(3) (emphasis added); 45 C.F.R. § 147.160(a).

The preamble to the final parity rules observed as a general matter that there has been insufficient transparency surrounding plan UM activities to determine if plans have comparable standards for behavioral and physical health services and whether they are applying these standards in comparable ways.[67] The rules, therefore, impose new disclosure requirements on plans.

First, the rules impose a general requirement that individual and small group plans make available "[t]he criteria for medical necessity determinations . . . with respect to mental health or substance use disorder benefits . . . to any current or potential participant, beneficiary, or contracting provider upon request."[68] This obligation runs at all times and extends beyond current members of the plans to reach potential beneficiaries as well as providers who are contracting with the plan.[69] While a plan may provide a summary document that describes the medical necessity criteria in layperson's terms, it still must provide the actual criteria if requested.[70]

If a plan denies reimbursement or payment for services for MH or SUD benefits, the final parity rules also require the plan to make the reason available to the participant or beneficiary.[71]

In addition to these express parity disclosure requirements, the final parity rules also remind plans that they must continue to comply with other provisions of state and federal law that "require disclosure of information relevant to medical/surgical, mental health, and substance use disorder benefits."[72]

Employer-sponsored plans that are subject to the Employee Retirement Income Security Act (ERISA) also are bound by ERISA's general disclosure obligation in Section 104(b), which generally requires plans to provide participants with the "instruments under which the plan is established or operated" . . . within 30 days of request."[73] Such instruments "include information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan."[74] A court may impose up to a $110 per day fine on an ERISA plan or administrator that fails to provide these documents.[75]

Although individual plans are not subject to ERISA, the final parity rule includes similar language to define the rights to disclosure that individual and group plan beneficiaries have in the context of appeals. In particular, an individual filing an appeal of an adverse benefit determination or a final internal adverse benefit determination, or his/her authorized representative, has the right to request and receive,

---

[67] Final Parity Rule Preamble, *supra* note 20, 78 Fed. Reg. at 68,247.

[68] 45 C.F.R. §§ 146.136(d)(1); 147.160(a).

[69] *See* MH Parity FAQs Part 31, *supra* note 29, at 14, Q.10.

[70] U.S. DEP'TS OF LABOR, HEALTH & HUMAN SERVCS., & TREASURY, "FAQs about Affordable Care Act Implementation (Part XXIX) and Mental Health Parity Implementation," at Q.13 (Oct. 23, 2015), *available at* https://www.dol.gov/ebsa/pdf/faq-aca29.pdf [hereinafter MH Parity FAQs Part 29].

[71] 45 C.F.R. §§ 146.136(d)(2); 147.160(a).

[72] *Id.* §§ 146.136(d)(3); 147.160(a).

[73] MH Parity FAQs Part 29, *supra* note 70, at 9 (citing ERISA Section 104(b) and 29 C.F.R. § 2520.104b-1).

[74] *Id.*; *see also* MH Parity FAQs Part 31, *supra* note 29, at 12, Q.8

[75] *See* MH Parity FAQs Part 31, *supra* note 29, at 12 & n.35, Q.8 (citing ERISA section 502(c)(1)).

free of charge, "reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits."[76] This information "includes documents with information on medical necessity criteria for *both* medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan."[77]

Disclosure at this level should facilitate parity analysis for individual market plan beneficiaries appealing adverse benefit determinations, but it is not apparent to us why this level of disclosure should be limited to the appellate context for individual but not group plan beneficiaries.[78] An example in recent guidance highlights the inconsistent standards that apply to different types of plans. If an employer-sponsored plan requires a provider to complete a pre-authorization form after a patient's ninth visit to treat depression, the provider, if acting as the patient's personal representative, may request – and must be provided:

> 1. A Summary Plan Description (SPD) from an ERISA plan, or similar summary information that may be provided by non-ERISA plans;
>
> 2. The specific plan language regarding the imposition of the NQTL (such as a preauthorization requirement);
>
> 3. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that the NQTL will apply to this particular MH/SUD benefit;
>
> 4. Information regarding the application of the NQTL to any medical/surgical benefits within the benefit classification at issue;
>
> 5. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered

[76] 45 C.F.R. §§ 146.136(d)(3) (citing *id.* § 147.136); 147.160(a); *see also* MH Parity FAQs Part 29, *supra* note 29, Q.4.

[77] 45 C.F.R. §§ 146.136(d)(3) (emphasis added); 147.160(a); *see also* Final Parity Rule Preamble, *supra* note 20, 78 Fed. Reg. at 68,247; U.S. DEP'TS OF LABOR, HEALTH & HUMAN SERVCS., & TREASURY, "FAQs about Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation," Q.8 (Nov. 8, 2013), *available at* https://www.dol.gov/ebsa/pdf/faq-aca17.pdf; MH Parity FAQs Part 29, *supra* note 70, at 9-10; MH Parity FAQs Part 31, *supra* note 29, at 12, Q.8.

[78] For more information on parity disclosure requirements, *see* PARITY IMPLEMENTATION COALITION & THE KENNEDY FORUM, *Parity Resource Guide for Addiction & Mental Health Consumers, Providers and Advocates* (Winter 2015, 2d ed.), *available at* https://parityispersonal.org/media/documents/KennedyForum-ResourceGuide_FINAL_1.pdf; *see also* AM'N PSYCHIATRIC ASSOC'N, *Law and Regulations Governing Disclosure of Health Plan Information for Purposes of MHPAEA Compliance Analysis* (Draft 2014) (on file with authors).

> by the plan (including factors that were relied upon and were rejected) in determining the extent to which the NQTL will apply to any medical/surgical benefits within the benefit classification at issue; and
>
> 6. Any analyses performed by the plan as to how the NQTL complies with MHPAEA.[79]

This information can help the provider assess whether the plan is complying with parity and directly address the plan's standards and evidence in the preauthorization response, which may help secure approval of continued treatment and avoid a denial. A beneficiary of an individual market plan, however, only is entitled to this information in the context of an appeal "related to the application of an NQTL to a MH/SUD benefit"[80] – *after* the benefit was denied.

Despite the clear regulatory language and guidance requiring disclosure, several patients, advocates, and providers have reported that they have experienced difficulty obtaining disclosures from plans. Plans sometimes have responded to requests by claiming that the requested information is proprietary and therefore not subject to disclosure. Recent guidance, however, expressly rejected this argument, stating that "[t]he criteria for making medical necessity determinations, as well as any processes, strategies, evidentiary standards, or other factors used in developing the underlying NQTL and in applying it, must be disclosed with respect to both MH/SUD benefits and medical/surgical benefits, regardless of any assertions as to the proprietary nature or commercial value of the information."[81]

The information also must be disclosed even if a third-party commercial vendor is its source.[82] Where an insurance company contracts with a Managed Behavioral Health Organization (MBHO) to provide or administer MH/SUD benefits under the plan, the insurer remains responsible to ensure parity compliance.[83] As a result, the plan or issuer will need to provide sufficient information in terms of plan structure and benefits to the MBHO to ensure that the MH/SUD benefits are coordinated with the medical/surgical benefits for purposes of compliance with the requirements of MHPAEA."[84]

As noted above, although a plan may provide a summary document that describes the medical necessity criteria in layperson's terms, doing so does not absolve it of its obligation to provide the actual criteria if requested.[85]

---

[79] MH Parity FAQs Part 31, *supra* note 29, at 13, Q.9.
[80] *Id.* at 14, Q.9.
[81] MH Parity FAQs Part 29, *supra* note 70, Q.12; *see also* MH Parity FAQs Part 31, *supra* note 29, at 13-14, Q.9.
[82] *See* MH Parity FAQs Part 29, *supra* note 70, Q.12.
[83] MH Parity FAQs Part 31, *supra* note 29, at 12, Q.8.
[84] *Id.*
[85] MH Parity FAQs Part 29, *supra* note 70, at Q.13.

III. Sentinel Project Findings in New Jersey

As reflected in Appendix A, in phase one of our research, we interviewed a number of consumer advocates, providers, carriers, and regulators to learn about consumers' experiences accessing BH services through federal Marketplace plans in New Jersey since implementation of the ACA and MHPAEA. In phases two and three of the project, we then conducted independent research of plan documents, plan and Marketplace web sites, and regulatory filings to assess market response to the ACA's requirements. What follows is a summary of the dominant themes from these interviews and highlights from our independent research.

A. Summary of Behavioral Health Access Issues Raised in Interviews

1. Network Adequacy

a. Provider & Advocate Perspectives on Network Adequacy

The providers and advocates with whom we spoke raised a number of concerns related to the adequacy of provider networks for the various plans offered on healthcare.gov in New Jersey in 2014 and 2015. Several prominent themes emerged from our conversations. We generally heard concerns that plan networks contained an inadequate number of appropriate BH providers, which meant that patients had to wait extended periods of time or travel long distances for appointments – or simply went without care. Some advocates also raised related concerns, including that consumers had difficulty accessing a provider of a specific gender, who speaks a common language, or who can address cultural sensitivities. We also heard concerns that in-network provider offices did not have flexible hours for patients who work or were not accessible by public transportation. Given how few Marketplace plans in New Jersey in 2015 offered out-of-network benefits, we also heard concerns that few networks included New York doctors.

We consistently heard about the dearth of pediatric psychiatrists in Marketplace networks. Many cited how few psychologists and psychiatrists participate in networks. Some attributed these low numbers of participation to low reimbursement rates and expressed concern that the providers willing to accept below market rates may be less qualified or may spend less time with patients to increase volume. Some providers wondered whether low reimbursement rates violate parity requirements. Some regulators, carriers, and advocates also asked whether the low participation rates may be due to inadequate supplies of these providers in New Jersey and larger pipeline issues.

Additionally, advocates raised concerns that individual and small group markets did not include adequate numbers of qualified providers of applied behavioral analysis (ABA) therapy for patients with

autism, which is a mandated covered benefit in New Jersey's individual and small group markets.[86] A few of those we interviewed also mentioned difficulty locating in-network treatment for eating disorders.

Another area of concern involved the availability of in-network services for SUD treatment. For example, we heard that there were inadequate private payer beds for addiction services. Patients could be housed in hospital emergency rooms for several days or more waiting to find a residential treatment program. In other instances, advocates recounted instances of patients returning home following inpatient detoxification with inadequate follow-up care because they could not find a rehabilitation program to continue treatment. We also heard reports that consumers were leaving the state to find inpatient SUD treatment because of waitlists in the state. One of the largest SUD residential programs in the state, however, reported that its wait list for commercial patients was not as long as it was for Medicaid patients.

Many also reported that they had experienced difficulties finding available providers to provide intermediate levels of SUD care, medication management, and counseling, although these problems varied by geography, carrier, and type of service. While hospitals in southern New Jersey, for example, did not report difficulties placing patients with commercial insurance in residential treatment facilities, they did report difficulty finding community treatment for follow-up care post-discharge. We heard that wait lists for IOPs ranged from four weeks to six months in some parts of the state. Advocates and providers also reported that patients were paying for methadone and Suboxone treatment out-of-pocket, even though these services were covered, because of difficulties accessing in-network facilities.

We also heard concerns regarding which providers carriers would reimburse for providing SUD treatment services. Advocates and providers claimed that addiction specialists were essentially shut out of networks. Treatment facilities suggested that Certified Alcohol and Drug Counselors (CADCs) could help them meet demand for services, but insurance would not reimburse these providers. Advocates reported that some carriers were beginning to reimburse peers,[87] who they maintained are an important, affordable way to provide ongoing recovery support, but many carriers were not.

Another common complaint concerned so-called phantom networks. Advocates claimed that there were not only an inadequate number of providers in-network, but carriers' published network directories often contained inaccurate information, which made it harder for patients to identify an appropriate, in-network provider. Dr. Russell Holstein and Dr. David Paul in 2012 found that 50% of

[86] *See* N.J.S.A. §§ 17B:27-46.1ii(c) (applying mandate to insurers), 17B:27A-7.16(c) (applying mandate to carriers offering individual health benefits plans), 17B:27A-19.20(c) (applying mandate to all carriers offering small employer health benefits plans), 26:2J-4.34(c) (applying mandate to HMO coverage).

[87] *See generally* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., Treatments for Substance Use Disorders, http://www.samhsa.gov/treatment/substance-use-disorders (last visited May 17, 2016) ("Peers are individuals in recovery who can use their own experiences to help others working towards recovery. Peer supports are a critical component of the substance use disorder treatment system. Many people who work in the treatment system as counselors or case managers are in recovery, and peers are central to many recovery support efforts.").

providers listed in networks for two counties in New Jersey were not, in fact, accepting new patients.[88] In September 2014, the Mental Health Association in New Jersey, Inc. released the results of a survey of preferred provider organizations (PPOs) in New Jersey, which found that of a random sample of 525 of the 702 doctors listed in the psychiatry lists in PPO provider directories, 33% had incorrect contact information in the directory.[89] Of the 361 doctors who responded to the survey, 16% were not accepting new patients; 8% were not psychiatrists; 12% were only taking patients who are being treated in their public agencies; and 13% were only taking patients in their hospitals.[90] Of the 126 psychiatrists who were accepting new patients, 24% reported wait times of more than two months; 25% had wait times of one to two months; 25% could offer an appointment in two to four weeks; and only 25% were able to offer an appointment in fewer than two weeks.[91] One respondent indicated that there was a 6 to 9 month wait for an appointment with a child psychiatrist at the time they were surveyed in 2014.[92] Another respondent noted that the psychiatrist listed in the directory had moved to Florida 10 years ago, while another noted that the directory continued to list an orthopedic surgeon as a psychiatrist.[93]

In addition, advocates seek greater transparency and education of consumers regarding in-plan, or out-of-network, exceptions. If a qualified network provider is not accessible and available to provide a specific medically necessary covered service, the plan has an obligation to grant the consumer an in-plan exception, which permits the consumer to be treated by an out-of-network provider at in-benefit coverage levels.[94] This does not mean that consumers may pick any out-of-network provider that they prefer. Rather, the plan will negotiate a single case agreement with a qualified provider. If the carrier refuses to grant an in-plan exception, DOBI permits the consumer to appeal the effective denial of a covered benefit as an adverse benefit determination through the internal and external appeal processes.[95]

New Jersey statutes and regulations, however, do not reference in-plan exceptions. DOBI included a reference to them in an appeals guide that it published on its web site in 2014, but this

[88] *See* Russell Holstein & David P. Paul III, "'Phantom Networks' of Managed Behavioral Health Providers: An Empirical Study of their Existence and Effect on Patients in Two New Jersey Counties," HOSPITAL TOPICS, vol. 90, issue 3, 65-73 (2012).

[89] *See* MENTAL HEALTH ASSOCIATION IN NEW JERSEY, INC., MANAGED CARE NETWORK ADEQUACY REPORT JULY 2013, at 3 (study embargoed until Sept. 15, 2014, 11:00 am), *available at* http://www.mhanj.org/wp-content/uploads/2014/09/Network-Adequacy-Report-Final.pdf.

[90] *See id.* at 3-4.

[91] *See id.* at 4.

[92] *See id.*

[93] *See id.* at 5.

[94] *See generally* NAIC HEALTH INS. & MANAGED CARE (B) COMM., PLAN MGT. FUNCTION: NETWORK ADEQUACY WHITE PAPER, at 6 (June 27, 2012), *available at* http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf ("If a health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the state insurance commissioner.").

[95] *See* N.J.A.C. § 11:24A-4.6(c); N.J. DEP'T OF BANKING & INS., APPEAL AND COMPLAINT GUIDE FOR NEW JERSEY CONSUMERS, at 1 http://www.state.nj.us/dobi/division_consumers/insurance/appealcomplaintguide.pdf (last visited Sept. 18, 2015).

reference did not provide any detail about how in-plan exceptions work in practice.[96]. Advocates want carriers to provide information about in-plan exceptions on their web sites and to beneficiaries the first time they call to note difficulty finding a qualified, accessible, and available provider in-network, requests that carriers reportedly have resisted.

Even with increased transparency, in-plan exceptions only provide a response to network concerns on a case-by-case basis and do not address systemic network adequacy questions. DOBI does not presently require carriers to report the number of and types of in-plan exceptions that they grant and deny. Perhaps monitoring the frequency and kinds of exceptions sought and granted would help detect systemic network failures that should be addressed directly.

b. Carrier & Regulator Perspectives on Network Adequacy

Carriers had a variety of responses to the complaints raised in the interviews of providers and advocates. While some carriers questioned whether New Jersey has a low supply of BH providers, principally they pointed to the reluctance of some BH professionals to be part of networks. They also expressed frustration because providers within their networks often do not provide updated contact information. Further, providers may not take new patients one week, but their availability might change the next, which makes it difficult to maintain an up-to-date directory. Carriers also questioned the extent of the problem and noted that advocates often refer to anecdotes but rarely follow up with specific data.

Regulators and carriers both have emphasized that network adequacy challenges are not new. The industry long has been attuned to the need to provide adequate networks of providers, well before the ACA. As we discussed in more detail in a September 2014 Report, New Jersey has fairly detailed network adequacy requirements.[97] DOBI reviews networks when carriers file applications with the Department and, as discussed below in Section III.B.2, in annual filings that some carriers have to file. But generally DOBI actively investigates network adequacy in response to complaints and does not perform secret shopper surveys as a matter of course to verify the accuracy of directories.

DOBI tried to improve the accuracy of provider directories in a recent rule change, which included, among other things, an obligation for carriers to confirm the participation of a provider who has not submitted a claim within twelve months or otherwise communicated his or her intention to continue to participate in the network.[98] Advocates, however, expressed to us that this regulation does not go far enough.

Carriers and regulators also point to in-plan exceptions as a response to and a protection for consumers from network adequacy concerns. In 2015, following collaboration between BH advocates

[96] *See* N.J. DEP'T OF BANKING & INS., *supra* note 95, at 1.
[97] *See* JACOBI, RAGONE, & GREENWOOD, THE SENTINEL PROJECT, *supra* note 1, at 40-45.
[98] *See* N.J.A.C. § 11:24C-4.6(d).

and New Jersey carriers, the New Jersey Association of Health Plans released a short FAQ-styled document on its website that provides more information to consumers about in-plan exceptions.[99]

This FAQ provides more detail about in-plan exceptions than the DOBI appeals manual, but it also leaves many unresolved questions. In defining what an in-plan exception is, which the FAQ refers to as an in-network exception, it uses the word "reasonable" three times and "reasonably" one time without defining what either word means in each instance. It remains unclear what consumers need to do to demonstrate that they are entitled to an in-plan exception or what process plans must follow. For example, it is not clear whether consumers need to call every provider who is in-network to see if s/he has an available appointment, or if instead it is sufficient for consumers to call some threshold of providers, such as five or ten. Advocates urged that consumers with BH needs find it difficult enough to call one provider for help, much less every provider in a list whose accuracy has been called into doubt. A number of other issues remain unclear as well, such as whether plans need to inform consumers about the availability of an in-plan exception, or whether the burden is on consumers to request one; whether the process takes into consideration gender or language preferences or cultural sensitivities that may impact the efficacy of care; and whether consumers may request an in-plan exception because a subspecialist is not in-network when a specialist is.

2. Utilization Management

a. Provider & Advocate Perspectives on Utilization Management

Another common theme in our interviews was UM techniques as applied to BH services.

When hospitals have difficulty placing patients in appropriate follow-up care settings, for example, they may end up housing the patients until an appropriate placement can be secured because they feel the patient is not ready to return home. Hospitals reported that carriers often refuse to pay for hospital charges once the patient is stabilized because they are not medically necessary, even though the hospital would gladly discharge the patient if the carrier could identify an available in-network provider to provide medically indicated follow-up care.

In addition to medical necessity disputes regarding transitions of care challenges, both MH and SUD treatment providers reported a perceived increase in the application of UM techniques to covered services. Several psychologists, for example, conveyed their belief that UM was a key loophole that commercial insurers were using to deny or reduce BH care and to violate parity requirements. They felt that carriers subject their long-term treatment plans for patients with chronic mental illness, like depression and anxiety, to intrusive, frequent, and time-consuming UM second-guessing, while non-BH chronic conditions, like diabetes, do not receive the same level of UM scrutiny. Some psychologists also

[99] *See* N.J. ASSOC'N OF HEALTH PLANS, *In-Network Exceptions for Insured Health Benefits Plans in New Jersey*, http://njahp.org/network-exceptions/ (last visited Sept. 18, 2015).

contended that carriers have been demanding confidential parts of patient records that psychologists are prohibited by their professional licensing rules from disclosing, even to insurers, as a ruse to deny care.

SUD providers also reported that the frequency and intensity of UM reviews had ramped up for some services. Partial day programs, for example, used to be approved initially for 5 to 10 days, but it had become common to receive approvals for only two days at a time before again needing to demonstrate medical necessity. Some SUD providers felt like carriers were using UM to push providers to use more IOPs. Other providers, on the other hand, believed that carriers routinely deny the requested level of treatment but approve a less-intensive treatment to save money, knowing the providers will accept the lower reimbursement and still provide the appropriate level of care.

We also have heard that UM reviews were becoming more taxing. Providers reported that each review used to take approximately ten minutes but now often last thirty minutes. They further complained that carriers more frequently were requiring reauthorization of these prescriptions every six months or so, and in some cases, more frequently, without clear clinical rationale. A common complaint was that front-line case workers without medical training conduct the reviews in strict adherence to a rigid template, leaving no room for critical thinking informed by expertise. Carriers also use different forms and have varying requirements. These UM requirements consume substantial provider resources. One psychiatrist in private practice estimated that he spends two to four hours each week doing pre-authorizations. Yet he estimated that carriers eventually authorize 19 out of 20 PAs, which raised the question of why carriers were bothering to put providers through these hoops.

Providers also raised concerns about various UM strategies that are applied to BH prescriptions. MH professionals, for example, reported that carriers increasingly were imposing PA or fail first requirements on prescriptions for patients who have been stable on psychotropic medications for long periods of time. We also were told that promising newer drugs often were subject to PA or fail first requirements.

SUD treatment providers similarly reported a number of UM strategies that can interfere with effective treatment protocols, especially medication-assisted treatment (MAT). They reported, for example, that Vivitrol, a once-per-month anti-abuse injection drug, often was subject to step therapy, also known as fail first, requirements. Patients first had to fail at an alternative, usually cheaper, drug before carriers would cover Vivitrol. But “failing” for a patient with a SUD may well mean relapsing, which can also mean overdosing. Providers reported UM hassles with insurance over sublingual buprenorphine or Suboxone, which are drugs of choice for treating narcotic addiction. We also heard that Chantix, which is a tobacco cessation drug, had a very high copayment.

Some SUD providers questioned the particular UM protocols that carriers were using. Although the ASAM standards are fairly universally accepted, they leave room for subjectivity, which gives carriers the ability to second-guess providers’ expert and front-line judgments. They also believe they are binary when patients’ conditions come in various grades, which require a more nuanced system. Some providers suggested that the standards inadequately take into account social factors that affect SUD treatment.

In addition, some providers shared concerns that carriers were trying to wear providers down so they will give up and prescribe less expensive medications, even if they are not as clinically effective. Another common sentiment was that these requirements were a symptom of persistent stigma against and misunderstanding of mental illness and clinically addictive disorders. Some of these BH providers were active supporters of an unsuccessful legislative movement in New Jersey to prohibit managed care companies from engaging in UM of BH services and to defer to the judgment of medical professionals.[100] They argued, among other things, that there is no evidence UM saves money, it burdens providers, and it can hurt patients by delaying and potentially even denying them clinically appropriate care.

Although all providers with whom we spoke shared concerns and frustrations with the UM process, larger entities tended to report that they were building processes and training staff to anticipate and satisfy UM reviewers. They also praised carriers that designated case managers to work with them. Both carriers and large providers cited the value of building trust, communication, and relationships that would make the UM process smoother on all sides. Intensive case management for the most complicated patients also can improve quality of care and systems efficiency. Small group plans also can rely on brokers to help navigate the UM system and appeals because brokers have established relationships with the carriers.

However, smaller providers and larger groups with more constrained resources generally did not have similar experiences. They often did not have the staff, training, experience, or resources to build systems and protocols. They also generally did not have dedicated UM contacts, so they could not build the trust and mutual respect that can come from repeated interactions. In general, small providers reported a more difficult road to navigate the UM process.

b. Carrier & Regulator Perspectives on Utilization Management

One large behavioral health organization (BHO) acknowledged the particular challenges for small providers and larger groups with more constrained resources when navigating UM requirements and shared that it was working towards solutions. Its provider relation teams were scheduling face-to-face meetings with outpatient providers because it wants to create pathways and relationships to handle problems that arise.

We did not have sufficient information to ask carriers to respond to specific anecdotes that providers and advocates shared, but carriers told us that generally they were moving away from using UM to manage outpatient BH services, unless the services were "nonstandard." For example, one BHO said that it generally was not requiring precertification for standard outpatient services like medication management from a doctor or for grief counseling, although it likely would require precertification of services like IOP, outpatient electroconvulsive therapy, and ambulatory SUD treatment. But not requiring precertification for services does not mean that the BHO is not monitoring utilization of those services.

[100] *See* LEGISCAN, N.J. Senate Bill 2180 (introduced June 16, 2014), *available at* https://legiscan.com/NJ/text/S2180/2014.

The carriers often develop evidence-based intervention protocols and will reach out to providers for justifications when patients exceed standard thresholds for the number of visits, for example.

Carriers reported that medical necessity criteria generally is available on their web sites. The variations in disclosure laws in the different states and how different states interpret federal law on disclosure, however, complicate the task of disclosure, particularly for carriers that operate in multiple states. We also heard from some carriers, regulators, and advocates that part of the tension about UM practices is due to consumers not understanding their benefits. In theory, disclosure and transparency should address these concerns by making it more plain what consumers' benefits are and how carriers reached the decisions they did. But in practice, it is not clear that disclosure alone has advanced the ball very far.

It is a step forward to put medical necessity criteria on public websites. But it is not clear that the average consumer can access, digest, or relate to this information. A research assistant for the Sentinel Project tried various search terms and clicked on a number of links before she unearthed the medical necessity criteria on various carrier sites. Some carriers housed the criteria several screens down and in the provider section of the web site, where curious consumers might not think to look. Links also sometimes brought the consumer to third party medical management sites like McKesson, which can be confusing to consumers. Some carrier sites were especially difficult to navigate, where numerous searches for terms like "medical necessity" and "utilization management" did not yield any viable links to the criteria.

Moreover, the parity analysis requires evaluation of how these criteria are being applied and translated into practice, and this information generally is not accessible to advocates and researchers, who may be able to help analyze and translate this information for consumers. Beneficiaries and their representatives in the context of appeals of adverse benefit determinations should be able to access "information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan."[101] Providers and legal advocates, however, have reported difficulties obtaining this information to help them determine whether UM techniques were being applied in a discriminatory manner or otherwise in violation of parity requirements.

* * *

Overall, carriers, regulators, and advocates alike mentioned the need for more guidance regarding how the parity analysis should be structured. There is uncertainty regarding a number of issues, such as how to assess formulary composition and structuring for parity compliance. In general, carriers, providers, regulators, and advocates crave more guidance regarding analyzing and evaluating NQTLs, like reimbursement rates and criteria used in selecting providers for networks.

[101] 45 C.F.R. §§ 146.136(d)(3); 147.160(a).

B. Sentinel Project Surveys of New Jersey Plans and Plan Filings

Subsequent to these informative interviews, we turned our attention to plans sold in New Jersey for evidence of the BH access concerns surfaced in phase one of the project. In phase two, we surveyed the plans themselves to determine what information was available to consumers to consider as they shopped for 2015 plans. In phase three, we assessed the information plans file with regulators. As discussed in more detail below, although important information is available to consumers and regulators, we concluded that current disclosure generally is inadequate to permit meaningful monitoring and oversight of plan compliance with the ACA's anti-discrimination provision and MH parity requirements.

1. Survey of Federal Marketplace Silver Plans in New Jersey in 2015

We took a closer look at sixteen plans that were offered through the federal Marketplace in New Jersey in 2015 to get a better sense of the plan designs and information about plans that were publicly available to regulators and consumers. We conducted a search on www.healthcare.gov for plans available to a thirty year-old individual, focusing on the silver plans with the lowest, second lowest, median, and highest premiums offered by the five New Jersey insurers offering individual Marketplace plans in 2015.[102] We evaluated the information available in the healthcare.gov search return as well as in the SBC, formulary, and provider directory for each plan surveyed, which documents were publicly available through links in the healthcare.gov search return. With this information, we attempted to evaluate a number of plan design features for compliance with the ACA and MH parity laws.

a. Summaries of Benefits and Coverage

Section 2715 of the ACA requires HHS to develop standards for individual and group insured plans to follow in compiling SBCs.[103] The ACA and its implementing regulations[104] prescribe the general content and format of a SBC, including that it may not exceed four double-sided pages, and its language must be "understandable by the average plan enrollee."[105] Further, it must contain uniform definitions of insurance and medical terms, information about covered benefits and the cost-sharing that applies to different benefits, and information about exceptions and limitations on coverage, among other things.[106]

---

[102] Because two of the five carriers only offered two silver plans, which we categorized as lowest and highest premium plans for purposes of our analysis, we analyzed a total of sixteen plans.

[103] *See* 42 U.S.C. § 300gg-15.

[104] *See* 45 C.F.R. § 147.200.

[105] 42 U.S.C. § 300gg-15(b)(1)-(2); *see also* 45 C.F.R. § 147.200(a)(3)(i).

[106] 42 U.S.C. § 300gg-15(b)(3). In 2012, HHS, DOL, and Treasury developed a template SBC for plans to use. *See* http://www.dol.gov/ebsa/pdf/correctedsbctemplate2.pdf (last visited Aug. 24, 2015). The Departments recently finalized a revised SBC template that must be used "by all health plans, including individual, small group, and large group; insured and self-insured; grandfathered, transitional, and ACA compliant," for plan years with open enrollment beginning after April 1, 2017. TIMOTHY JOST, HEALTH AFFAIRS BLOG, *CMS Releases Final Summary Of Benefits And Coverage Template, Accompanying Materials (Update)* (Apr. 7, 2016), http://healthaffairs.org/blog/2016/04/07/cms-releases-final-summary-of-benefits-and-coverage-template-accompanying-materials/ (last visited May 22, 2016). While the revised template makes a number of valuable

Plans also must include a website or other contact information where consumers may find information about a plan's network of providers, prescription drug formulary, and the uniform glossary.[107] The intent is for the SBC to "help consumers better understand the coverage they have and, for the first time, allow them to easily compare different coverage options."[108]

We examined the SBCs for each of the 16 silver plans that we surveyed. As required by the ACA, the SBCs provided the cost-sharing amounts that apply to the ten EHBs, which include MH/SUD benefits. The SBC itemized cost-sharing for a primary care office visit to treat an injury or illness; a specialist office or clinic visit; other practitioner office visit; outpatient and inpatient mental/BH and SUD treatment; outpatient surgery physician/surgeon fee; and inpatient hospital physician/surgeon fee, among others.

By looking at these numbers disclosed in the SBCs for the plans we surveyed, we noticed that in most plans, outpatient specialist office visits and MH/SUD outpatient treatment were subject to the same cost-sharing requirements. For example, in a plan offered by Carrier A,[109] a beneficiary paid a $35 copay for an in-network, outpatient office visit for mental/BH services; an in-network, outpatient office visit for SUD services; or an in-network specialist or other practitioner office visit. Thus, consumers had the same financial requirement for *a category of* outpatient med/surg services (in-network, outpatient specialist office visits) as they did for in-network, outpatient BH office visits.

But parity requires more than this superficial comparison. As discussed in Section II.A above, to charge *any* copay for in-network, outpatient BH office visits, it must be true that copays apply to at least two-thirds – or substantially all, to use the language of the quantitative parity test -- of *all* in-network, outpatient med/surg benefits – and not just to in-network specialist and other practitioner office visits.[110] Plans may not create sub-classifications for specialist and generalist providers.[111] If the plan satisfies the "substantially all" prong of the quantitative parity analysis, the copay that it applies to BH in-network, outpatient office visits may be no greater than the copay that applies to more than half of all med/surg benefits with copays in that subclassification.[112] In the Carrier A plan discussed above, a beneficiary only had to pay a $15 copay for an in-network, primary care office visit to treat an injury or illness. Because

changes, the revisions largely do not address the parity transparency concerns identified in this Report. *See Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services,* OMB Control Nos. 1545-2229, 1210-0147, and 0938-1146 (released Apr. 6, 2016), https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SBC-Template-508-MM.pdf (last visited May 22, 2016).

[107] *See* 45 C.F.R. § 147.200(a)(2)(i)(K)-(M).

[108] CENTERS FOR MEDICARE & MEDICAID SERVICES, THE CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT, *Summary of Benefits & Coverage & Uniform Glossary*, https://www.cms.gov/cciio/programs-and-initiatives/consumer-support-and-information/summary-of-benefits-and-coverage-and-uniform-glossary.html (last visited Aug. 24, 2015).

[109] For purposes of anonymity, we will refer in this Report to the five carriers offering plans through the federal Marketplace in New Jersey in 2015 as Carriers A, B, C, D, and E.

[110] As discussed in Section IV.A.2.c below, after requiring plans to perform the quantitative parity analysis, California regulators determined that several plans could not charge a copay for outpatient BH office visits because one did not apply to substantially all outpatient med/surg office visits.

[111] *See* U.S. DEP'T OF LABOR, EMPLOYEE BENEFITS SECURITY ADMIN., *FAQ about Mental Health Parity and Addiction Equity Act*, http://www.dol.gov/ebsa/faqs/faq-mhpaea.html (last visited Sept. 4, 2015).

[112] *See* Final Parity Rule Preamble, *supra* note 20, 78 Fed. Reg. at 68,242.

the SBC did not disclose what the predominant copay was for all med/surg outpatient services, a consumer or regulator would be unable to perform the quantitative parity analysis based on the information provided in the SBC. The itemized cost-sharing in SBCs does not map the parity classifications and is not a proxy for the quantitative parity calculation. It thus is not possible to monitor parity compliance from the SBC alone.[113]

SBCs also do not provide sufficient information to assess NQTLs for parity compliance. PA[114] is a form of NQTL, and thus the plans may not apply PA to mental health or substance use disorder benefits in any classification unless under the terms of the plan "as written and in operation, any processes, strategies, evidentiary standards, or other factors" used in applying PA to MH or SUD benefits in the classification "are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification."[115] Generally, plans that required PA for in-patient MH or SUD services in-network, inpatient services also required it for inpatient hospital stays.[116] In 2015, however, Carrier C only required PA for the facility but not for the physician/surgeon fees associated with an elective hospital admission. If Carrier C continues to have this policy, it would need to demonstrate that it does not violate parity to apply the PA NQTL to all BH inpatient services but to only a slice of med/surg inpatient services. Moreover, the SBCs do not include any information regarding how plans are applying NQTLs, which is a critical aspect of the parity requirement.

In addition, the SBCs do not include any information to assess plan reliance on a number of additional NQTLs, such as the standards for provider admission to participate in a network, including reimbursement rates, or plan methods for determining usual, customary, and reasonable charges.[117]

---

[113] *See generally* THE NATIONAL CTR. ON ADDICTION & SUBSTANCE ABUSE, UNCOVERING COVERAGE GAPS: A REVIEW OF ADDICTION BENEFITS IN ACA PLANS, at 5 (June 7, 2016) ("Applying the 'predominant and substantially all' test requires information not typically provided in plan documents: the classification (e.g., inpatient/outpatient) of the SUD benefit, the type of financial requirements/QTLs applied to all medical/surgical benefits in that same classification, and the expected annual dollar amount of all payments made by the plan for medical/surgical benefits in that classification."), *available at* file:///C:/Users/Tara/Downloads/Uncovering-coverage-gaps-a-review-of-addiction-benefits-in-aca-plans.pdf.

[114] For plan years with open enrollment beginning after April 1, 2017, HHS, DOL, and Treasury's revised SBC template will require plans to list when prior authorization is required for services in the "Limitations, Exceptions, & Other Important Information" column. *See Summary of Benefits and Coverage Instruction Guide for Individual Health Insurance Coverage*, at 11, *available at* https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Individual-Instructions-508-MM.pdf.

[115] 45 C.F.R. §§ 146.136 (c)(4)(i) (emphasis added); 147.160(a).

[116] Carriers A, B, and C's SBCs reflected that PA was required for MH or SUD in-network, inpatient services in 2015. Carrier D's SBCs indicated that pre-approval may have been required for these services. Carrier E's SBCs did not reference PA.

[117] *Cf.* Kelsey N. Berry *et al.*, *A Tale of Two States: Do Consumers See Mental Health Insurance Parity When Shopping on State Exchanges?*, 66 Psychiatry Services 565, 565-66 (June 2015) ("With regard to parity in nonquantitative treatment limitations, several dimensions of compliance are not observable, because summary documents do not provide information on how medical management protocols (for example, provider network admission standards, fee schedules, step therapy protocols, and medical necessity determinations) are applied to covered benefits."), *available at* http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201400582.

We recognize that SBCs are intended to offer a standardized snapshot of the benefits and coverage available through a given plan in no more than four pages and thus cannot be a comprehensive compilation of all facts relevant to coverage. HHS could modify the template, however, to enhance transparency regarding parity compliance. For example, the SBC template could incorporate the parity classifications to facilitate comparisons. But given the nature of the quantitative parity analysis for financial limits and QTLs and the level of inquiry needed to assess NQTL compliance with parity both in design and application, SBCs are not an appropriate tool for monitoring plan compliance with parity.

b. Formularies

In spring 2015, we also examined the formularies for the same 16 silver plans to see whether and how they covered 58 BH and SUD medications.[118] Specifically, and as reflected in Table A in Appendix B, we identified 10 drugs commonly prescribed to treat bipolar disorder; 28 drugs commonly prescribed to treat schizophrenia; 15 drugs that treat alcohol and drug dependence; and five of the FDA-approved smoking cessation drugs.[119]

We focused on bipolar disorder and schizophrenia because these are the two BH conditions that the Centers for Medicare and Medicaid Services (CMS) identified[120] when it indicated that it would be reviewing plans' prescription drug templates to ensure that qualified health plan (QHPs) are not "employ[ing] marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs."[121] As CMS explained:

> Based on data submitted by issuers in the prescription drug template, this review will analyze the availability of covered drugs recommended by nationally-recognized clinical guidelines used in the treatment of the following four medical conditions: bipolar disorder, diabetes, rheumatoid arthritis, and schizophrenia. The purpose of the analysis is to ensure that issuers are offering a sufficient number and type of drugs needed to effectively treat these conditions, and on some first line drugs, are not restricting access through lack of coverage and inappropriate use of utilization management techniques.[122]

---

[118] Carriers periodically update their formularies. The Sentinel Project conducted the bulk of these searches in May and June 2015, although some follow-up searches were conducted in August, September, and October 2015.

[119] *See* U.S. DEP'T OF HEALTH & HUMAN SERVCS., FOOD & DRUG ADMIN'N, "FDA Approved Smoking Cessation Products Currently Marketed" (as of June 12, 2009), http://www.fda.gov/TobaccoProducts/ResourcesforYou/ucm168231.htm (last visited Aug, 28, 2015) [hereinafter FDA-Approved Smoking Cessation Products].

[120] DEP'T OF HEALTH & HUMAN SERVCS., CENTERS FOR MEDICARE & MEDICAID SERVICES, CENTER FOR CONSUMER INFO. & INS. OVERSIGHT, *FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces*, at 41 (Feb. 20, 2015), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf [hereinafter *2016 Letter to Issuers*].

[121] 45 C.F.R. § 156.225(b); *see also id.* § 156.125 (EHB prohibition on discrimination provision).

[122] *2016 Letter to Issuers*, *supra* note 120, at 41.

CMS further warned that "if an issuer places most or all drugs that treat a specific condition on the highest cost tiers, that plan design might effectively discriminate against, or discourage[] enrollment by, individuals who have those chronic conditions."[123]

In our survey, we included the commonly used antipsychotic medications identified in the most recent publicly available clinical practice guidelines published by the American Psychiatry Association for the treatment of schizophrenia as well as the name brand and/or generic therapeutic equivalents of these drugs: Abilify, aripiprazole, chlorpromazine, clozapine, Clozaril, Fazaclo, fluphenazine, Geodon, Haldol, haloperidol, loxapine succinate, Navane, olanzapine, perphenazine, quetiapine fumarate, Risperdal, risperidone, Seroquel, thioridazine, thiothixene, trifluoperazine, ziprasidone, and Zyprexa.[124] Based on interviews, and to reflect FDA drug approvals that occurred after these guidelines were published, we also included the following recently-approved drugs for the treatment of schizophrenia: Adasuve, Fanapt, Invega, Saphris, and Versacloz.

For bipolar medications, we included the first-line pharmacological treatments identified in the most recent publicly available bipolar practice guidelines published by the American Psychiatric Association, as well as the name brand and/or generic therapeutic equivalents of these drugs: Depacon, Lamictal, lamotrigine, lithium, Lithobid, and valproate sodium.[125] Based on interviews, we also included additional valproate products: Depakene, Depakote, divalproex sodium, and valproic acid.

In addition to focusing on medications that treat bipolar disorder and schizophrenia, we included drug and alcohol dependence and tobacco cessation treatment medications because interviews indicated that consumers were having trouble getting these medications covered by their Marketplace plans. We included the drugs identified in the most recent publicly available SUD clinical practice guidelines

[123] *Id.* at 37.

[124] *See* AM. PSYCHIATRIC ASSOC., Practice Guideline for the Treatment of Patients with Schizophrenia Second Ed. (Feb. 2004), *available at* http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia.pdf; Hilary Smith Connery, M.D., Ph.D. & Herbert D. Kleber, M.D., Guideline Watch: Practice Guideline for the Treatment of Patients With Substance Use Disorders, 2nd Ed. (Apr. 2007), *available at* http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse-watch.pdf; U.S. FOOD & DRUG ADMIN., Drugs@FDA: FDA Approved Drug Products, http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm?fuseaction=Search.Search_Drug_Name (permitting searches by drug name or active ingredient to identify therapeutic equivalents of FDA-approved drugs). We did not include drugs that are listed in the guidelines but no longer marketed.

[125] *See* AM. PSYCHIATRIC ASSOC., Practice Guideline for the Treatment of Patients with Bipolar Disorder Second Ed. (Apr. 2002), *available at* http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar.pdf; Robert M. A. Hirschfeld, M.D., Guideline Watch: Practice Guideline for the Treatment of Patients with Bipolar Disorder, 2nd Ed. (Nov. 2005), *available at* http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar-watch.pdf; U.S. FOOD & DRUG ADMIN., *supra* note 124. The guidelines note that the first-line treatment usually is paired with an antipsychotic, including many of the drugs that we surveyed for the treatment of schizophrenia, such as olanzapine and Risperdal. To keep our survey relatively focused, we did not include adjunctive or alternative treatment options and instead focused on the front-line bipolar treatments.

published by the American Psychiatric Association, as well as their name brand and/or generic therapeutic equivalents: acamprosate calcium, Antabuse, buprenorphine hydrochloride (hcl), Campral, disulfiram, Dolophine, methadone, Methadose, naltrexone, Revia, and Vivitrol.[126] We also included the following drugs based on interviews with providers and advocates: Bunavail, buprenorphine and naloxone, Suboxone, and Zubsolv.[127] Finally, we selected the five name brand and generic FDA-approved, on-label smoking cessation products that require a prescription and cannot be purchased over the counter, based on a list on FDA's web site: bupropion hcl, Chantix, Nicotrol inhalation, Nicotrol NS nasal, and Zyban.[128]

i. Access to Drugs Based on Formulary Design

Although we did not find evidence that any plan surveyed violated the general EHB requirement that plans cover at least one drug in every United States Pharmacopeia (USP) category and class (or the same number of prescription drugs in each category and class as the EHB-benchmark plan),[129] we did observe a fair degree of variation in formulary design and some concerning gaps in coverage. As summarized in Table B in Appendix B, Carrier D had the most robust formulary in terms of breadth of coverage, including 56 of the 58 drugs surveyed and excluding only 3.4% of the drugs. Carriers A and C also covered more than 90% of the drugs surveyed. On the other extreme, Carrier E did not cover 14 of

[126] AM. PSYCHIATRIC ASSOC., Practice Guideline for the Treatment of Patients with Substance Use Disorder Second Ed. (Aug. 2006), *available at* http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf; Hilary Smith Connery, M.D. & Herbert D. Kleber, M.D., (April 2007): Practice Guideline for the Treatment of Patients With Substance Use Disorders, 2nd Edition (Nov. 2005), FOCUS: THE JOURNAL OF LIFELONG LEARNING IN PSYCHIATRY, Vol. V, No. 2 (Spring 2007), *available at* http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse-watch.pdf.

[127] *See also* CASAColumbia, EHB Recommendations for States: Critical Addiction Prevention and Treatment Benefits for Essential Health Benefits Benchmark Plans, at 6 (July 2013), *available at* https://www.casacolumbia.org/sites/default/files/files/EHB-recommendations-for-states.pdf ("All FDA-approved medications designed to treat and manage addiction should be covered within the parameters of EHB. These medications include, but are not limited to: 1. Campral (acamprosate), naltrexone formulations and Antabuse (disulfiram) for addiction involving alcohol[.] 2. Zyban (bupropion), Chantix (varenicline), and the five FDA-approved forms of nicotine replacement therapy (NRT), including patch, gum, lozenge, nasal spray and inhaler for addiction involving nicotine[.] 3. Naltrexone formulations, methadone, and buprenorphine formulations (including Suboxone) for addiction involving opioids[.]"). As this Report was going to print, Rebecca Peters and Erik Wengle published a study that looked at marketplace coverage and cost-sharing of a number of the same SUD drugs in six cities, Albuquerque, Chicago, Kansas City, Los Angeles, Manchester, and Memphis. *See* Rebecca Peters & Erik Wengle, COVERAGE OF SUBSTANCE-USE DISORDER TREATMENTS IN MARKETPLACE PLANS IN SIX CITIES (Urban Institute June 2016), *available at* http://www.rwjf.org/en/library/research/2016/06/coverage-of-substance-use-disorder-treatments-in-marketplace-pla.html.

[128] *See* FDA-Approved Smoking Cessation Products, *supra* note 119; *see also* WebMD, Drugs & Medications Search: Smoking Cessation, http://www.webmd.com/drugs/condition-11008-Smoking+Cessation.aspx? (last visited Sept. 24, 2015) (identifying which of the FDA-approved tobacco cessation products are available via prescription versus over the counter).

[129] *See* 45 C.F.R. § 156.122(a)(1); *see also* THE NATIONAL CTR. ON ADDICTION & SUBSTANCE ABUSE, *supra* note 113, at 3 (identifying the four classes of drugs for the therapeutic category for SUD medications, Anti-Addiction/Substance Use Treatment Agents).

the 58 drugs (24.1%), and Carrier B excluded 17 of the 58 drugs (29.3%).[130]

Drilling down into the specific drug categories that we surveyed, we see that Carriers B and E consistently excluded the highest percentages of drugs from their formularies, and Carrier D consistently excluded the lowest. Of the 28 drugs commonly prescribed to treat schizophrenia, Carrier E excluded 7 (25%), Carrier B excluded 5 (17.9%), Carriers A and C excluded 2 (7.1%), and Carrier D excluded 1 (3.6%). Carrier B excluded 50% (5 drugs) of the 10 bipolar disorder medications, while Carriers A, C, and E each excluded 10% (1 drug), and Carrier D did not exclude any. Carrier B also excluded the highest percentage of drug cessation drugs surveyed – 6 of the 15 drugs (40%) -- closely followed by Carrier E, which excluded 33.3% (5 drugs); Carriers A and C each excluded 13.3% (2 drugs), and Carrier D excluded 6.7% (1 drug). Carriers B and E each excluded 1 of the 5 (20%) smoking cessation drugs from their formularies while Carriers A, C, and D did not exclude any. Although no carrier excluded all drugs to treat a condition, focused analysis of formularies that exclude significant percentages of medications to treat BH conditions is important to ensure that plan design is non-discriminatory and in compliance with MH parity requirements.

It is important to note that our counts overstate the extent of formulary coverage because we considered a drug to be excluded from a formulary only if all forms and dosages of the drug were excluded. There were numerous instances, however, of a formulary including one of the 58 surveyed drugs in some dosage amount or format but not in others. Thus, it is important to probe beyond the specific tally of drugs covered because the specific form of the drug on or excluded from the formulary may have clinical significance. Carriers A and E, for example, covered haloperidol tablets and oral concentrate but did not cover haloperidol injectable solutions, which are the therapeutic equivalent of Haldol, and these same carriers also did not cover Haldol. Carrier A covered Geodon capsules but not Geodon injectable solution, which had no therapeutic equivalent. Carriers A and E covered olanzapine and chlorpromazine tablets but not the injectable solution. Similarly, while all carriers had some version of methadone on their formularies, there was great variation in the specific form that was covered. Some covered tablets but not certain solutions. Although we are not clinicians, it stands to reason that in some situations, the alternative formats have clinical value.

Relatedly, there were instances in which an active ingredient was covered in one form but not the form preferred by providers. Carrier E's formulary, for example, included Zubsolv but not Bunavail or Suboxone film. These three drugs share the same active ingredients, buprenorphine and naloxone, but Zubsolv comes in tablet form whereas the other two come in a film. We have heard from providers who prefer to prescribe the film because if the tablets are crushed and injected, "it can bring on opioid withdrawals."[131]

[130] It is important to note that these numbers overstate the extent to which drugs were covered by the different formularies. As discussed below, there were numerous instances of a formulary including one of the 58 surveyed drugs in some dosage amount or format but not in others. We considered a drug to be excluded from a formulary only if it was not included in the carrier's formulary for *any* dosage or form of the given drug.

[131] SUBSTANCE ABUSE & MENTAL HEALTH SERVCS. ADMIN., Buprenorphine, http://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine (last visited Oct. 11, 2015).

There also were a number of examples of formularies either excluding a formulation of a name brand drug that has no available therapeutic alternative or excluding both the name and generic versions of a drug. For example, Carriers B and C excluded Adasuve; Carriers B and E excluded Versacloz; Carrier E excluded Suboxone, aripiprazole, and Abilify; Carrier B excluded Zubsolv; Carriers B, D, and E excluded Bunavail; and Carriers A, C, and E excluded Vivitrol.

A related issue is access to more recent formulations of a drug that may improve clinical response. CMS cautioned plans that it might constitute impermissible discrimination against individuals with chronic diseases to refuse "to cover a single-tablet drug regimen or extended-release product that is customarily prescribed and is just as effective as a multi-tablet regimen, absent an appropriate reason for such refusal" because "such a plan design . . . might effectively discriminate against, or discourage enrollment by, individuals who would benefit from such innovative therapeutic options."[132] We noted several instances of plans not covering extended release or single-tablet treatments. For example, patients have to take generic naltrexone orally on a daily basis. Vivitrol, in contrast, is an injectable form of naltrexone that is administered on a monthly basis, which can improve medication adherence and thus stability in recovery.[133] Vivitrol has no therapeutic equivalent, however. While all five carriers included naltrexone on their formularies, Carriers A, C, and E excluded Vivitrol, and Carrier D classified it as a specialty drug, which had a 30-50% coinsurance. Similarly, Carriers A and E did not cover Abilify Maintena[134] or Invega Sustenna,[135] both of which are once-per-month long-acting injections that do not have therapeutic equivalents. Nor did these carriers cover Risperdal Consta, a long-acting injectable form of Risperdal that is administered every two weeks and also does not have a therapeutic equivalent.[136] Carriers A, D, and E also did not cover the long-acting intramuscular injection, fluphenazine decanoate.[137] These findings echo concerns that BH providers raised regarding the difficulty that consumers in New Jersey experience when accessing drug innovations that improve medication compliance, and they warrant closer analysis to ensure these formulary designs are not discriminating against patients with BH conditions or violating parity requirements.

We noted that many of the excluded drugs or drugs placed in high tiers have therapeutic equivalents that were on the formularies. The idea behind therapeutic equivalence is that the generic drug may be substituted for the name brand. We have heard anecdotes, however, in which medical experts opine that the name brand should not be substituted for the generic. To evaluate the significance

---

[132] *2016 Letter to Issuers*, *supra* note 120, at 37.

[133] *See* Cara Tabachnick, THE WASHINGTON POST MAGAZINE, *Breaking good: Vivitrol, a new drug given as a monthly shot, is helping addicts stay clean* (Mar. 13, 2015), *available at* https://www.washingtonpost.com/lifestyle/magazine/his-last-shot-will-a-monthly-jab-of-a-new-drug-keep-this-addict-out-of-jail/2015/03/05/7f054354-7a4c-11e4-84d4-7c896b90abdc_story.html.

[134] *See* OTSUKA AMERICA PHARMACEUTICAL, INC., *Facts about Abilify Maintena™ (aripiprazole) for extended-release injectable suspension in patients with Schizophrenia* (Feb. 2013), http://www.lundbeck.com/upload/us/files/pdf/fact_sheets/0912n5218abilifymaintenafactsheetfinal2.28.pdf (last visited Aug. 29, 2015).

[135] *See Once-Monthly Invega Sustenna*, http://www.invegasustenna.com/ (last visited Oct. 11, 2015).

[136] *See Risperdal Consta*, http://www.risperdalconsta.com/schizophrenia (last visited Oct. 11, 2015).

[137] *See* WebMD, *Fluphenazine Decanoate Injection*, http://www.webmd.com/drugs/2/drug-14460/fluphenazine-decanoate-injection/details (last visited Oct. 11, 2015).

of excluding a name brand drug from a formulary, it is necessary to know whether that drug is one for which substitution bears clinical significance.

For example, a clinical professor of psychiatry and member of the Council of Psychiatry and Law for the American Psychiatric Association took a look at an early draft of this analysis and noted that it was "really odd" to exclude Depakote because, "along with lithium, it is very clearly first-line as a mood stabilizer." He also reported that it was "odd" to exclude Haldol and Risperdal, since "both are older, [he] assume[s] cheaper, and perfectly fine drugs for psychotic symptoms." He further found it "REALLY odd . . . perverse even" to exclude Clozaril from a formulary since the drug is inexpensive, one of the first antipsychotics, and "one of the few drugs with proven suicide reduction." He noted that there is a considerable literature that notes that Clozaril "is really underutilized as a policy matter," and he described it as "unconscionable" to put up any barriers to its use. We found that although some carriers excluded these drugs from their formularies, they included generic forms, which made it difficult for us to assess the significance of the exclusion of the brand drug. For example, although Carrier B excluded Clozaril and Depakote from its formulary, it included different forms of clozapine, Clozaril's generic form, in either Tier 1 or Tier 3,[138] and divalproex sodium, generic Depakote, as a Tier 1 preferred generic. All five carriers excluded some forms of Haldol, and Carriers A, B, and E excluded all forms of Haldol from their formularies, although all included some form of its active ingredient, haloperidol. Carrier E did not include any form of Risperdal in its formulary, and Carriers A and B excluded some forms of the drug. Again, however, all five carriers included its active ingredient, risperidone. It would be helpful to have clinical expertise opine whether the generics of these drugs are medically appropriate substitutes for the excluded front-line name brand drugs.

ii. Access to Drugs As a Result of Utilization Management Techniques

Even where formularies included a given drug, we identified a number of UM techniques that the carriers were using to regulate access to these BH formulary medications. The tools carriers use to manage utilization of benefits – and *how* they use them –are NQTLs that directly impact access to covered benefits and thus must be evaluated to ensure they do not violate the ACA's anti-discrimination or parity provisions.[139]

As reflected in Table B in Appendix B, all five carriers place PA requirements on some of the BH drugs that they include in their formularies. Carriers A and B required PA for the most drugs (11 of 58, 19%), whereas Carrier D required it for the fewest drugs (4 of 58, 7%). Focusing on the carriers with the

[138] Given the clinical psychologist's description of Clozaril as an inexpensive drug, it is curious that Carrier B classified certain clozapine tablet forms in Tier 3 as non-preferred generic drugs. It would be helpful to know the cost of clozapine and the carrier's basis for tiering it as a non-preferred generic to help evaluate the propriety of this formulary design.

[139] *See generally* THE NATIONAL CTR. ON ADDICTION & SUBSTANCE ABUSE, *supra* note 113, at 9 ("Utilization management practices, such as requirements for prior authorization, can add a further barrier to the already complex process of motivating patients to begin and stay in treatment. Addiction affects the parts of the brain associated with motivation, decision making, risk/reward assessment and impulse control; therefore, engaging and retaining patients in treatment can be difficult.").

highest percentages of PA requirements within each category of drug that we surveyed, Carrier B required PA for 6 of 28 schizophrenia drugs (21.4%); Carrier A required PA for 7 of the 15 drug cessation drugs (46.7%); and Carrier E required PA for 2 of 10 bipolar disorder drugs (20%) and 4 of 5 tobacco cessation drugs (80%). Carriers A, B, C, and D required PA for a higher percentage of drug cessation medications than for the other categories we surveyed. Relatedly, three of the five carriers – Carriers C, D, and E -- employed step therapy, also known as "fail first," requirements before beneficiaries could access specific BH drugs, albeit for relatively few drugs in the survey.

All of the carriers also imposed quantity limits (QLs) on some drugs: Carrier E imposed QLs on the largest percentage of drugs surveyed – 11 of 58 (19%)[140] -- and Carrier A imposed QLs on all 5 of the surveyed tobacco cessation drugs. As we saw with PA requirements above, drug cessation benefits were subject to QLs in relatively high percentages. Carrier C, for example, imposed 9 QLs on the 58 surveyed drugs (15.5%), 8 of which were on drug cessation products (8 of 15, 53.3%); it also imposed a QL on 1 tobacco cessation drug (1 of 5, 20%), but it did not impose QLs on any schizophrenia or bipolar drugs surveyed.

Carriers B and D also categorized some of the 58 drugs as specialty drugs, although it was not apparent what impact these classifications, standing alone, had on access to these medications. Carrier B, for example, classified 3 of the 28 (10.7%) schizophrenia drugs and 1 of the 15 (6.7%) drug cessation drugs as specialty drugs. Carrier B's website suggested that specialty drugs would require PA, but that already was separately disclosed for these drugs on the formulary. Carrier D placed Vivitrol in Tier 4 as a specialty drug, but the coinsurance amount for Tier 4 was the same as in Tiers 2 and 3.

Because these various UM techniques can operate as a direct barrier to these covered medications, it is important to ensure that there is a valid basis for these requirements. As a general matter, we noticed that Carrier B frequently required PA for long-acting drugs. We also observed that Carriers A, B, C, and D required PA and QLs more frequently for drug cessation treatments than for the other drugs surveyed (with the exception of tobacco cessation for Carrier A, for which 100% of drugs had QLs). It is important to evaluate the carriers' rationale for employing these UM techniques in varying ways for different types of drugs to ensure their formulary designs are not discriminatory or in violation of parity.[141]

iii. Access to Drugs Based on Cost-Sharing & Adverse Tiering

In surveying plan formularies, we also explored whether there was evidence that plans were placing all drugs that treat a particular condition in the highest cost-sharing tier -- even when those drugs

[140] It is notable that Carrier E's formulary did not include details about its QLs. It seemed as though consumers would need to register with the plan before they would be able to access that information. For plan years beginning on or after January 1, 2016, plans must include "any restrictions on the manner in which a drug can be obtained," *2016 Letter to Issuers*, *supra* note 120, at 39, including PA, step therapy, and QLs, among others, *see* 45 C.F.R. § 156.122(d)(1), in its formulary drug list, which consumers must be able to view on the plan's public website without having "to create or access an account or enter a policy number," 45 C.F.R. § 156.122(d)(1)(i).

[141] *See generally* MH Parity FAQs Part 31, *supra* note 29, at 14-15, Q.11 (confirming that MHPAEA applies to medication assisted treatment for opioid disorder).

are relatively low-cost generic drugs –as a means of deterring individuals with high-cost conditions from enrolling in the plan. Douglas B. Jacobs and Benjamin D. Sommers have referred to this plan design practice as "adverse tiering" and have noted that it can undermine the ACA's prohibition on health status discrimination.[142] CMS has acknowledged that "if an issuer places most or all drugs that treat a specific condition on the highest cost tiers, that plan design might effectively discriminate against, or discourage[] enrollment by, individuals who have those chronic conditions."[143]

Douglas and Jacobs defined adverse tiering as placing all drugs in a class used to treat a condition "in tiers with a coinsurance or copayment level of at least 30%."[144] An Avalere analysis of the formularies for silver plans in eight states found that in 2015, approximately 13% of the plans required coinsurance of 30% or higher for all single source brand atypical antipsychotics, and approximately 14% of the plans required the same for all single source brand bipolar agents.[145] The percentages dropped by a percentage or two when the coinsurance floor was changed to forty percent.[146]

A New Jersey regulation requires that "[t]he most preferred tier of a formulary, that is, the tier with the lowest cost sharing . . . include more than one drug used to treat each covered disease state where more than one drug is available."[147] Consistent with this requirement, we did not find in our survey that all of the drugs to treat a particular condition were placed into the tier with the highest cost-sharing. A variety of the drugs we surveyed in each group were placed in Tiers 1 and 2.

We observed, however, that a substantial number of tiers in the plans we surveyed had high cost-sharing. 41 of the 64 (64.1%) tiers in the sixteen plans surveyed met Jacobs and Sommers's criteria that medications would incur a cost-sharing of 30% or greater: 15 required a 30% coinsurance; 7 required a 40% coinsurance; and 19 required a 50% coinsurance. As reflected in Tables C-1-C-4 in Appendix B,

---

[142] *See, e.g.,* Douglas B. Jacobs & Benjamin D. Sommers, *Using Drugs to Discriminate — Adverse Selection in the Insurance Marketplace*, 372 NEW ENG, J. OF MED., 399, 400 (Jan. 29, 2015), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1411376 .

[143] *2016 Letter to Issuers*, *supra* note 120, at 37.

[144] *See, e.g.,* Jacobs & Sommers, *supra* note 142, at 401.

[145] *See Avalere PlanScape® Analysis of Prescription Drug Tier Placement and Cost Sharing in Health Insurance Exchange Plans*, at 10 (Feb. 11, 2015), *available at* http://go.avalere.com/acton/attachment/12909/f-017c/1/-/-/-/-/-/20150211_Avalere%20Planscape%202015_Class%20Tiering%20Analysis.pdf. "A single-source branded medication is a brand name drug without a generic equivalent." *Avalere, Exchange Benefit Designs Increasingly Place All Medications for Some Conditions on Specialty Drug Tier*, at 2 (Feb. 11. 2015) *available at* file:///C:/Users/Tara/Downloads/1423668263_20150211_Exchange_Class_Tiering_Analysis.pdf.

[146] *See Avalere PlanScape® Analysis*, *supra* note 145, at 9.

[147] N.J.A.C. § 11:22-5.9(b)(3). We note, however, that Carrier B sent a corrective action letter to beneficiaries in 2015, announcing that its "formulary incorrectly classified all specialty drugs as Tier 4 prescription medications, which means they were subject to the highest level of cost sharing. Specialty drugs are prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, hemophilia, and more." As a temporary measure, the carrier placed all specialty drugs in Tier 1 until it could assign specialty drugs to appropriate tiers.

significant numbers of the 53 drugs we surveyed for schizophrenia, bipolar, or drug cessation treatment[148] either were excluded from the formulary or were in one of these 41 tiers with high cost-sharing, including many generic drugs. Tier 1 – the lowest tier - for Carrier D's median premium plan, for example, required a 50% coinsurance. 52.8% of the 53 drugs we surveyed either were not on Carrier C's formulary or were in tiers that had 30% or higher coinsurance. The remainder of the drugs (47.2%) also were in tiers with at least 30% coinsurance for Carrier C's lowest, second lowest, and highest premium plans surveyed. Similarly, 54.7% of the 53 drugs we surveyed either were not on Carrier D's formulary or were in tiers that had 30% or higher coinsurance. The remainder of the drugs (45.3%) also were in tiers with 50% coinsurance for Carrier D's median premium plan.

These numbers undercount the number of drugs in high cost-sharing tiers because we included in these counts drugs for which every dosage amount and form listed in the carrier's formulary was in a tier that had at least 30% coinsurance (or was excluded from the formulary). There were several instances where the formulary put certain dosages or forms of a drug into a high cost-sharing tier, but at least one dosage amount or form had less than a 30% coinsurance. We did not count these drugs.

It is interesting to note that although a high percentage (49.1%) of the drugs we surveyed would not be covered or would be in high cost-sharing tiers in Carrier A's plans, it generally[149] employed a $125 maximum out-of-pocket cap per 1-30 day prescription filled. This plan design feature, which is included in some of New Jersey's standardized plans in 2015,[150] helped to address the affordability concerns raised by high cost-sharing tiers. Note, however, that like many of the plans we surveyed, at least one of Carrier A's plans surveyed required consumers to meet a $1,350 deductible *before* the per prescription out-of-pocket cap would apply.

Nothing from the face of the formularies suggested that the surveyed plans were placing drugs in tiers based on whether they were used to treat behavioral or physical health conditions.[151] Further analysis is needed to assess whether in practice BH drugs disproportionately are classified in tiers with higher cost-sharing. Even if there is no discriminatory plan design or parity violation, however, these findings raise concerns about consumers' ability to afford their coinsurances.[152]

---

[148] We did not include the tobacco cessation drugs in this analysis because they are supposed to be available with zero cost-sharing, as a preventive service, as discussed below in Section III.B.1.b.iv.

[149] We note, for example, that the cap on prescription costs does not apply to Tier 1 in Carrier A's lowest premium plan.

[150] *See, e.g.,* STATE OF N.J., DEP'T OF BANKING & INS., Standard Policy Form for the Individual Health Benefits Plan [A/50] [B] [C] [D] for Standard Plans Issued on or After January 1, 2015, at 25 (Example EPO (with PCP Copayment)) [hereinafter 2015 IHC Standard Policy Form], http://www.state.nj.us/dobi/division_insurance/ihcseh/rules/ihcprn1014/a50_Dadopt.docx (last visited May 24, 2016).

[151] 45 C.F.R. §§ 146.136 (c)(3)(iii)(A); 147.160(a).

[152] *See generally* THE NATIONAL CTR. ON ADDICTION & SUBSTANCE ABUSE, *supra* note 113, at 10 ("[C]ost is a significant barrier to SUD services, even for people who have insurance. High daily or per admission co-payments may deter patients from seeking treatment. Even if these requirements are in parity with cost-sharing requirements for comparable medical services, such high cost-sharing requirements impede access to care.").

iv. Focus on Tobacco Cessation Medication Coverage

The ACA requires Marketplace plans to cover services with a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with no patient cost-sharing.[153] Since April 2009, the USPSTF has recommended, with a rating of A, "that clinicians . . . provide tobacco cessation interventions for those who use tobacco products."[154] In a guidance issued on May 2, 2014, HHS, DOL, and Treasury stated that they will consider an insurer to be in compliance with the requirement to cover tobacco cessation interventions, if, for example, the plan or issuer covers without cost-sharing "at least two tobacco cessation attempts per year" for those who use tobacco products, which attempts include, in addition to screening and counseling, coverage of "[a]ll Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization."[155] The five tobacco cessation drugs that we included in our formulary survey -- bupropion hcl, Chantix, Nicotrol NS, Nicotrol Inhaler, and Zyban -- are all FDA-approved smoking cessation products.[156]

As reflected in Table D in Appendix B, only one of the five carriers, Carrier C, classified all five of the surveyed FDA-approved smoking cessation drugs in 2015 as preventive drugs that did not require cost-sharing.[157] Note, however, that Carrier C imposed a QL on Chantix that may not be permissible. The guidance requires plans to provide at least two ninety-day tobacco cessation attempts per year, so at least 180 days of treatment per year. But Carrier C imposed a limit of 168 days per lifetime.[158]

Carriers B and E categorized four of the drugs as preventive services but did not include Zyban in their formularies. This may have been permissible, however, because both formularies covered Zyban's generic form, bupropion hcl extended release, at zero cost-sharing. Plans may use "reasonable medical management techniques to determine the frequency, method, treatment, or setting for" coverage of

[153] *See* 42 U.S.C. § 300gg-13(a)(1).

[154] U.S. PREVENTIVE SERVICES TASK FORCE, "USPSTF A and B Recommendations," http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ (last visited Aug. 27, 2015).

[155] U.S. DEP'T OF LABOR, EMPLOYEE BENEFITS SECURITY ADMIN'N, "FAQs about Affordable Care Act Implementation (Part XIX)," Q.5 (May 2, 2014), *available at* http://www.dol.gov/ebsa/faqs/faq-aca19.html. Note, however, that New Jersey's benchmark plan in 2014 reportedly contained only three smoking cessation drugs. *See* CENTERS FOR MEDICARE & MEDICAID SERVICES, THE CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT, "New Jersey EHB Benchmark Plan," https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/new-jersey-ehb-benchmark-plan.pdf (last visited Aug, 28, 2015). *But see also* IHC Standard Policy Form, *supra* note 150, at 129 (including "Charges for drugs for the management of nicotine dependence" in list of exclusions for outpatient coverage of prescription drugs).

[156] *See* FDA-Approved Smoking Cessation Products, *supra* note 119.

[157] Interestingly, Carrier C listed bupropion hcl as both a Tier A and Tier 1 drug, depending on whether it was being used as a smoking deterrent or as an antidepressant. Carrier D similarly tiered bupropion hcl as either Tier 0 or Tier 1, depending on if it was being used as a smoking deterrent.

[158] Carrier C also imposed a QL of 56 tablets per 28 days for Chantix, but this appears to be consistent with the standard dosing for this drug. *See CHANTIX dosing at a glance*, http://www.chantix.com/what-to-expect (last visited Sept. 23, 2015).

recommended preventive health services, relying "on the relevant clinical evidence base and established reasonable medical management techniques."[159] A federal FAQ guidance document has interpreted this language to permit plans to "cover a generic drug without cost-sharing and impose cost-sharing for equivalent branded drugs" as long as the "plan or issuer must accommodate any individual for whom the generic drug (or a brand name drug) would be medically inappropriate, as determined by the individual's health care provider, by having a mechanism for waiving the otherwise applicable cost-sharing for the branded or non-preferred brand version."[160] Although this answer was in response to a question about coverage of contraceptive methods, its language seems broad enough to apply equally to tobacco cessation treatments. Carriers B and E thus likely were permitted to exclude Zyban from their formularies as long as they had a system in place for waiving the cost-sharing for Zyban if the generic alternative was medically inappropriate in a particular case.

Carrier D categorized bupropion hcl, Chantix, and Zyban as preventive drugs with no cost-sharing, but Nicotrol Inhaler and Nicotrol NS were both put in Tier 3 as non-preferred brand drugs, which would have required a 30 or 50-percent coinsurance, depending on the plan.

Most surprising was that Carrier A did not classify any of the five drugs as preventive services in its formulary. Four -- Chantix, Zyban, Nicotrol NS, and Nicotrol Inhaler -- were classified as Tier 3 Non-Formulary Brand Drugs, which meant they would have required a 50-percent coinsurance in all of the plans surveyed. The fifth, bupropion hcl, was listed as a Tier 1 Formulary Generic, which required a $7 copay after deductible in two of the surveyed plans and a fifty-percent coinsurance in the other two plans. It thus appeared that Carrier A's formulary impermissibly required cost-sharing for all of the five FDA-approved tobacco cessation drugs that we surveyed.

Carrier E also seemed to violate the HHS, DOL, and Treasury guidance by requiring PA for the four tobacco cessation medications on its formulary. Patients were directed to "[a]sk your doctor to obtain notification/prior authorization. Your doctor will need to let us know you are also getting counseling to help you stop using tobacco products." For Chantix, Nicotrol Inhaler, and Nicotrol NS, Carrier E imposed a combined step therapy-PA requirement: "These three prescription medications are covered with Prior Authorization after members have tried: 1) One over-the-counter nicotine product and 2) Bupropion sustained-release (generic Zyban) separately." Although the guidance does not specifically prohibit step therapy, this seems to violate the requirement to cover all FDA-approved tobacco cessation medications without PA and does not appear to be a reasonable medical management technique.[161]

Like Carrier C, Carrier A also imposed QLs on the tobacco cessation drugs that were on its formulary. The limits on bupropion hcl, Chantix, and Zyban (60 tablets per 30 days) seem consistent with

[159] 45 C.F.R. § 147.130(a)(4).

[160] U.S. DEP'T OF LABOR, EMPLOYEE BENEFITS SECURITY ADM., "FAQs about Affordable Care Act Implementation Part XII," Q. 14 (Feb. 20, 2013), http://www.dol.gov/ebsa/faqs/faq-aca12.html (last visited Sept. 23, 2015).

[161] It also is noteworthy that the step therapy requirement for these three drugs was only disclosed at page 162 of Carrier E's 164-page formulary, on a page specific to tobacco cessation medications; it was not disclosed in the column for "Step Therapy" in the chart of medications.

the typical dosing schedule for these medications[162] and thus did not seem to conflict with the federal guidance. Dosing for Nicotrol Inhaler and Nicotrol NS, however, is individualized, based on a patient's nicotine dependence.[163] Depending on the patient, Carrier C's limits may not have been reasonable medical management techniques.

v. Summary of Findings and Need for Further Research

As noted above, the various UM tools as well as the designs of the formularies are NQTLs and thus must comply with the final parity rule. But, like with anti-discrimination analysis, raw numbers reporting the number of drugs on the formulary or subject to UM, in isolation, do not tell a complete story. To effectively monitor parity compliance, we must do more than just add up the number of PA or step therapy requirements applied to BH and physical health services. It is critical also to know the bases used to impose these requirements and to evaluate whether they are being applied more stringently to BH than physical health.[164]

Although the final parity rule removed the exception to the NQTL requirement that permitted variation "to the extent that recognized clinically appropriate standards of care may permit a difference,"[165] the NQTL requirement includes the flexibility for plans to "take into account clinically appropriate standards of care when determining whether and to what extent medical management techniques and other NQTLs apply to medical/surgical benefits and mental health and substance use disorder benefits, as long as the processes, strategies, evidentiary standards, and other factors used in applying an NQTL to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those with respect to medical/surgical benefits."[166] Thus, as with the non-discrimination analysis, independent, expert clinician input will help evaluate the bases used to develop NQTL standards and how they are applied in specific cases.

We note that the example in the final parity rule regarding formulary tiering assumes all of the tricky questions, including that the standards are applied without regard to whether a drug is generally prescribed for med/surg or BH purposes, that the process for certifying drugs in different tiers complies

---

[162] *See CHANTIX dosing at a glance*, http://www.chantix.com/what-to-expect (last visited Sept. 23, 2015); GlaxoSmithKline, *Highlights of Prescribing Information: ZYBAN (bupropion hydrochloride) Sustained-Release Tablets, for oral use*, *available at* https://www.gsksource.com/pharma/content/dam/GlaxoSmithKline/US/en/Prescribing_Information/Zyban/pdf/ZYBAN-PI-MG.PDF; Bupropion Dosage, Drugs.com, http://www.drugs.com/dosage/bupropion.html (last visited Oct. 7, 2015).

[163] *See* Nicotrol: Dosage and Adminstration, http://www.rxlist.com/nicotrol-drug/indications-dosage.htm (last visited Sept. 23, 2015); Nicotrol NS: Dosage and Administration, http://www.rxlist.com/nicotrol-ns-drug/indications-dosage.htm (last visited Sept. 23, 2015); Nicotrol NS: Drug Description, http://www.rxlist.com/nicotrol-ns-drug.htm (last visited Sept. 23, 2015).

[164] *See* 45 C.F.R. §§ 146.136(c)(4)(i) (emphasis added); 147.160(a); *see, e.g., id.* § 146.136(c)(4)(iii) (example 8);146.136(c)(4)(iii) (example 11).

[165] Final Parity Rule Preamble, *supra* note 20, 78 Fed. Reg. at 68,241, 245.

[166] *Id.* at 68,245.

with the NQTL requirements; and that the bases for establishing different levels or types of financial requirements are reasonable.[167] There is little guidance regarding how to establish each of these assumptions. At a minimum, it appears that carriers must identify the basis for how they assigned drugs to different tiers to facilitate the parity analysis, information that was not available to our project.

Further research would be needed to assess whether any of these formulary designs violate the ACA's non-discrimination provisions by employing marketing practices or benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.[168] CMS has encouraged states like New Jersey that are performing plan management functions in federally-facilitated Marketplaces to "review each QHP's formulary drug list to ensure non-discrimination in QHP prescription benefit design. CMS will "perform an outlier analysis [on each QHP's formulary drug list] to identify QHPs that are outliers based on an unusually large number of drugs subject to prior authorization and/or step therapy requirements in a particular [United States Pharmacopeia (USP)] category and class."[169] Our analysis takes a first slice at identifying potential outliers, but a more comprehensive analysis, tracking all of the USP categories and classes, is needed.

In sum, as we saw with the SBCs, monitoring for compliance with the ACA's non-discrimination provision and parity requirements is more nuanced than just reviewing a list of covered drugs. A common barrier that we confronted is that, as non-clinicians, we need clinical input to fully assess whether formularies offer "a sufficient number and type of drugs needed to effectively treat" schizophrenia, bipolar disorder, and SUDs "and, on some first line drugs, are not restricting access through lack of coverage and inappropriate use of utilization management techniques."[170] Clinical expertise will help policymakers assess the extent to which formulary exclusions, tiering, and UM may adversely impact access to medically appropriate care. In addition, there is a need for greater disclosure of the reasons for formulary decisions to facilitate nondiscrimination and parity analyses.

c. Network Directories: Focus on Methadone Treatment Facilities

Although we did not have the data or software needed to assess the adequacy of the plans' networks of providers in general,[171] we focused on methadone treatment facilities, given concerns we heard in interviews that many of these facilities were not in-network in Marketplace plans in New Jersey.

---

[167] 45 C.F.R. §§ 146.136 (c)(3)(iv) (example 4); 147.160(a).

[168] *See id.* § 156.225(b); *see* also *id.* § 156.125(a) ("An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.").

[169] *2016 Letter to Issuers*, *supra* note 120, at 40.

[170] *Id.* at 41.

[171] New Jersey's network adequacy regulations require, among other things, that ninety percent of members within each county or sub-county are able to access specialists including psychiatrists within the lesser of 45 miles or one hour of driving. *See* N.J.A.C. § 11:24-6.1(a)(1)(ii)-(iii); *see generally* JACOBI, RAGONE, & GREENWOOD, THE SENTINEL PROJECT, *supra* note 1, at 40-45 (reviewing New Jersey's network adequacy requirements). Thus, to evaluate network adequacy, we need the addresses of providers and members in each county and geomapping software that can analyze the relationship of these data points in each county.

Indeed, our review of the networks for the five carriers offering plans in the federal Marketplace in New Jersey in 2015 confirmed these reports.

Due to the risk of relapse, the Office of National Drug Control Policy has taken the position that "ongoing [medication-assisted treatment (MAT)] may be the safest and best approach for opioid rehabilitation."[172] Methadone is one of three drugs approved by the FDA for use in MAT of opioid dependence, in conjunction with behavioral therapy.[173] It has been used successfully for more than 40 years to treat opioid dependence.[174] Although buprenorphine and naltrexone, the other two drugs approved by the FDA to treat opioid dependence, have been increasing in popularity, methadone remains an important tool to fight opioid use disorder. Indeed, according to New Jersey's buprenorphine guidelines, "*methadone is still the pharmacotherapy of choice for the treatment of opiate dependent pregnant patients*."[175]

SUD treatment is among the ten EHBs,[176] but the scope of covered benefits depends on the benchmark plan.[177] While New Jersey's benchmark plan includes SUD outpatient treatment,[178] that does not necessarily mean that it must cover every form of treatment.[179] But as our review of the five New Jersey carriers' formularies found, methadone is on the formulary for each of the five carriers offering plans through the Marketplace in New Jersey. Thus, consumers with Marketplace plans should have access to this covered benefit.

To access methadone maintenance therapy for opioid dependence other than in an emergency, federal law requires consumers to go to an outpatient opioid treatment program (OTP) certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and registered with the Drug

---

[172] OFFICE OF NATIONAL DRUG CONTROL POLICY, EXECUTIVE OFFICE OF THE PRESIDENT, *Healthcare Brief: Medication-Assisted Treatment for Opioid Addiction*, at 4 (Sept. 2012) (internal footnotes omitted), *available at* https://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf.

[173] *Id.* at 1, 2. The other two approved MAT medications are naltrexone and buprenorphine. *See id.* at 1.

[174] *Id.* at 2.

[175] N.J.A.C. § 10:161B, Appx. B (emphasis in original).

[176] See 42 U.S.C. § 18022(b)(1)(E).

[177] *See generally* THE NATIONAL CTR. ON ADDICTION & SUBSTANCE ABUSE, *supra* note 113, at 1, 4 (noting that the ACA did not define the specific SUD benefits that must be covered, choosing instead to permit states to define the scope of covered SUD benefits by selecting a benchmark plan to serve as a template).

[178] *See* CENTERS FOR MEDICARE & MEDICAID SERVCS., CENTER FOR CONSUMER INFO. & INS. OVERSIGHT, *New Jersey EHB Benchmark Plan*, at 6, https://www.cms.gov/cciio/resources/data-resources/downloads/new-jersey-ehb-benchmark-plan.pdf (last visited Sept. 28, 2015).

[179] SUBSTANCE ABUSE & MENTAL HEALTH SERVCS. ADMIN., *Insurance and Payments* ("The Affordable Care Act now requires most insurers to cover addiction treatment benefits. In addition, The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires health insurers and group health plans to provide the same level of benefits for BH services that they do for primary care. However, not all insurance plans cover every available addiction treatment medication. And some plans cap the number of dosages and prescription refills a MAT patient receives."), http://www.samhsa.gov/medication-assisted-treatment/treatment/insurance-payments (last visited Sept. 28, 2015); *see generally* THE NATIONAL CTR. ON ADDICTION & SUBSTANCE ABUSE, *supra* note 113, at 3 (noting that the EHB requirement does not require coverage of methadone because it "is not included in the USP Medicare Model Guidelines because methadone is excluded from Medicare prescription drug (Part D) coverage").

Enforcement Administration (DEA).[180] New Jersey also restricts the dispensing of methadone to OTPs licensed by the Office of Licensure (OOL) within the State's Department of Human Services.[181] Federal law prohibits doctors from prescribing methadone for the purpose of treating addiction.[182] Generally patients go to federally-certified and State-licensed OTPs on a daily basis to receive their dose of methadone until they demonstrate sufficient stability to then receive take-home doses.[183]

Presently, patients in New Jersey in need of methadone to treat addiction need to seek treatment at one of 29 SAMSHA-certified and New Jersey licensed OTPs.[184] Carrier A's network included two of these 29 OTPs, one in Phillipsburg, and one in Irvington, although the facility in Phillipsburg was only participating in a regional plan that we did not survey for this project. It initially looked like Carrier C also had two OTPs in-network. But one of these facilities was listed in the carrier's directory with the same name as a certified and licensed OTP but with a different address, Paterson versus Paramus. Facilities need a separate license for each site, and only the Paramus site is a licensed OTP. Thus, it looks like only one OTP was in-network for Carrier C, and it was located in Phillipsburg.[185] Similarly, Carrier E initially looked like it included two OTPs in its network, one in Atlantic City and one in Phillipsburg. But the Atlantic City OTP informed us that its methadone program was not in-network with any Marketplace plans as of September 2015,[186] which raises phantom network concerns and left Carrier E's network with only one in-network OTP in Phillipsburg in 2015. Carriers B and D did not seem to have a single OTP in-network,

[180] *See* 42 C.F.R. § 8.12; OFFICE OF NATIONAL DRUG CONTROL POLICY, *supra* note 172, at 1, 2.

[181] *See* N.J.A.C. § 10:161B-11.1 *et seq.*

[182] *See* Joseph O. Merrill, *Policy Progress for Physician Treatment of Opiate Addiction*, 17 J. Gen. Intern. Med. 361, 362 (May 2002), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495048/.

[183] See 42 C.F.R. § 8.12(i); N.J.A.C. § 10:161B-11.10; OFFICE OF NATIONAL DRUG CONTROL POLICY, *supra* note 172, at 1, 2. The other two medications are naltrexone and buprenorphine. *See id.* at 1.

[184] As of September 28, 2015, although there were 33 SAMSHA-certified OTPs in New Jersey, *see* DEP'T OF HEALTH & HUMAN SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CENTER FOR SUBSTANCE ABUSE TREATMENT, DIV. OF PHARMACOLOGIC THERAPIES, *Opioid Treatment Program Directory*, http://dpt2.samhsa.gov/treatment/directory.aspx (last visited Sept. 28, 2015), only 29 of them also were licensed by OOL in New Jersey to dispense methadone to the general public, *see* DMHAS Licensed Opioid Treatment Providers (as of 8/27/15) (spreadsheet on file with authors). The State also maintains an addictions treatment directory on a web site maintained by Rutgers University. It contained much of the same information contained in the spreadsheet that DMHAS provided to us, although we did notice a few discrepancies. *See* N.J. DEP'T OF HUMAN SERVCS., DIV. OF MENTAL HEALTH & ADDICTION SERVCS., *Addiction Services Treatment Directory (Licensed Agency Only)*, https://njsams.rutgers.edu/dastxdirectory/txdirmain.htm (last visited Sept. 30, 2015). A representative of the state explained why four facilities were certified as OTPs by SAMSHA but not included in New Jersey's list of licensed OTPs. One was a program at a veterans hospital that, as a federal facility, is not required to have a license from New Jersey. This facility was not listed in any of the directories for plans offered through the Marketplace in New Jersey in 2015. Two facilities were licensed OTPs only for their residential clients and were not licensed to dispense methadone to the general public. The fourth facility was certified as an OTP by SAMSHA for prescribing and dispensing buprenorphine by individual doctors, but it was not permitted to prescribe or dispense methadone.

[185] Carriers A and C had a facility in network that was certified by SAMSHA but not licensed in New Jersey as of September 28, 2015. We learned from DMHAS that this facility's New Jersey OTP license expired on June 30, 2015, and thus beneficiaries of Carriers A and C had access to this facility in Seabrook in-network for half of 2015.

[186] The Atlantic City OTP shared in September 2015 that it recently was approached by a carrier about joining its network.

even though both carriers included some dosage amounts and formats of methadone on their formularies.[187]

These findings raise significant questions about the adequacy of the carriers' networks with respect to methadone maintenance therapy in 2015. The best case for a consumer living in Cape May, in the southern part of the state, for example, would have been to choose Carrier A's plan and drive approximately 300 miles roundtrip to Irvington each day for treatment – and this assumes that the facility was accepting new patients. This does not seem reasonable or adequate. It arguably is misleading for carriers to claim to cover methadone but then not to include an adequate number of certified OTPs that may dispense methadone in their networks.

We recognize that private physicians are permitted to prescribe methadone to treat chronic pain, as distinguished from addiction.[188] If carriers were including methadone on their formularies for pain management, and not for opioid abuse treatment, further analysis would be necessary to see if the plans were satisfying their EHB requirement to cover SUD treatments when they omitted one of only three drugs approved for this purpose – especially a drug that is "incredibly cheap"[189] and the preferred drug for pregnant women. It also should be considered whether the carriers should have to make plain in their formularies for what uses methadone will be covered so that patients who are comparing coverage options offered by different plans do not erroneously believe a plan covers methadone maintenance therapy to treat addiction when it only covers methadone to treat pain.

d. Transparency and Consumer Accessibility Concerns

As we noted in our earlier Report, "A Guide to Assist New Jersey Consumer Selection of Health Insurance Plans for 2015," when consumers search on healthcare.gov for available plans, the search return:

> provides only some of the important cost, network, and coverage information that consumers should consider before choosing a plan. . . . [T]here are a variety of details about each plan that consumers will not be able to tell from the original search return screen on HealthCare.gov. For example, consumers will not always know from the main search screen whether the deductible applies to all health care services, such as prescriptions or office visits, so they will not have a complete picture of how much they need to pay out-of-pocket for health care. They also will

[187] Indeed, we ran separate searches in Carrier D's directory using prepopulated search terms for "outpatient alcohol and substance abuse detox," "inpatient alcohol and substance abuse detox," and "alcohol and substance abuse clinics" within "20+ miles" – the greatest distance we were permitted to search – from four different zip codes around the state, and all searches returned zero results.

[188] *See* Merrill, *supra* note 182, at 362.

[189] Leah Lawrence, *Methadone challenging option for treatment of chronic pain*, ACP INTERNIST (Sept. 2014), *available at* http://www.acpinternist.org/archives/2014/09/methadone.htm.

> not know whether the plan offers out-of-network benefits and, if it does, how deductibles, copays, coinsurance, and out-of-pocket maximums will vary depending on whether the consumer receives care in or out of the network.[190]

The same concerns face consumers who are trying to access BH services. To get a fuller – though usually still not complete – picture of the BH coverage offered by different plans, consumers need to seek out more detailed plan information from a variety of documents, including SBCs, drug formularies, and network directories.

These additional resources generally are available to consumers through links in the healthcare.gov search result, but consumers do not always know that they should follow these links or what to look for in these materials. Moreover, the links do not always bring consumers directly to the pertinent information. For example, as we noted in our earlier report, some links for SBCs for 2015 brought consumers to a pdf file with SBCs for different plans or to a web page with options for different plans, and then consumers needed to navigate to find the correct plans.[191] Some network directories required consumers to select the applicable plan name from a drop-down box, while others required consumers to look for notations in the search result for which plans the provider is in-network.[192] Carrier D's 2015 provider directory was even more complicated to find because there were two – one for physical health and a separate link for BH providers.

i. Transparency in Network Directories

We noticed several transparency issues when we surveyed 2015 provider directories for methadone OTPs. It generally was not intuitive how consumers should search for methadone clinics because most sites were set up to search by an individual provider's name. Most, but not all, sites permitted searching by facility name, but it could take some digging, guesswork, and sheer luck to figure out how.

For example, one directory let us run a search by entering the name of a facility in the search box without entering additional search terms, like zip code, specialty, and the like. But after running several searches, with zero search returns, we realized that we had to select "hospitals and facilities" from an advanced search drop-down menu along the left margin in order actually to search for facilities in the directory. There was no warning to the consumer that s/he could be running flawed searches, which in turn can produce misleading results.

---

[190] TARA ADAMS RAGONE, THE SENTINEL PROJECT, CENTER FOR HEALTH & PHARMACEUTICAL LAW & POLICY, SETON HALL LAW SCHOOL, A GUIDE TO ASSIST NEW JERSEY CONSUMER SELECTION OF HEALTH INSURANCE PLANS FOR 2015, at 14 (Dec. 2014), *available at* http://law.shu.edu/Health-Law/upload/sentinel-project-guide-assist-nj-consumer-health-insurance.pdf.

[191] *See id.* at 16.

[192] *See id.* at 17.

We also observed that several search features permitted consumers to search for partial names of providers, but some would only return reliable results if the searcher started with the beginning letters. Searching for "Brooks," for example, returned the names of individual doctors with the last name, Brooks, but it did not return the John Brooks Recovery Center. In four of the carriers' directories, we were not able to limit the search to methadone providers. As a result, the search results included a number of SUD treatment facilities that were not certified OTPs and thus could not dispense methadone. We determined this by cross-referencing the search returns with SAMHSA and New Jersey's OTP lists, but the average consumer is unlikely to know that this step is necessary. One carrier's directory let consumers select methadone maintenance as an area of expertise. But when we used this search criterion, believing it would narrow our search returns, the opposite happened. The search results included numerous individual providers, who were not permitted to dispense methadone. Some of the facilities are doing business under names that differ from their incorporated names, which also complicated the search process. Again, consumers are bound to be confused and misled by these features.

ii. Transparency in Drug Formularies

We also observed transparency issues with the carriers' drug formularies. Drug lists are not standardized from carrier to carrier, which adds to a consumer's task of uncovering and comparing the terms of different policies. Some formularies provide a list of all medications in pdf format that consumers may search. Others require consumers to type the name of the drug into a search field. Both features have their strengths and weaknesses. The searchable field permits consumers to enter a drug's name and quickly find out if it's covered without having to look through a long list of drug names. It also may be able to suggest a generic alternative to a consumer. Carrier A's search field, for example, let consumers enter only a portion of a drug's name. The search return also provided both the name brand and generic drugs for a given active ingredient even though the search was done for only one or the other.

But there are situations when the search field is less helpful to consumers. For example, consumers may not be sure of the exact spelling of their drugs, or they may mis-type when they begin the search. Functionality varied among formularies. It also can be tedious for consumers to have to search separately for each prescription they are taking rather than being able to scan down a comprehensive list.

Providing a comprehensive list of all drugs also offers consumers and advocates an opportunity to look for patterns in coverage. For example, they can scan the list to see which drugs have PA or step therapy requirements, or how drugs are assigned to tiers. Carrier D's formulary, for example, was provided as a searchable pdf document that included columns disclosing medical management requirements. It also provided the name brand and generic names for each drug. Carrier B also had a searchable pdf formulary, but it did not provide generic and brand name alternatives for each drug.

Formularies also could be difficult to navigate. Although Carrier A's search function helpfully listed both name brand and generic drugs with the same active ingredient along with their respective tiers, consumers then needed to click separately on each of those drugs to see what other UM tools might apply to them, such as step therapy or PA. It would help consumers compare coverage options if this

information were included along with tiering information in the original search return. Carrier C put the details of its QLs in a separate file, which made it harder for consumers to understand their benefits. Carrier E never defined what its tiers mean in its 164-page formulary.

In addition to navigational issues, formularies also could be confusing. Carrier C's formulary, for example, organized drugs by categories of drugs. Consumers may be familiar with some of these labels, like anti-infective agents and antivirals, such that grouping the common types of drugs together could help consumers get a sense of the scope of coverage within that group. But many labels likely are not familiar to the average consumer, like aminoglycosides and antineoplastic agents. The categorization also could lead to confusion. The antidepressant category listed "bupropion hcl tab sr 12hr 150 mg" as a Tier 1 drug. But consumers looking for coverage of this drug as a smoking cessation drug needed to keep searching to find that "bupropion hcl (smoking deterrent) tab sr 12hr 150 mg" is listed as a Tier A drug sixteen pages later under "psychotherapeutic and neurological agents - misc." Similarly, Carrier E's formulary did not disclose in the "Step Therapy" column that Chantix, Nicotrol Inhaler, or Nicotrol NS were subject to step therapy. A consumer needed to scroll almost to the bottom of the 164-page document to a page specific to preventive medication coverage to unearth this information.

We also observed that the tiers themselves could be confusing. As reflected in Table E in Appendix B, carriers defined the tiers in different ways. Three carriers, A, C, and D, put all generics in their lowest, non-preventive services tier. Carrier B, however, divided generics between Tiers 1 and 3, and Carrier E classified generics in all three of its tiers. All five carriers denoted drugs as specialty medications, but only one, Carrier D, appeared to have a Tier 4 for specialty drugs.[193] Four of the carriers also had tiers or at least categories devoted to preventive services, although they did not all use the same names for these tiers. Carriers B and D put preventive drugs in Tier 0, Carrier C placed them in Tier A, and Carrier E designated preventive drugs as "HCR Preventive Care." These variations made it very difficult for consumers to compare plan features.

Another transparency concern with formularies is that the tiers standing alone do not provide much information to consumers about how much different drugs will cost them. In our survey, that a given drug was in Tier 3 could have meant that a consumer had to pay a $75 copayment, 30% coinsurance,

[193] Carrier D's tiers were confusing. Its searchable formulary did not define all of the tiers in one place, but when a consumer searched for a specific drug, the search return identified which of four tiers the drug was in: Tier 1 – Generic Drugs, Tier 2 - Preferred Brand-Names, Tier 3 – Non-preferred Brands, or Tier 4 – Specialty Drugs. But we also identified a formulary medicine list for Carrier D, which said that it used three tiers, Tier 3 being Non-Preferred Brand-Names and Specialty Tier Medicines. This separate file indicated which drugs were specialty drugs by an "SP" icon next to the drug name. Given that healthcare.gov directs consumers to Carrier D's search feature rather than the separate medicine list, we are characterizing Carrier D as having a 4-tier system, but it is not clear how it tiers specialty drugs. In the two Carrier D plans we evaluated, the SBCs showed that the cost-sharing was the same for Tier 3 and the Specialty Tier, so whether specialty drugs were deemed to be in Tier 3 or 4 would not make a substantive difference to consumers.

It also was not clear how Carrier A handled specialty drugs. Its SBCs listed a fourth tier for Specialty Drugs, although its formulary noted specialty drugs with a special notation in the table of covered drugs. Because the cost-sharing was the same in the SBC for Tier 3 and the Specialty Tier, we are following the formulary and describing Carrier A's coverage in terms of three tiers.

or 50% coinsurance, depending on the particular plan. Tier 1 also ranged from a $0 copayment to a 50% coinsurance in the plans we surveyed.

The amount of cost-sharing for a given tier also can vary from plan to plan for the same carrier. For example, Carrier B's Tier 3 carried a $75 copay in one of the silver plans analyzed and a 50% coinsurance in another. Consumers needed to cross-reference the SBC and formulary to learn what cost-sharing applied to a given drug in a given tier for each plan that s/he was considering. Moreover, when the cost-sharing was in the form of coinsurance, which is a percentage of the cost, rather than fixed copays, the formularies did not provide reference prices, so consumers were not able to calculate what their likely out-of-pocket costs would be.

In addition, some plans put medications in tiers that did not satisfy the definitions that the plan had chosen to employ for its tiers. For example, Carriers C and D assigned some forms of the generic drug, clozapine, to Tier 3, which these carriers defined as non-preferred brand name drugs, rather than to Tier 1, the only tier in their respective formularies that included generics. In Carrier C's median premium plan, this categorization meant the difference between a $15 retail copay in Tier 1 and a 50% coinsurance in Tier 3, and in Carrier D's lowest premium plan, Tier 1 had no copay whereas Tier 3 had 50% coinsurance. Further scrutiny is appropriate to evaluate the propriety of putting a generic drug in a non-preferred brand tier.

There also were plans that created tiers that were meaningless distinctions because the cost-sharing was the same for several tiers. In two of the plans offered by Carrier A, for example, there were three tiers, Generic, Preferred Brand, and Non-preferred Brand. While generic drugs had a $7 copay, all other drugs, regardless which of the two other tiers they were placed in, had a 50% coinsurance up to a maximum of $125. In the two other Carrier A plans surveyed, all three tiers had the same cost-sharing, a 50% coinsurance up to a maximum of $125. It is not clear why the carrier chose to stratify drugs into categories that had no practical impact on coverage.

Another source of confusion could stem from plans having tiered provider networks as well as tiered formularies. Consumers may not understand which tier the SBC is referencing and how it impacts their coverage and out-of-pocket responsibilities. In addition, the SBC template only provided two columns, one for in-network and one for out-of-network costs, and it did not account for plans that tier within these categories.

* * *

In short, it is an arduous process for consumers to identify, understand, compartmentalize, and compare the information they need to assess plan options – much less to evaluate if plans are complying with the ACA's market reforms and providing access to BH services in parity with medical services. It is imperative to improve transparency and functionality of SBCs, formularies, and provider directories. As part of its efforts to increase the accuracy and transparency of provider directories and drug formularies, CMS is requiring plans to make their up-to-date and accurate provider directories and formularies publicly

available on their web sites in a machine-readable file format specified by HHS.[194] HHS expressly intends for third parties to create "user-friendly aggregated information sources" on different plans to increase transparency and consumer understanding of plan design and coverage options.[195] Having access to machine-readable data should make it easier for advocates, consumers, and researchers to compare provider networks and drug formularies, which could help identify possible discriminatory plan designs or parity violations. But these standardized formats will not reveal the standards used to develop networks or formularies nor how these standards are applied, which are essential components of a comprehensive parity analysis.

2. Survey of Carrier Filings to New Jersey Department of Banking & Insurance

In addition to evaluating what information is readily available to consumers when they shop for and try to evaluate plans, we also took a closer look at what information regulators evaluate and what they do to monitor plans for compliance with the ACA's anti-discrimination principles and MH parity requirements.

a. Overview of DOBI's Regulatory Oversight of Marketplace Plans

States have primary responsibility for regulating insurance and are responsible for enforcing the ACA's market provisions, which include the parity requirements.[196] In addition, New Jersey makes recommendations to CMS regarding which plans CMS should certify as QHPs.[197] CMS will ask DOBI to confirm that plans seeking to be offered through the federal Marketplace satisfy state laws regulating insurance as well as a number of QHP requirements such as EHBs, which include MH parity requirements, and network adequacy.[198] It thus is important to understand New Jersey's enforcement structures and tools and what information the State reviews to fulfill its enforcement responsibilities.

We spoke with representatives of New Jersey's DOBI to learn what tools DOBI uses to monitor carriers' compliance with federal and state requirements. In addition to financial filings to assess carrier solvency and the like, DOBI also employs a number of tools to monitor market behavior.

DOBI receives, investigates, and tracks complaints from providers and consumers regarding plan behavior. Often DOBI works with the carrier to resolve the complaint, and both the complaint and its

[194] *See 2016 Letter to Issuers*, *supra* note 120, at 24, 39.

[195] *See id.*

[196] *See* 42 U.S.C. § 300gg-22(a); 45 C.F.R. § 101(b)(1); *2016 Letter to Issuers*, *supra* note 120, at 5 n.3; Final Parity Rule Preamble, *supra* note 20, 78 Fed. Reg. at 68,252.

[197] *See 2016 Letter to Issuers*, *supra* note 120, at 5-6.

[198] *See id.* at 5-6, 10, 21-23, 36.

resolution are not matters of public record.[199] DOBI also conducts market conduct examinations.[200] Sometimes these are done as a matter of course, on a cyclical basis. DOBI also may initiate a market conduct examination in response to a trigger, such as a high number of denials for coverage of a particular drug. Similarly, the Commissioner has authority to conduct a limited scope examination of a carrier's method of conducting business, at the expense of the carrier.[201] The Department does not conduct consumer surveys.

In addition, carriers are required to submit information about their plan designs to DOBI. When carriers seek licensure, for example, they file information about their networks. HMOs in New Jersey are required to file annual supplement reports each March 1 with DOBI.[202] Selective Contracting Arrangements (SCAs)[203] and Certified (but not licensed) Organized Delivery Systems (ODSs)[204] also have annual filing requirements.

DOBI requires all managed care plans to develop a utilization management plan (UM Plan), which must be made available to DOBI.[205] Like with their directories, carriers must file their UM plans with their license applications. DOBI reported that this generally is a one-time filing requirement. Plans must ensure

[199] We were unable to obtain any information about the specific complaints that DOBI has received because the Department takes the position that all information about pending or completed investigations, including redacted abstracts or summaries of them, are confidential unless they result in formal disciplinary action, citing N.J.A.C. 11:17-2.16(b)(6) (finding that "[i]nvestigative files in any matter pending investigation, or in any completed investigation in which no formal disciplinary action was taken" are "nonpublic records in accordance with N.J.S.A. 47:1A-1 et seq."). While this regulation provides that the investigative files are confidential, it is not clear that redacted summaries describing the types of issues being raised in complaints constitute investigative files.

[200] *See* STATE OF N.J. DEP'T OF BANKING & INS., *Health Maintenance Organizations (HMOs) Regulatory Requirements*, http://www.state.nj.us/dobi/division_insurance/managedcare/hmoregreq.htm (last visited Sept. 6, 2015).

[201] *See* N.J.S.A. §§ 17:48E-37; 26:2J-18.1 (HMOs).

[202] *See* N.J.A.C. §§ 11:24-3.8(a)(2), 11.6(c).

[203] *See id.* § 11:4-37.4(e). DOBI approves selective contracting arrangements (SCAs), which are arrangements "for the payment of predetermined fees or reimbursement levels for covered services by the carrier to network providers, HMOs, certified ODSs, licensed ODSs or, with respect to prescription drug coverage only, to PPOs." STATE OF N.J., DEP'T OF BANKING & INS., *Selective Contracting Arrangements (SCAs)*, http://www.state.nj.us/dobi/division_insurance/managedcare/scas.htm (last visited Sept. 7, 2015). According to DOBI's web site, BH is among the five most common types of SCAs. *See* N.J.A.C. § 11:4-37.2.

[204] *See* STATE OF N.J., DEP'T OF BANKING & INS., *2014 Certified Organized Delivery System (ODS) Annual Report Form* (on file with authors) [hereinafter 2014 ODS Annual Report Form]. We note that although a regulation requires various financial filings each year by ODSs, *see* N.J.A.C. § 11:22-4.9, we did not identify a statute or regulation that requires this specific ODS annual regulatory filing.

It has become commonplace for a carrier to contract with a legal entity called an Organized Delivery System (ODS) to provide or arrange for the provision of health care services to those covered under the carrier's plan. *See* N.J.A.C. § 11:24B-1.2. Some common types of ODSs are preferred provider organizations (PPOs), Physician Hospital Organizations (PHOs), and Independent Practice Associations (IPAs). *See* STATE OF N.J., DEP'T OF BANKING & INS., *Organized Delivery Systems*, http://www.state.nj.us/dobi/division_insurance/managedcare/mcods.htm (last visited Sept. 7, 2015). In New Jersey, DOBI generally licenses ODSs that assume financial risk and certifies those that assume no more than *de minimis* financial risk. *See* N.J.A.C. § 11:22-4.2.

[205] *See* N.J.A.C. § 11:24-8.1(a); N.J.A.C. §24A-3.4(a).

that they remain in compliance with the substantive regulatory requirements concerning UM, but they are not required to refile their UM Plans if they change. DOBI's annual HMO supplement template, however, requires HMOs to submit their UM Plans as an attachment to each year's filing.[206] HMOs also must submit with their annual supplement copies of the most recent oversight reports for any vendor to which it delegates services, including BH.[207] Some BH vendors or BHOs are certified ODSs, and so they file an ODS Annual Report. But the filing requirements for licensed ODSs are keyed to financial solvency because licensed ODSs take on risk, and they do not have a plan design filing obligation. If an HMO contracts with a BHO, the HMO's annual supplement will include information from the BHO regarding BH complaints and UM appeals.

These different reports contain varying amounts of information, as discussed in more detail in the subsections that follow. DOBI reviews these reports for gaps, but it generally does not test their accuracy. For example, the HMO annual supplements contain information on the provider networks for each managed care plan. DOBI does not independently verify that the networks comply with the state's network adequacy rules. The Department may conduct a survey of a network if it receives complaints about a phantom network, but generally the Department does not conduct secret shopper surveys to verify the accuracy of networks.

DOBI also does not require any special filing from plans to demonstrate compliance with parity. Some information relevant to the parity analysis is contained in existing filings. For example, the policy form requires disclosure of PA requirements for different drugs. As a general matter, DOBI represented that it knows that plans on the Marketplace comply with parity because they must comply with the state's standardized benefit plans. But New Jersey individual and small group standardized plans do not address a number of plan design features that are essential aspects of parity analysis. For example, New Jersey individual and small group standard plans do not standardize a number of NQTLs, such as UM standards and tools, formulary design, and reimbursement rates or credentialing processes for providers.[208] Although several of the standard plans establish specific copays for physician visits, some leave room for variation. An exemplar EPO plan, for example, categorically permits higher copays for specialists than primary care physicians without reference to the substantially all and predominant requirements of the quantitative parity analysis.[209] Parity enforcement requires the quantitative parity test for financial limits

[206] *See* STATE OF N.J. DEP'T OF BANKING & INS., *2014 HMO Annual Supplement Commercial Report Form*, § K(1) [hereinafter 2014 HMO Annual Supplement Commercial Form] (on file with authors). The 2014 HMO Annual Supplement Commercial Form, which carriers filed in 2015 and we evaluated, no longer is available on DOBI's web site because it has been replaced by the 2015 HMO Annual Supplement Commercial supplement, which carriers were due to file in March 2016. *See* 2015 HMO Annual Supplement Commercial Form, *available at* http://www.state.nj.us/dobi/division_insurance/managedcare/hmopage.htm. Although DOBI made some minor adjustments to the 2015 form, they do not address the issues that we highlight in this Report.

[207] *See* 2014 HMO Annual Supplement Commercial Form, *supra* note 206, at Section Q.

[208] *See* STATE OF N.J., DEP'T OF BANKING & INS., IHC Program Forms, http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcforms.html (last visited May 24, 2016); STATE OF N.J., DEP'T OF BANKING & INS., SEH Program Forms, http://www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html (last visited May 24, 2016).

[209] *See* IHC Standard Policy Form, *supra* note 150, at 25 (Example EPO (with PCP Copayment)); *see also* discussion of application of parity requirements to copays in Section III.B.1.a, *supra* and in discussion of California's parity enforcement efforts in Section IV.A.2.c, *infra*..

and QTLs and analysis of NQTL standards and application of those standards for each type of limitation and in each parity classification.

In response to questions, DOBI acknowledged that if it recognizes a significant disparity between approvals of inpatient psychiatric and inpatient med/surg treatment, for example, it may need to determine if there is a NQTL problem with the approval process. When asked how the Department would detect such a disparity, the regulators seemed to believe that consumers would raise concerns. But DOBI also has acknowledged that few patients are filing complaints, and in fact DOBI recently has noticed a drop in the numbers of appeals filed. It thus is not clear how these disparities would be unearthed by the existing regulatory processes in New Jersey.

There are some regulatory gaps regarding reporting requirements. Two carriers that sold plans on healthcare.gov in New Jersey in 2015 are licensed insurers and not HMOs. They have to file financial reports keyed to solvency, but they do not have an annual reporting requirement that gets to issues of network configuration or UM akin to the reporting obligation of HMOs, ODSs, or SCAs. Another example of a regulatory gap concerns SCA reporting requirements. If a company wants to offer a PPO product using its service corporation license and not its HMO paper, it is not legally obligated to file SCA reports.

b. Analyzing Templates for Annual Filings to DOBI

We examined the templates for the HMO,[210] ODS,[211] and SCA[212] reports that DOBI required carriers to file in 2015 for the 2014 plan year to get a better understanding of the kinds of information available to regulators.

The 2014 HMO Annual Supplement reporting form that DOBI used required a wealth of information from the preceding plan year, including detailed narratives about the methods of maintaining, monitoring, or executing specific health services, the provider network, ambulatory utilization data, member complaints, UM, medical expenses by type of payment, internal and external UM appeal processes, among others.[213]

---

[210] *See* 2014 HMO Annual Supplement Commercial Form, *supra* note 206.

[211] *See* 2014 ODS Annual Report Form, *supra* note 204. The 2014 ODS Annual Report Form, which carriers filed in 2015 and we evaluated, no longer is available on DOBI's web site because it has been replaced by the 2015 ODS Annual Report Form, which carriers were due to file in 2016. *See* STATE OF N.J., DEP'T OF BANKING & INS., *2015 Certified Organized Delivery System (ODS) Annual Report*, *available at* http://www.state.nj.us/dobi/formlist.htm#insuranceformsandapps. Although DOBI made some minor adjustments to the 2015 form, they do not address the issues that we highlight in this Report.

[212] STATE OF N.J., DEP'T OF BANKING & INS., *2014 SCA Annual Report Form* (on file with authors) [hereinafter 2014 SCA Annual Report Form]. The 2014 SCA Annual Report Form, which carriers filed in May 2015 and we evaluated, no longer is available on DOBI's web site because it has been replaced by the 2015 SCA Annual Report Form, which carriers were due to file in May 2016. *See* 2015 SCA Annual Report Form, *available at* http://www.state.nj.us/dobi/formlist.htm#insuranceformsandapps. Although DOBI made some minor adjustments to the 2015 form, they do not address the issues that we highlight in this Report.

[213] *See* 2014 HMO Annual Supplement Commercial Form, *supra* note 206.

Section E, for example, required carriers to provide information about their network(s) of providers. In addition to providing the numbers of providers per county and region in the state, it also asked for narrative responses about the plan's processes and procedures for satisfying network adequacy requirements, including:

- Explain how the HMO maintains and monitors the network of contracted providers to ensure that the number and type of providers is sufficient to meet the needs of the population served.
- Explain the process for maintaining a current Provider Directory. This explanation should address how the HMO monitors the status of providers panels to ensure that providers are continuing to accept new patients. How frequently is the Provider Directory updated?

The reporting table that asked about physician turnover only asked about primary care physicians, gynecologists, obstetricians/gynecologists, and all other physicians; it did not seek data specific to BH or SUD physicians. Similarly, the tables collecting data about the number of primary care and 21 different specialty physicians in each county and in different regions of the state did not ask about psychiatrists[214] – even though psychiatrists are among the thirteen specialties itemized in New Jersey's network adequacy regulations.[215]

Instead, on the ancillary and specialized provider table, the report asked for the number of a variety of BH and SUD providers, including psychiatrists, psychologists, licensed clinical social workers, board certified behavior analysts (BCBAs), inpatient psychiatric and substance abuse treatment facilities, outpatient psychiatric and substance abuse centers, among others. But when it did, it only asked for the number in each county and did not seek separate numbers for those in adjacent counties,[216] as the report did on the regional charts for physicians. As a result, carriers often reported the aggregate number of providers in the county as well as in adjacent counties, which, despite an explanatory asterisk, can obscure the fact that a number of counties did not have any BH and SUD providers, as discussed below.

Moreover, the state's network adequacy regulations are not written simply in terms of numbers of providers per county. Rather, they focus on geographic proximity in terms of miles and driving distance between providers and beneficiaries,[217] which cannot be assessed with only the number of providers per county. Although New Jersey's network adequacy regulation does not address wait times and provider capacity for specialists, as it does for primary care providers,[218] it does require carriers to maintain an "adequate network" or "a sufficient number" of specialists. The network adequacy tables in the carrier filings did not provide any information to evaluate whether the number of providers per county was adequate or sufficient, given beneficiary needs or provider capacity. The data required in the network charts also did not permit a full parity analysis. They did not contain information about credentialing standards or reimbursement rates, for example.

[214] *See id.*, Tables E(i)-(ii).
[215] *See* N.J.A.C. § 11:24-6.2(a)(1)(ii)(12).
[216] *See* 2014 HMO Annual Supplement Commercial Form, *supra* note 206, Table E(iv).
[217] *See* N.J.A.C. §§ 11:24-6.1(a)(1)(ii)-(iii); 11:24-6.3(a)(3)(ii).
[218] *Id.* §§ 11:24-6.2(a) & (a)(1)(ii).

In collecting data, the HMO annual supplements often required carriers to report data separately for BH, SUD, and physical health. For example, when it collected ambulatory utilization data in Section F, it required carriers to provide data separately for inpatient and outpatient services for a number of types of care, including BH and for substance abuse referral and treatment. Similarly, Section G collected data for both in-network and out-of-network facilities for both inpatient and outpatient services, and BH and SUD services each were separately reported in each of these categories. Section I required carriers to report member complaints separately for BH, substance abuse treatment, and all other complaints. Carriers also had to divide complaints into categories and did so separately for BH, SUD, and all other complaints. UM of inpatient services in Section L of the report also required a fair amount of categorization that was consistent with parity categories, including requiring data to be reported separately for in-network and out-of-network inpatient services. Internal UM appeals in Section N also must be reported separately for formulary, BH, SUD, and all other UM appeals. In collecting data on medical expenses by type of payment, Section H also required separate data for both BH and SUD expenses, but it did not separate off in-network and out-of-network or specify whether the charges were for inpatient or outpatient services, which distinctions are relevant for the parity classifications.

Some sections of the HMO annual supplements, however, did not require the separate reporting of BH and SUD data, which makes it more difficult to monitor for differential treatment. Section K, for example, required data on UM requests and denials for formulary requests as an aggregated category and did not subdivide the data into UM requests for drugs prescribed for BH, SUD, and physical health diagnoses. Although BH and SUD UM requests were reported separately than general medical, they were lumped together as one category. Section J also did not track provider complaints separately for BH or SUD providers, so it is not possible to look for possible differential treatment. Although BH, SUD, and other physical health internal UM appeals were reported separately, internal UM formulary appeals were not categorized by type, and they were not broken down by whether the drug was being prescribed to treat a medical, BH, or SUD primary diagnosis. In Section O, the report collapsed all external UM appeals data and did not differentiate external UM appeals based on med/surg, BH, or SUD services.[219] The report did not even have a category for UM external appeals specific to BH or SUD appeals.

Interestingly, although the HMO annual supplement requires carriers to categorize complaint and appeals data, it employed different categories for BH and SUD complaints and appeals than it did for all other complaints. Some of the differences make sense, such as excluding dental and vision care questions from the BH/SUD table. But the reasons for other variations are not as clear. For example, the BH/SUD chart did not ask about complaints for laboratory issues. In addition, the BH/SUD chart did not require HMOs to report the number of internal UM appeals for denials of covered medications even though that information was tracked for med/surg appeals.[220] The BH/SUD chart also did not include categories for appeals of denial of outpatient medical treatment/diagnostic testing, denial of outpatient rehabilitation therapy, or service considered experimental/investigational even though these categories – or at least close analogues to them – seem to be relevant in the BH/SUD context as well. These category variations

[219] *See* 2014 HMO Annual Supplement Commercial Form, *supra* note 206, Section O.
[220] *See id.*, Section N, Table III.

make it more difficult to compare complaints to look for possible discriminatory plan designs or parity violations.

It is noteworthy that Section C of the HMO supplement collected a wide array of information about benefit design both in- and out-of-network, such as differences in copayments, deductibles, coinsurance, numerical benefit caps, and limits on benefits in a variety of categories, including inpatient psychiatric care, inpatient SUD care, outpatient MH services, outpatient SUD, services for biologically-based mental illness, among others. Like an SBC, it did not provide enough information to perform a comprehensive parity analysis. However, regulators and activists could get a good sense of the plan design and begin to assess where they might focus efforts for a full parity review. But only large group commercial plans needed to populate this section of the 2015 HMO supplement report.

Both the 2014 Certified ODS Annual Report and the 2014 SCA Annual Report required similar but generally less information than the HMO supplement. The 2014 ODS Annual Report template, for example, was only six pages long, compared to the 40-sheet 2014 HMO Supplement spreadsheet template. The ODS report only asked for the top three categories of provider and member complaints received. It also did not require carriers to provide data on BH and SUD services separate from other health care services. The ODS report, however, did require some additional information that the HMO supplement did not but that may be worth obtaining for all managed care plans, such as a description of how providers can access a copy of the ODS' internal UM criteria, a summary of the nature of any written comments submitted by providers regarding the internal UM criteria, and mechanisms used by the ODS to detect under and over utilization of services.

The 2014 SCA Annual Report, in turn, required even less information than the ODS report. It focused on getting contact information for the network and plan experience and membership; it did not ask about the process of developing or maintaining the network nor about complaints received about the network. The SCA Annual Report did require a copy of the vendor oversight report, which may contain useful information. We did not receive the oversight reports filed with SCAs in 2015, however, so we were unable to evaluate their substance and structure.

Based on this review of the 2014 Annual Report templates, there is good reason to be concerned that State regulators are not able to assess parity and otherwise effectively monitor ACA compliance based on the reports carriers are filing with DOBI.

The Drug Policy and Public Health Strategies Clinic at the University of Maryland Carey School of Law reached a similar conclusion after reviewing all publicly available plan documents from the Maryland Insurance Administration (MIA), which included all forms included in the Evidence of Coverage, including all attachments. The Clinic and eighteen provider and consumer organizations and coalitions expressed its concerns in a letter to CMS in July 2014, stating that because the MIA does not review most NQTLs, it cannot ensure that plans offered through the Marketplace comply with parity requirements.[221] CMS

[221] *See* Letter from Ellen M. Weber, Professor of Law and Supervisor, Drug Policy and Public Health Strategies Clinic, University of Maryland Francis King Carey School of Law, *et al*., to Steve Chu & Jeffrey Kelman, Centers for Medicare & Medicaid Servcs., July 11, 2014, at 1, 4 (on file with authors).

responded to this letter by indicating that it was analyzing comments it had received regarding how to improve transparency to consumers, including regarding NQTLs, and that it plans to initiate further discussions with stakeholders to determine how to make the NQTL process more transparent.[222] The Sentinel Project intends to play a role in these discussions.

In sum, while HMO Annual Reports gather a rich collection of data about plan design, there are a number of potential structural and substantive flaws with the HMO supplement reports that, if addressed, could support more effective regulatory oversight and enforcement. The above overview highlights some of these issues, such as inconsistently collecting separate data on BH and SUD services. It also would be helpful to consider how the report could incorporate elements that would facilitate the parity analysis, including having carriers report data in the parity categories, provide the methodology for the quantitative parity analysis, identify NQTLs, and elicit narratives regarding the selection of standards for NQTLs and how they are being applied. DOBI has authority under the applicable New Jersey regulations to prescribe the format of these reports.[223]

DOBI should also consider what entities should file these reports. Presently, only New Jersey HMOs are required to file the more comprehensive reports. That means only three of the five insurers offering plans in the federal Marketplace in New Jersey in 2015 were required to file these reports, and only for their HMO lines of business. HMOs are a shrinking portion of New Jersey's individual market. In the fourth quarter of 2014, only 15.22% of covered lives in contracts issued through the Marketplace in New Jersey were in HMO standard plans.[224] It is not apparent why HMOs should be treated differently than other managed care plans. Given the need to monitor and enforce compliance with the ACA and parity laws, it would seem all managed care plans should be required to file reports that include meaningful, comprehensive data that facilitates efficient monitoring and enforcement.

In addition, these reports reflect a carrier's entire HMO book of business and are not broken down by market much less by plan. It is difficult, if not impossible, to evaluate whether a particular plan is in compliance with the ACA's market reforms and parity requirements if the reporting is at the carrier level. Network adequacy can be evaluated at the carrier level, if the carrier uses the same network for all plans. But complaints, appeals, and UM, for example, could vary substantially at the plan versus the carrier level.

c. Observations from Review of 2015 Regulatory Filings

Although New Jersey's regulatory filings have shortcomings that limit the extent to which regulators may effectively rely on them to monitor plan behavior for compliance with the ACA's non-

[222] *See* Letter from Kevin Counihan, Chief Executive Officer, Health Insurance Marketplace, Director, Center for Consumer Information & Ins. Oversight, Centers for Medicare & Medicaid Servcs., to Professor Ellen M. Weber, Professor of Law and Supervisor, Drug Policy and Public Health Strategies Clinic, Oct. 20, 2014, at 1-2 (on file with authors).

[223] *See, e.g.,* N.J.A.C. §§ 11:24-3.8, 11:24-11.6, 11:4-37.4(e). *See* Section IV.A.2, *infra* for a discussion of efforts in other states like California to use regulatory filings to improve parity compliance.

[224] *See* N.J. Dep't of Banking & Ins., Individual Health Coverage Program, 4Q2014 Enrollment Report, http://www.state.nj.us/dobi/division_insurance/ihcseh/enroll/4q14ihcmarket.pdf (last visited Sept. 27, 2015).

discrimination provisions and market reform requirements, including parity, the information collected can provide some indication of market behavior. Accordingly, we took a closer look at the regulatory filings filed in spring 2015 to see if they reveal potential areas of concern where regulators, advocates, and researchers might focus their attention. Specifically, we requested from DOBI copies of all HMO annual supplements filed in March 2015 for the 2014 plan year, including copies of the UM Plans that are required to be attached to the reports.[225] We also reviewed the ODS report filed by a vendor used by an insurer that offered plans in the federal Marketplace in New Jersey in 2014 but that was not independently required to file a HMO supplement, ODS, or SCA report with DOBI. In addition, we reviewed one SCA report filed by a carrier offering plans in the Marketplace for, among other things, a selective contracting arrangement with a BH certified ODS.[226] What follows are observations we made as we reviewed these filings. Given the limitations in the information available, these observations do not establish violations. But they do raise questions that warrant further inquiry.

The bulk of our observations concern the HMO supplement filings that three of the five insurers that offered products in the federal Marketplace in New Jersey in 2014 had to file with DOBI. The first observation is how little of the data contained in the HMO supplement concerned the individual market, which is where our project is focused. While 28.5% of Carrier A's HMO business involved individual market plans, both on and off-Exchange, a mere 1.4% of Carrier C's and 1.2% of Carrier E's HMO business derived from the individual market. Small group market plans made up a somewhat larger (but still minority) percentage of each carrier's HMO business: 24.9% for Carrier A, 3.7% for Carrier C, and 12.9% for Carrier E. Medicare represented the largest percentage of all three carriers' HMO business.

We also observed how little of the carriers' HMO business involved BH and SUD services. As reflected in Table F in Appendix B, BH services constituted only 0.24% of Carrier A's, 0.04% of Carrier C's, and 1.6% of Carrier E's total in-network inpatient facility expenses; 0% of Carrier A's, 0.6% of Carrier C's, and 0.03% of Carrier E's total in-network outpatient facility expenses; and 0.14% of Carrier A's, 0.045% of Carrier C's, and 0.9% of Carrier E's total in-network hospital expenses. The numbers were equally low for in-patient SUD services: SUD treatment services constituted only 0.28% of Carrier A's, 0.006% of Carrier C's, and 0.38% of Carrier E's total in-network inpatient facility expenses; 0% of Carrier A's, 0.008% of Carrier C's, and 0% of Carrier E's total in-network outpatient facility expenses; and 0.17% of Carrier A's, 0.007% of Carrier C's, and 0.2% of Carrier E's total in-network hospital expenses.

Similarly, Table G in Appendix B reflects how generally few ambulatory encounters there were for BH or SUD treatment. For Carrier A, BH was 0.6% and SUD was 0.5% of total ambulatory encounters; for Carrier C, BH was 0.7% and SUD was 0.02% of total ambulatory encounters; and for Carrier E, BH was 8.6% (significantly higher, but still not an overwhelming percentage) and SUD was 0.7% of total ambulatory encounters. Based on data from Section H of the HMO supplement reports, as a percentage of total

[225] Initially DOBI indicated that the UM Plans were confidential. But after reviewing our request, DOBI released the UM Plans to us after determining that they did not contain any proprietary information.

[226] The same carrier filed a second SCA Annual Report in 2015, but it did not report any individual market business for that arrangement, so we did not include it in our study. The remainder of the SCA reports that we received seemed to be for products that were not within the scope of our project, such as vision or dental plans or coverage in the large group market, so we did not include them in our study.

expenses for primary care physicians, referral/specialty physicians, oral surgeons, podiatrists, optometrists, BH, SU, Laboratory, Radiology, Pharmacy, and other individual providers, Carrier A spent 3.4% on BH and 0% on SU; Carrier C spent 4.6% on BH and 0.02% on SU; and Carrier E spent 2.7% on BH and 0.74% on SU. These numbers are so incredibly low that either there was very little spending on BH and SUD services, which raises concerns about access to these EHBs, or these reports fail to reflect the spending on these services, which suggests the need to reform how carriers report to DOBI.

Interestingly, in some instances, BH and SUD member complaints represented a higher percentage of total complaints filed than BH and SUD services were a percentage of total services or spending. As reflected in Table H in Appendix B, for example, 16 (7.4%) of the 217 member complaints filed with Carrier A were BH and 10 (4.6%) were SU; and 5 (0.5%) of 968 complaints filed with Carrier C were BH, which percentages are considerably higher than the percentages of services and spending reported in Tables F and G and summarized above.

Although the numbers were small, making it difficult to draw definitive observations, there were some interesting findings when we examined the UM appeals data. As reflected in Tables I and J in Appendix B, all of Carrier E's stage 1 and stage 2 internal SUD UM appeals involved reductions in acuity level, which is consistent with concerns expressed to us by SUD providers and advocates. The vast majority of Carrier C's categorized stage 1 internal BH UM appeals and internal SUD UM appeals concerned denial of inpatient admissions, compared with only 2.6% of Carrier C's non-BH stage 1 internal appeals (Table I). Similarly, two out of Carrier A's 3 (66.7%) BH stage 1 internal UM appeals and 54.5% of its SUD stage 1 internal appeals involved denial of inpatient hospital days, compared with only 19.7% of its non-BH stage 1 internal UM appeals.

There are similar trends reflected in Table J regarding stage 2 UM internal appeals. Two of the three (66.7%) Carrier A SUD stage 2 internal UM appeals involved denial of inpatient hospital days, compared with only 36.8% of non-BH stage 2 internal UM appeals. While 16.7% of Carrier C's BH and 12.5% of its SUD stage 2 internal UM appeals involved denial of inpatient hospital days, none of its non-BH stage 2 internal UM appeals did.

The external appeals data in Table K in Appendix B generally were not helpful for our purposes because they do not separate out BH and SUD from physical health appeals. The categories for external appeals also did not map those used for internal appeals, which further frustrated comparisons. However, when Carrier A voluntarily added "Denial of BH/SA – inpatient and outpatient" to its report, one of its four (25%) external appeals fell into that category. It would be interesting to know how many other external appeals involved BH or SUD services, but the 2014 (and 2015) report did not require data to be reported in this manner.

These tables regarding appeals also revealed that significant percentages of BH and SUD stage 1 and 2 appeals were categorized as "other" – for example, 81.6% of Carrier C's and 45.5% of Carrier A's stage 1 SUD internal appeals, and 87.5% of Carrier C's stage 2 SUD and 83.3% of its stage 2 BH internal appeals. This suggests to us that perhaps the template needs to be updated to include more categories

that reflect the common BH and SUD bases for appeals. Carriers also need to be pressed to explain their use of the "other" designation to permit DOBI to track the reasons being given.

Although BH and SUD represented strikingly small percentages of Carrier C's ambulatory encounters (0.7% BH and 0.02% SUD), in-network inpatient facility expenses (0.04% BH and 0.006% SUD), in-network outpatient facility expenses (0.6% BH and 0.008 SUD), in-network hospital expenses (0.045% BH and 0.007% SUD), and expenditures on a number of providers (4.6% BH and 0.02% SUD), as discussed above, BH/SUD UM requests represented 11.8% of Carrier C's UM requests (Table I, Appendix B). Interestingly, however, Carrier C's rate of denial for BH/SUD UM requests (6.7%) was nearly half the rate for general medical UM request denials (12.3%) (Table L, Appendix B).

The percentage of denials of UM requests was higher for BH/SUD than for general medical for some carriers, however. As summarized in Table L in Appendix B, Carrier E's rate of denial of BH/SUD UM requests (19.8%) was more than five times its percentage of denials of general medical UM requests (3.9%). Carrier A, in turn, denied three times as many BH/SUD UM requests (12.7%) as it did general medical UM requests (3.8%). Without knowing more about the UM standards employed to determine these requests and how they were applied, it is difficult to determine if these variations reflect discrimination or parity violations. But they raise a question that deserves further scrutiny to ensure UM policies are not being applied in a more stringent manner to BH/SUD services. It also might help if the annual report required carriers to report the reasons for the denials to help DOBI monitor for patterns.

Table L also shows that formularies represented a large percentage of the UM requests for two carriers – 29.7% for Carrier A and 28.4% for Carrier E. Formulary UM requests also were denied at fairly high rates – 38.19% for Carrier A, 37.9% for Carrier C, and 17.4% for Carrier E. Because formulary UM data were not broken down by whether the primary diagnosis code was to treat medical, BH, or SUD conditions, it is not possible to determine if these signal any parity or discrimination concerns.

Table M in Appendix B reports data on utilization of inpatient services, which revealed some interesting numbers. Consistent with the UM appeals data discussed above, Carrier A denied 12.8% of in-network BH admissions sought and 11.8% of SUD admissions sought, although it only denied 0.7% of in-network med/surg admissions sought. Carrier A also denied a large percentage of in-network psychiatric hospital (16.2%) and residential SUD admissions sought (13.8%). While Carrier C denied similar percentages of in-network BH (4.1%), SUD (5.6%), and med/surg admissions (4.4%), it denied far greater percentages of BH (62.5%) and SUD (33.3%) out-of-network admissions than it did of med/surg out-of-network admissions (2.7%). These findings warrant follow-up to explore whether the reasons for the denials were justified or signal impermissible discrimination or violations of parity.

Both the HMO supplement and ODS Annual Reports also raised questions about network adequacy. This is not a surprise, given that CMS identified MH providers as a type of provider that has "historically raised network adequacy concerns" and that CMS, as a result, will focus most closely on when it analyzes carrier network data.[227]

[227] *2016 Letter to Issuers*, *supra* note 120, at 23; DEPT. OF HEALTH & HUMAN SERVCS., CENTERS FOR MEDICARE & MEDICAID SERVS., CENTER FOR CONSUMER INFO. & INS. OVERSIGHT, *2017 Letter to Issuers in the Federally-facilitated*

As noted above,[228] we do not have the data or the software needed to assess the distance from beneficiaries to providers, the demand for services in a given region, and the capacity of providers to meet that demand, which we need to determine if a network is adequate. That said, scanning the network charts raised some red flags that warrant follow-up.

For example, the chart of ancillary and specialty providers in the HMO supplement revealed the following about Carrier A's network in 2014: 5 counties (Cape May, Hunterdon, Passaic, Salem, and Warren) did not have an inpatient adult psychiatric facility in-network; 12 of 21 counties lacked a single inpatient pediatric psychiatric facility in-network – there were only 10 state-wide; and 11 counties did not have any inpatient substance abuse facilities in network, including Camden, Essex, Passaic, and several southern counties. There were only 3 psychiatrists in-network in Cape May County, 2 in Cumberland, and 3 in Gloucester. There then were only 3 psychologists in Cumberland County. Despite New Jersey's autism mandate,[229] there were no BCBAs in Cape May and Cumberland Counties, only 1 in Atlantic, Gloucester, Hunterdon, Salem, and Sussex Counties, 2 in Camden County, 3 in Hunterdon, Union, and Warren Counties, and 4 in Essex County. Depending on population needs and distance between beneficiaries and providers, these numbers may not satisfy network adequacy requirements.

There were similar potential network gaps in Carrier C's network: 9 of 21 counties had either none or only 1 inpatient adult psychiatric facility within the county and were relying on facilities in adjacent counties to satisfy network adequacy. As we saw with Carrier A, a significant number of these counties were clustered in southern New Jersey. There were no outpatient adult psychiatric centers in Cape May County. 10 of 21 counties either had no or only 1 inpatient pediatric psychiatric facility or outpatient pediatric psychiatric service centers within the county and were relying on facilities in adjacent counties to satisfy network adequacy. There were only 3 psychiatrists in each of Cape May and Salem Counties, and only 3 psychologists in Cape May and Cumberland Counties. Again, there were no BCBAs in-network in Cape May County, although services were provided by companies that did not have locations in these counties.

Carrier E's network filings were more voluminous but not always more informative. It had different networks for different plans, and it was not clear which plans were offered through the Marketplace. If the Freedom Plan was offered in the individual or small group market in 2014, it was not clear how it was complying with New Jersey's autism mandate because there were no BCBAs (or Board Certified Assistant Behavior Analysts (BCaBAs)) in-network in any county in the state. Generally the networks seemed more robust than the other carriers' surveyed, although there were some spots in the state with few providers that warrant closer evaluation for adequacy. Carrier E provided the names, addresses, and specialties for all providers in their networks. While this information is transparent, there

Marketplaces, at 23 (Feb. 29, 2016), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf [hereinafter *2017 Letter to Issuers*].

[228] *See supra* note 171 & accompanying text.

[229] *See supra* note 86; *see also* IHC Standard Policy Form, *supra* note 150, at 112.

is a limit to its usability. CMS's requirement that plans provide network data in machine-readable format aims to make this data more user-friendly.[230]

The ODS filing that we reviewed raised similar network adequacy concerns. The same 5 counties -- Cape May, Gloucester, Passaic, Sussex, and Warren -- lacked a single inpatient adult psychiatric facility, outpatient adult psychiatric center, inpatient pediatric psychiatric facility, or outpatient pediatric psychiatric service center. Seven counties had only 1 of each of the following: inpatient pediatric psychiatric facility, outpatient pediatric psychiatric services, inpatient SU, and outpatient SU. The ODS included only 1 psychiatrist in Cape May County, although it had 34 in adjacent counties. Salem County was left blank, so we presume that means there were no psychiatrists in-network in that county, with only 8 in adjacent counties. The number of in-network psychologists also was small, with 3 in Cape May County and 3 in Salem. Counties with densely-populated urban centers also had surprisingly low numbers of some providers. Essex and Hudson Counties, for example, each had only 1 inpatient adult psychiatric facility and 1 outpatient adult psychiatric center.

We cannot tell from these numbers alone whether the networks violate network adequacy requirements. New Jersey's network adequacy regulations are written in terms of how far providers are from beneficiaries in each county,[231] so it is possible that providers in surrounding counties are close enough to beneficiaries in counties with no or few providers to satisfy the law. To evaluate network adequacy, we need the addresses of providers and members in each county, geomapping software that can analyze the relationship of these data points in each county, and more information regarding the demand for services and the capacity of the providers. We also cannot tell from the face of the reports if these networks complied with parity. We do not know, for example, anything about the standards used to credential providers or to establish reimbursement rates, which CMS has identified as NQTLs that must be evaluated using the parity analysis.[232] But these reports raise the specter that in 2014, there were considerable network adequacy concerns in numerous counties, with heightened concerns in southern New Jersey, northwest New Jersey, and possibly in heavily populated urban centers. These concerns warrant close follow-up to ensure compliance.

One interesting aside about the ODS filing as it relates to network adequacy is that it seemed to list more specialists and subspecialists in its tables of providers than the HMO supplement, which can help identify network gaps that otherwise would go undetected. Despite this increased detail, it did not require data on child psychiatrists, although it asked about several pediatric specialists. Given the chorus of people we interviewed who noted the dearth of pediatric psychiatrists available in networks in New Jersey (and possibly just available as a supply issue, whether or not they are participating in panels), this would seem to be an important data point to monitor.

The ODS report that we reviewed also provided generally substantive, responsive narrative responses that would be useful to the regulator. For example, it provided details about the methodologies the ODS uses to ensure its network of providers remains accessible to consumers, including regular

[230] *See supra* notes 194-195 & accompanying text.
[231] *See* N.J.A.C. §§ 11:24-6.1(a)(1)(ii)-(iii); 11:24-6.3(a)(3)(ii); *supra* note 171 & accompanying text.
[232] *See supra* note 19 & accompanying text.

GeoAccess plotting, contractually requiring providers to comply with the state's regulations regarding access to PCP providers, and asking if providers are accepting new patients at recredentialing. With respect to the question about how it keeps its provider directory accurate, it mentioned, among other things, that once per year it pulls a random sample of its hard copy directory to audit for accuracy. It also provided some details regarding its UM processes, including some detail about the data it mines to detect under and over utilization of services.

By reviewing this information, the regulator can assess if these actions and processes are adequate and monitor industry for potential deficiencies as well as emerging best practices. The parity analysis, with its focus on the bases for selecting various standards and how carriers are applying those standards, seems to demand regulators to engage in granular review of narrative responses from industry that get beyond raw numbers and evaluate processes and standards in a comparative manner. The current reports do not require sufficient information to perform this analysis, but there are seeds in the current reporting that can be watered.

Not all of the carriers' narrative responses, however, were helpful. Carriers A and E's responses, for example, did not provide valuable information that would enable a regulator to monitor for compliance. Carrier E formally responded to the questions, but its responses were not very informative. For example, it unhelpfully stated that it relies on a variety of processes without detailing those processes. There was little specificity. In the HMO supplement that we received, Carrier A did not respond to these questions. Perhaps it attached its responses to the report, without indicating that within the body of the report, and we were not provided copies of those attachments.[233] But these findings remind of the need for regulators to review filings critically and carefully. To the extent a carrier fails to respond to a question or responds with conclusory statements attesting, without demonstrating, to their compliance, DOBI should reject the filing and demand a complete response.

The SCA report filed by a carrier that offered plans in the federal Marketplace in New Jersey in 2014 regarding an arrangement with a BH certified ODS, among other networks, did not provide any information that would help us assess its plan design, network configuration, or UM policies. The eight-page report primarily provided contact information and data on plan membership and plan experience. None of the data separated out BH, and there were no questions about complaints, UM requests, or appeals.

The UM Plans that HMOs have to file also did not offer enough specificity to permit a thorough discrimination or parity assessment. New Jersey's regulation requires an HMO's UM Plan to identify a number of things, including the scope of UM activities; procedures to evaluate clinical necessity, access, appropriateness, and efficiency of services; mechanisms to detect underutilization and overutilization; clinical review criteria and protocols used in decision-making; mechanisms to ensure consistent application of review criteria and uniform decisions; and the development of outcome and process

[233] We note that Carrier C indicated in the body of the report that it was attaching a response to one of the narrative questions, and its attachment was not part of the report we received from DOBI.

measures for evaluating the UM program.[234] The UM Plans that we reviewed provided useful, general, macro-level information about the carrier's UM processes, goals, and appeal procedures. But they generally did not get into specific criteria used to make coverage determinations for various types of benefits. They also did not get into the standards used in identifying clinical criteria for different categories of care, including BH and SA, as compared with general med/surg services, nor how they were being applied so that we could perform a parity analysis.

For example, one carrier's UM Plan detailed the purpose of its UM program; its hierarchical committee structure that monitors and supports clinical services; and training that it provides to UM staff. While it described different types of UM techniques that it uses, like preauthorization, these descriptions were more about the processes than the substantive standards used in deciding which services are subject to PA and what standards will apply to these medical necessity decisions. Although it mentioned that it uses InterQual criteria, it also qualified this by saying, *or* plan-approved medical policy, thus leaving it unclear what medical criteria it uses in particular cases. Similarly, it identified *some* of the types of services that it *may* apply Clinical Decision Support Criteria to, leaving it ambiguous how, in practice, its clinical criteria are applied. The only BH/SA-specific content was that the carrier disclosed that it delegates UM and case management determinations for BH/SUD to a BHO, but it did not get into specific criteria used by the BHO nor how those criteria or their application compared with those used for med/surg benefits.

This is not to say that UM Plans serve no purpose. There is value in outlining the processes and appeal rights consumers have regarding UM determinations. They also are valuable to the extent they identify which medical necessity criteria plans employ and to which benefits. UM Plans, as they currently are structured, have a role to play in enhancing transparency, but it is not to facilitate parity monitoring and enforcement of individual plans.

* * *

We note that in many instances, many of our observations in this Report are based on calculations that we computed using raw data reported in the carrier filings. For example, we aggregated the numbers of UM requests for medical, BH/SU, and formulary and then calculated the percent of the total that each represented. We then divided the number of UM denials by the number of requests to get the denial rate for each category. To facilitate monitoring and enforcement by DOBI and transparency for advocates, researchers, and consumers, thought should be given to building these or similar calculations into the reporting forms. The State also could explore making the filed reports available online in a format that permits meaningful analysis and comparison.

IV. Our Discussions Outside of New Jersey

As is reflected in Appendix A, we spoke with a number of advocates, regulators, and some insurers outside of New Jersey to learn how they are monitoring and enforcing the ACA's market conduct rules

[234] N.J.A.C. § 11:24-8.1(a).

and parity requirements. All agreed that the task is challenging but critical, and they are experimenting with a variety of methods to meet the challenge.

A. Parity Enforcement in Other States

1. Complaint-Driven Enforcement: New York

New York has taken a lead on parity enforcement by devoting investigative resources through its Health Care Bureau in the Office of the Attorney General. Michael Reisman, an assistant attorney general with the New York Attorney General's Office, spoke at a conference that we convened in February 2015 about New York's investigative efforts to monitor parity compliance. After noticing a number of complaints lodged through New York's complaint hotline regarding a lack of residential treatment and medical necessity denials for BH, the New York Attorney General's Office used its regulatory subpoena power to review a large volume of information that is not generally publicly available. Through its review, New York found, for example, that one carrier "denied inpatient substance use disorder rehabilitation recovery services seven times as often as inpatient medical services."[235] Similarly, it found that another carrier "issued denials twice as often for behavioral health claims as insurers did for other medical or surgical claims and four times as often for addiction recovery services."[236] As a result of its investigations, the New York Attorney General has executed five consent orders with carriers and BH vendors that include reforms of claims processing procedures and coverage of previously denied services, among other terms.

2. Focus on Disclosure

Most advocates, however, expressed their belief that we cannot rely on a complaint-driven system to monitor for nondiscrimination or parity compliance. Far too few patients file complaints. California advocates, for example, reported that 28 times more physical health than BH complaints are filed. It also has been urged that BH patients cannot be expected to pursue complaints or appeals in times of crisis. Advocates suggested that stigma plays a role as well. There also are few legal resources to support consumers through the appeals process.

In addition, often carriers resolve complaints on an individual basis, and the results are not made public. For example, although HHS reportedly found 196 possible parity violations between September 2013 and September 2014, "[n]o federal agency has taken any public action such as filing a lawsuit or

[235] N.Y. State Office of the Attorney General, Attorney General Eric T. Schneiderman, Press Releases: A.G. Schneiderman Announces Settlement With Excellus Health Plan To End Wrongful Denial Of Mental Health And Addiction (Mar. 18, 2015), *available at* http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-excellus-health-plan-end-wrongful-denial-mental.

[236] N.Y. State Office of the Attorney General, Attorney General Eric T. Schneiderman, Press Releases: A.G. Schneiderman Announces Settlement With ValueOptions To End Wrongful Denial Of Mental Health And Substance Abuse Treatment Services (Mar. 5, 2015), *available at* http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-valueoptions-end-wrongful-denial-mental-health.

levying a fine."[237] Instead, "plans voluntarily made changes or told the agency they believed their plan was in compliance with the law."[238] Carol McDaid of the Parity Implementation Coalition has been quoted as noting that because these investigations are kept secret, "[t]hey have no effect on what other employers or insurers do, and consumers don't learn what to look out for . . . ."[239]

Despite the clear regulatory disclosure requirements in the context of appeals discussed in Section II.B above, advocates also reported difficulty getting carriers to disclose sufficient information to permit parity analysis. The Parity Implementation Coalition, for example, reported that more than half of the witnesses who testified at fourteen field hearings around the country complained about difficulties getting disclosure from plans on appeal. Advocates have found that they cannot perform the parity analysis without adequate disclosure of the UM criteria for physical medical services and how they are applied in practice. The National Center on Addiction and Substance Abuse recently found that the plan documents for 88 percent of the states' 2017 EHB benchmark plans, including New Jersey's, "lack sufficient detail to fully evaluate compliance with the ACA and/or the adequacy of SUD benefits."[240]

Thus, after initially focusing on filing complaints and appeals, the Parity Implementation Coalition and a number of its allied organizations have been focused on improving disclosure of plan information to permit comprehensive parity analysis and improving consumer education about their rights and how to file appeals.[241]

a. Massachusetts

Massachusetts, for example, passed legislation in 2012 requiring "all carriers and their contractors[] to submit an annual report to the division of insurance and to the attorney general, which shall be a public record, certifying and outlining how their health benefit plans comply" with federal and state MH parity laws.[242] To implement this statutory requirement, the Massachusetts Commissioner of Insurance issued a Bulletin in 2013 that required carriers to file a certification each July 1 attesting to their compliance with parity requirements in the preceding calendar year.[243] In support of its certification, a carrier must also submit "information regarding financial and treatment limitations, medical necessity

[237] *See* Jenny Gold, KAISER HEALTH NEWS, *Congress tried to fix mental health care in 2008. Lawsuits charge it isn't working* (Aug. 3, 2015), *available at* http://www.vox.com/2015/8/3/9069643/mental-health-parity-lawsuits.

[238] *Id.*

[239] *Id.*

[240] The NATIONAL CTR. ON ADDICTION AND SUBSTANCE ABUSE, *supra* note 113, at 1.

[241] *See generally* ParityTrack, https://www.paritytrack.org/ (last visited May 24, 2016) (tracking state and federal efforts to implement parity requirements).

[242] *See* Commonwealth of Mass., S. 2395, § 254, *available at* http://b.3cdn.net/pcouncil/31a679da6f61e5d047_7hm6b01ou.pdf.

[243] *See* MASSACHUSETTS OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION, DEP'T OF INS., Bulletin 2013-06; Disclosure and Compliance Requirements for Carriers, and Process for Handling Complaints for Non-Compliance with Federal and State Mental Health and Substance Use Disorder Parity Laws (May 31, 2013), *available at* http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2013-doi-bulletins/bulletin-2013-06.html.

criteria, and authorization processes that demonstrate the Carrier's compliance with the Mental Health Parity Laws, including but not limited to the following information":

1. Explanations of any differences in (a) the Carrier's processes used to develop the MH/SUD criteria and med/surg criteria; (b) how MH/SUD providers and med/surg providers are notified of the Carrier's medical necessity criteria; and (c) in the processes the Carrier may require MH/SUD providers and med/surg providers to follow to request authorization for services and/or to provide information that demonstrates the medical necessity of a requested service (and the reasons why the processes differ).

2. An analysis of how the plan meets federal parity standards if there are any differences between processes, standards and criteria that apply to MH/SUD services and med/surg services.

3. A report providing the following information separately regarding treatment for med/surg services and MH/SUD services in the prior calendar year:

    i. Number of times patients/providers requested authorization for services, the number of services requested (e.g., inpatient days or outpatient visits), and the number of requests authorized, modified, and denied.

    ii. Number of reduced or denied requests appealed through the internal appeals process, number of internally appealed requests approved and denied, and number of internally appealed requests sent for external appeal.
    iii. Number of externally appealed adverse determinations overturned and upheld.

4. An explanation of any differences in the standards for granting authorization for out-of-network services between MH/SUD services and med/surg services.

5. For each plan offered, a list of any differences in cost-sharing features and benefit limitations that apply to MH/SUD services and med/surg services (and an explanation of why the differences may be acceptable under federal standards).[244]

While these annual filings hold the promise of containing useful data, advocates expressed concern that filings are voluminous, and the information is not being analyzed in a meaningful way. Carriers essentially are being trusted to comply. In addition, carriers are not required to directly address and explain their application of NQTL standards, which limits the ability to assess parity compliance.[245]

[244] *Id.*

[245] *Cf.* Letter to Donna Dorris from Saul Levin, MD, MPA, CEO and Medical Director, Am'n Psych'c Ass'n, regarding Insurance Commissioner Matter No. R2012-29, at 3 (Nov. 5, 2014), *available at* http://www.insurance.wa.gov/laws-rules/legislation-rules/recently-adopted-rules/2012-29/comments/documents/2012-29apa.pdf ("Given the primary significance of NQTLs to the parity inquiry, it is essential that, at a minimum, the plans be required to provide the beneficiary with (a) the strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to mental health or substance

b. Connecticut

Connecticut similarly has implemented a retrospective MH parity annual compliance filing that carriers must submit on or before May 1 each year.[246] This survey includes a number of important questions about parity compliance, including:

1. Whether the plan performed the "substantially all" and predominant level tests for each of the six parity benefit classifications and an explanation of any differences.

2. An explanation of any differences in the ways that MH/SUD and med/surg providers are notified about the plan's medical necessity criteria.

3. An explanation of any differences in the processes the plan requires MH/SUD and med/surg providers to follow to request authorization for services and/or to provide information that demonstrates the medical necessity of a requested or provided service, including the reasons why the processes may differ.

4. An analysis of how the plan meets federal parity standards if there are any differences between processes, standards and criteria that apply to MH/SUD and med/surg services.

5. An explanation of any differences in the health plan's processes used to develop the MH/SUD and med/surg criteria used to evaluate medical necessity.

6. An explanation of any differences in the standards for granting authorization for out of-network services for MH/SUD and med/surg services.

7. For each plan offered, a list of any differences in cost-sharing features, penalties and benefit limitations that apply to MH/SUD and med/surg services, including an explanation of why the differences may be acceptable.

8. A comparison of how the fee schedules and reimbursement rates are determined for med/surg and MH/SUD providers.

It is not clear that these questions, however, adequately require carriers to address how criteria for NQTLs are applied in practice. Reportedly, plans have refused to disclose their criteria and how they

use disorder benefits and those used with respect to medical surgical benefits in the classification; (b) its rationale and analysis of comparability between the two; (c) its justification for concluding that they are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification. The plan should also produce evidence that this is true not only on paper but in practice as well. Insurance plans have tremendous ability to mine data and adding these requirements produces no meaningful additional burden.") (emphasis in original).

[246] *See* State of Conn., Ins. Dep't., Bulletin MC-20: Mental Health Parity Annual Compliance Survey (Jan. 2, 2014), *available at* http://www.ct.gov/cid/lib/cid/Bulletin_MC-20_MHP_Annual_Compliance_Survey.pdf.

are applying them, claiming that they are "copyrighted" or "proprietary." Advocates expressed their belief that it is difficult to detect parity violations without reviewing medical and insurance records, including the denial letters, and speaking with consumers. Connecticut's Office of the Healthcare Advocate has advocated for the Connecticut Insurance Department (CID) to perform audits of plan application of NQTLs, although they have not yet been implemented in Connecticut. The compliance surveys are not public at this time, and advocates expressed a desire for greater transparency regarding what the CID is doing with the filings.

c. California

California arguably has taken the most proactive stance in terms of regulatory oversight and monitoring of parity enforcement. It has enacted a two-step compliance program. First, carriers in fall 2014 had to file a report with the California Department of Managed Health Care (DMHC) in which they demonstrated that the financial requirements, QTLs, and NQTLs in a sample of the most popular plans comply with parity requirements.[247] Second, the DMHC will follow-up on the filings by performing audits beginning in 2016 to see how the carriers are applying these standards in practice. Clinical consultants will assist with the audits to help assess the application of standards in specific cases.

The DMHC has taken an active role in the first phase. First, it developed templates for the carriers to use for their filings.[248] Each template was keyed to the federal parity requirements, including having separate tables for deductibles, out-of-pocket maximums, copayments/coinsurance, QTLs, and NQTLs.[249] For each financial requirement or QTL, a plan must provide detailed information, such as what benefits the limitation applies to and whether it applies to substantially all medical/surgical benefits within each classification/subclassification.[250] Copayments, coinsurance, and QTLs must be separately reported for the eight permissible parity classifications and subclassifications for med/surg as well as MH/SUD, and the predominant financial requirement or QTL applicable to substantially all med/surg benefits must be reported for each classification or subclassification.[251] The report also must include a written description

[247] *See* Ca. Dep't of Managed Health Care, The Mental Health Parity and Addiction Equity Act of 2008, https://www.dmhc.ca.gov/LawsRegulations/MentalHealthParityandAddictionEquityActof2008(MHPAEA).aspx#.VifJ6H6rS70 (last visited Oct. 21, 2015). The parity compliance filing is not a prerequisite to a plan being offered on California's insurance exchange, but DMHC can bring an enforcement action against a non-compliant plan.

[248] *See* Workbook that Includes Index and Tables 1-4 (Table 1: Financial Requirements – Deductibles; Table 2: Financial Requirements - Out-of-Pocket Maximums; Table 3: Financial Requirements - Copayments and Coinsurance; Table 4: Quantitative Treatment Limitations), https://www.dmhc.ca.gov/Portals/0/LawsAndRegulations/MentalHealth/Workbook_including_Index_and_Tables_1_through_4.pdf (last visited Oct. 21, 2015); Table 5: Non-Quantitative Treatment Limits, https://www.dmhc.ca.gov/Portals/0/LawsAndRegulations/MentalHealth/Table_5-Non_Quantitative_Treatment_Limitations.pdf (last visited Oct. 21, 2015); Table 6: List of Exhibits, Supporting Documentation, https://www.dmhc.ca.gov/Portals/0/LawsAndRegulations/MentalHealth/Table_6-List_of_Exhibits,Supporting_Documents.pdf (last visited Oct. 21, 2015).

[249] Instructions for the Federal Mental Health Parity and Addiction Equity Act Compliance Filing, at 2, https://www.dmhc.ca.gov/Portals/0/LawsAndRegulations/MentalHealth/Instructions_for_Federal_MHPAEA_Compliance_Filing.pdf (last visited Oct. 21, 2015).

[250] *Id.* at 5-6.

[251] *See id.* at 6-13.

of the methodology that the health plan used to estimate the annual health plan payment volume for each benefit that has a financial requirement or QTL and how the predominant and significant financial requirements and QTLs were calculated for each of the benefit classifications or subclassifications.[252] The NQTL table requires a plan to identify every NQTL used for med/surg and MH/SUD benefits, noting any variations by benefit; to provide a description of "the processes, strategies, evidentiary standards or other factors used to apply the NQTLs;" and to explain how the application of these factors is consistent with the parity law.[253] Plans must describe the logic used to assign benefits to the different parity classifications and subclassifications and submit documentation to substantiate the information that they provide in the various tables, such as methodologies, policies and procedures, evidences of coverage, and SBCs.[254] Regulators worked with clinical consultants and actuaries both to develop the templates and to evaluate the carriers' filings. The state provided webinars and posted resource materials on its web site to help carriers learn how to complete the filings.

The DMHC spent months going back and forth with the carriers to make sure their filings were complete. Although in late August 2015 regulators were still working with 25 of the 26 plans to finalize the stage 1 filings, there were some early findings. For one, DMHC found that almost all filings inadequately described the benefits that they covered. In addition, although plans generally looked like they were in compliance from a scan of the templates, analysis of the plan methodologies for calculating predominant and significant financial restrictions and QTLs disclosed that a number of plans were not in compliance.

A common violation involved copayments or deductibles for outpatient items and services other than office visits, such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items. Regulators found that a panoply of cost-sharing and deductibles applied to outpatient med/surg non-office visit services or items. A significant percentage, for example, were for preventive or other services that do not have cost-sharing or deductibles. Remaining services or items had a mix of coinsurance and copayments. As a result, fewer than two-thirds of outpatient med/surg other than office visit services or items had copayments or deductibles applied to them in these plans. Thus, under the parity regulations, outpatient BH items and services other than office visits could not be subject to copayments or deductibles in these plans. Clinical consultants also helped regulators find that some plans employed different definitions of medical necessity for med/surg and MH/SUD services.

Where violations were identified, plans then needed to update their SBCs and other plan documents as a result of the parity analysis. Regulators also required plans to revise SBCs and other plan documents to provide fuller disclosure of NQTLs, such as prior authorization requirements, that were disclosed in the stage 1 filing but not in the plan documents that consumers receive.

The DMHC began the stage 2 on-site audits in spring 2016, which the office expects to take more than one year to complete. These on-site reviews likely will focus on whether NQTLs are being administered in parity. For example, if a plan says that it does not have limits on the number of residential

[252] *Id.* at 2, 15-16.
[253] *Id.* at 15.
[254] *Id.* at 2, 5, 6, 11-12, 13, 15.

inpatient psychiatric treatment days, but a review reveals that almost all patients are discharged after three days, DMHC may ask the plan for an explanation. Clinician consultants will be important for these reviews. Regulators note that they often see disconnects between carriers and their BH vendors due to inadequate coordination.

Advocates with whom we spoke express optimism that California regulators are taking parity enforcement seriously. While they are not sure that California's efforts will help at the beneficiary level, they believe the filings and audits will impact plan behavior. Advocates have not yet requested redacted versions of the filings, so they are not sure how much information will be redacted and how valuable the redacted reports will be to activists, providers, researchers, and consumers. They expressed hope that regulators will post redacted filings on the internet to increase transparency. Although California's increased regulatory role has required more staff, advocates urged that long-term, the system should see reduced physical health expenses as a result of better access to appropriate BH services.[255]

Although California's stage 1 compliance filing is a one-time initial filing, existing state law requires plans to submit filings when they make changes to plan design, such as cost-sharing or NQTLs like prior authorization. The stage 2 on-site surveys also are a one-time special pilot project, but DMHC will fold the parity-specific audit features into the state's existing routine and non-routine plan surveys.

Recognizing how laborious stage 1 has been and stage 2 is likely to be, it will be interesting to see if DMHC feels that both stages are necessary, or if, perhaps, a state could focus on either rigorous review of filings or detailed site reviews, given resource constraints. Given the parity problems unearthed thus far in stage 1, however, it seems that California's labor has been quite valuable in advancing parity monitoring and enforcement. The National Association of State Mental Health Program Directors also recommends "annual audits or market conduct surveys of plans to confirm parity compliance" as a state best practice that "is essential to identifying non-compliance and creating incentives for full compliance with the law."[256]

d. Maryland

A coalition of advocates in Maryland has worked to enact a prospective parity compliance demonstration bill in that state as well, but to date, their efforts have not been successful.[257] Unlike

[255] California's experience is too early in its implementation to test this hypothesis. But it will be interesting to see how the costs the state is investing in monitoring and enforcement compare with health care expenditures in the long-term.

[256] NAT'L ASSOC. OF STATE MENTAL HEALTH PROGRAM DIRECTORS, *Assessment #6b: Parity Implementation: A State Best Practices Guide*, at 6 (Sept. 15, 2014), *available at* http://dev.nasmhpd.seiservices.com/sites/default/files/Assessment%206b%20-%20parity%20best%20practices.pdf.

[257] *See* H.B. 1001/S.B. 585, Health Insurance - Federal and State Mental Health and Addiction Parity Laws - Report on Compliance (2013 Reg. Sess.), http://mgaleg.maryland.gov/webmga/frmMain.aspx?id=hb1001&stab=01&pid=billpage&tab=subject3&ys=2013rs (last visited Oct. 21, 2015); H.B. 1010/S.B. 586, Health Insurance - Federal and State Mental Health and Addiction

California's law, the Maryland proposal would make the compliance reports public documents. We heard that insurers maintained that information concerning a number of NQTLs, including credentialing standards, factors used in establishing reimbursement rates, and criteria used to determine networks, is proprietary. While they would disclose this information to regulators if they were kept confidential, they opposed disclosing them to advocates and researchers. They also opposed having to disclose them prospectively or on an annual basis. The MIA, however, reportedly took the position that it did not need this information, citing staffing and resource issues. Rather, the state regulator indicated that it will use its market conduct authority in 2015 to retroactively review carriers' plan behavior. As discussed above in Section II.B.2.b, Maryland advocates continue to press for greater prospective disclosure of information, questioning how the MIA can monitor for parity compliance and certify QHPs without this information.[258]

3. Seeking Judicial Enforcement of Parity

Some consumers and providers are not waiting for regulators or legislators to act and instead are turning to the courts to adjudicate claims of parity violations.[259] The New York State Psychiatric Association (NYSPA) is the lead plaintiff in a class action against UnitedHealth Group and its affiliates that alleges violations of the federal parity law, among other provisions, through an action under Section 502 of the Employee Retirement Income Security Act (ERISA).[260] NYSPA alleged in the complaint that UnitedHealth "unlawfully imposed financial requirements and treatment limitations on mental health benefits for patients of NYSPA members."[261] A patient specifically alleged that UnitedHealth applied prior authorization exclusively to BH and had different financial requirements for BH and physical health services.[262] The United States Court of Appeals for the Second Circuit in 2015 found, at least at the motion to dismiss stage, that NYSPA had associational standing on behalf of its members, who have standing to sue in their own right as assignees of ERISA benefits, to bring an action against UnitedHealth Group, which was serving as the claims administrator.[263] It further permitted the patient's parity claims to proceed against United.[264]

Parity Laws - Report on Compliance (2015 Reg. Sess.), http://mgaleg.maryland.gov/webmga/frmMain.aspx?pid=billpage&tab=subject3&id=hb1010&stab=01&ys=2015RS (last visited Oct. 21, 2015).

[258] *See supra* notes 221-222 & accompanying text.

[259] *See, e.g.,* Gold, *supra* note 237 (reporting that an attorney and psychotherapist, who has filed a number of parity lawsuits in New York, Illinois, and California, had said that "attorneys are acting because government hasn't"); ParityTrack, https://www.paritytrack.org (last visited May 24, 2016) (tracking parity litigation in the fifty states).

[260] *See* N.Y. State Psych'c Ass'n, Inc. v. UnitedHealth Grp., 798 F.3d 125 (2d Cir. 2015), *cert. denied sub nom* UnitedHealth Group, Inc. v. Jonathan Denbo, 136 S. Ct. 506 (2015).

[261] *Id.* at 129.

[262] *Id.* at 130.

[263] *See id.* at 131.

[264] *See id.* at 133. It is interesting to note that the Second Circuit recently affirmed the dismissal of an ERISA Section 502 suit that the American Psychiatric Association and psychiatrists filed on behalf of their members and patients against Anthem Health Plans in 2013, which alleged that Anthem's reimbursement rates and billing structure violated parity requirements. *See* Am. Psychiatric Ass'n v. Anthem Health Plans, Inc., No. 14-3993-cv, 2016 U.S. App. LEXIS 8797 (2d Cir. May 13, 2016). The Anthem court found that the psychiatrists did not have standing to

Individual patients also are looking to the courts to vindicate their rights. A judge in the United States District Court for the Western District of Washington certified a class of plaintiffs and granted their motion for a preliminary injunction against Regence Blue Shield and Cambria Health Solutions based on alleged violations of the federal and Washington state MH parity laws for failure to cover medically necessary neurodevelopmental therapy.[265] The case ultimately settled. The United States District Court for the District of Vermont refused to dismiss an action alleging parity violations.[266] The plaintiff alleged that the BH administrator conducted prospective and concurrent medical necessity reviews of routine, outpatient, out-of-network MH office visits while the medical claims administrator did not conduct these reviews for comparable medical office visits.[267] She further alleged that the BH claims administrator, but not the medical claims administrator for her plan, imposed a numerical cap on the number of routine outpatient visits before pre-approval would be required for all subsequent visits.[268] In reaching its decision, the district court reasoned that "plan administrators . . . bear the burden of establishing, under the Parity Act, why mental health and medical benefits are treated differently based on divergent clinical standards."[269] A class action complaint filed in November 2014 in the United States District Court for the Western District of Kentucky alleged that an insurer violated parity and the ACA's non-discrimination provisions by imposing cumulative financial requirements, cumulative quantitative treatment limitations, and dollar limits on ABA treatment for autism.[270] The case is still pending.

A number of cases also have been filed in state courts alleging violations of state parity laws. For example, a docket search in spring 2016 revealed that more than a dozen cases had been filed in the Los Angeles Superior Court alleging violations of California's MH parity law since 2011.

Reportedly, "[p]arity advocates believe these lawsuits are just the 'tip of the iceburg' . . . ."[271] The parity cases can be likened to the surge of litigation against managed care companies in the 1980s and 1990s, reflecting dissatisfaction with denial of coverage on grounds such as medical necessity.[272] A cause of this upsurge in health litigation was distrust of managed care plans, due in part to a lack of transparency in decision-making. A result of this upsurge was the injection of judicial decision-making on a case-by-case basis, arguably in default of regulatory action to increase consumer confidence and plan

---

bring ERISA claims on behalf of their patients, as distinguished from on their own behalf. *See id.* at *9-18. The APA then did not have associational standing since its members lacked standing. *See id.* at *19-20.

[265] *See* K.M. v. Regence BlueShield, Case No. C13-1214 RAJ, 2014 U.S. Dist. LEXIS 27685 (Feb. 27, 2014).

[266] *See* C.M. v. Fletcher Allen Health Care, Inc., Case No. 5:12-cv-108, 2013 U.S. Dist. LEXIS 124069, *19 (U.S. Vt. Apr. 30, 2013).

[267] *See id.* at *13.

[268] *See id.*

[269] *Id.* at *17.

[270] *See* Wilson v. Anthem Health Plans of Ky., Inc., No. 3:14cv-743-R, Complaint, at 7, 9 (filed Nov. 10, 2014) (on file with authors).

[271] COMMUNITY CATALYST & HEALTH LAW ADVOCATES, *Mental Health Parity: Advocacy Is Increasing State Enforcement*, at 2 (June 2013), *available at* http://www.communitycatalyst.org/doc-store/publications/mh-parity-state-enforcement_062013.pdf.

[272] *See* William M. Sage, *Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance,* 53 DUKE L. J. 593 (2003); Mark Hall and Gerald Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PENN. L. REV. 1537 (1992).

accountability. Such judicial decision-making tended to seem somewhat *ad hoc*, and to lack full examination of the broad goals of health insurance regulation. This experience might be thought of as a cautionary tale, suggesting that stakeholders should work toward a transparent regulatory system in which consumers are protected while the genuine concerns of insurers and payers are taken into account.

B. Efforts to Address Network Adequacy in Other States

States also are taking steps to address network adequacy concerns. Secret shopper surveys have been a powerful wake-up call in some states for the need for further work to improve the accuracy and adequacy of provider networks. The American Psychiatric Association Foundation recently released the results of a secret shopper survey of the three largest insurers offering plans on the Washington, D.C. Health Link Health Insurance Exchange.[273] Researchers called a random sample of 50 psychiatrists listed in the online public network directories for each carrier: 86-percent of the psychiatrists either were not reachable (despite at least three calls per number over seven days) or were not taking new patients; 23 percent of the listed phone numbers did not work or were nonresponsive, de; 51 percent of the psychiatrists were practicing at the listed phone numbers; 64 percent of one plan's psychiatrists were not currently practicing at the number listed in the directory; only 14 percent of the callers were able to schedule appointments, which number dropped to 4 percent for one plan; the average wait time for a new outpatient appointment was 19.1 days; and only 7 percent of the psychiatrists were able to schedule a new outpatient appointment within two weeks, 3 percent were able to schedule an appointment within 15 to 28 days, and 4 percent only had available appointments more than three weeks in the future.[274] Advocates are urging state attorneys general to investigate phantom networks as fraudulent.

A secret shopper survey sponsored by a MH advocacy organization in Maryland similarly found that only 156 of 1,154 psychiatrists listed as participating in QHPs in the state were accepting new patients and had availability for an appointment in 45 days or fewer.[275] BH advocates are using this study to encourage the state to more proactively review network adequacy because to date, carriers simply filed their networks with little scrutiny. Advocates would like carriers to have an obligation to audit their networks. We note that the National Association of Insurance Commissioners' recently revised model network adequacy bill would require carriers to "periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request.[276]

---

[273] *See* AM. PSYCH'C ASS'N, APA Poll Finds Access to Care Stymied by 'Phantom' Networks in D.C. (May 17, 2016), *available at* http://www.psychnews.org/update/2016_apa_daily_4d.html.

[274] *See id.*; *see also* Heather Kugelmass, "*Sorry, I'm Not Accepting New Patients": An Audit Study of Access to Mental Health* Care, Journal of Health & Social Behavior, at 1-16 (American Sociological Assoc'n 2016) (performing audit study of psychotherapist availability in New York City and finding differences in accessibility of appointments based on race and social class), *available at* http://hsb.sagepub.com/content/early/2016/05/18/0022146516647098.abstract.

[275] *See* Mental Health Assoc'n of Maryland, *Access to Psychiatrists in 2014 Qualified Health Plans: A Study of Network Accuracy and Adequacy Performed from June 2014-November 2014*, at 7 (Jan. 26, 2015), *available at* https://www.mhamd.org/wp-content/uploads/2014/01/2014-QHP-Psychiatric-Network-Adequacy-Report.pdf.

[276] Nat'l Assoc'n of Ins. Comm'rs, Health Benefit Plan Network Access and Adequacy Model Act, § 9(A)(2)(b) (4th Quarter 2015), *available at* http://www.naic.org/store/free/MDL-74.pdf.

In response to consumer complaints, California's regulator also conducted secret shopper surveys in 2014 that discovered a significant number of errors in two carriers' directories. 12.5% of the physicians listed in Anthem Blue Cross's directory were not at the location listed in the directory, and 12.8% would not accept patients enrolled in the state's insurance exchange products.[277] Similarly, 18.2% of the physicians listed in Blue Shield of California's directory were not at the location listed in the directory, and 8.8% would not accept members enrolled in exchange products.[278]

As part of the Behavioral Health Clearinghouse Informational website that it launched in December 2014,[279] Connecticut's Office of the Healthcare Advocate staff are contacting BH providers to confirm if they are accepting new patients and what insurance they accept. The goal is to develop a searchable directory of BH providers who are accepting new patients.[280] OHA plans to partner with a MH advocacy group to staff a call center that will help consumers connect to care.

CMS decided not to finalize proposed network adequacy time and distance standards, opting to give states time to adopt the NAIC's revised network adequacy model act.[281] But it did publish a table of maximum time and distance standards that it will use when reviewing plans for network adequacy as part of the certification process.[282] At least 90 percent of enrollees must have at least one MH, including SUD, provider within the following time and distance standards, depending on the applicable county type: 20 minutes or 10 miles in large county; 45 minutes or 30 miles in metro county; 60 minutes or 45 miles in micro county; 75 minutes or 60 miles in rural county; and 110 minutes or 100 miles in Counties with Extreme Access Considerations (CEAC).[283]

C. Additional Efforts to Improve Access to Behavioral Health Services

There are a number of other reforms states are exploring to address discrimination and parity concerns and generally to improve access to behavioral health services. Some states are trying to cabin carrier's discretion by legislating what mental health coverage must include and what specific standards carriers may employ when making medical necessity determinations. New York, for example, passed

[277] *See* Ca. Dep't of Managed Health Care Help Center, Division of Plan Surveys Final Report: Non-Routine Survey of Anthem Blue Cross A Full Service Health Plan, at 3 (Date Issued to Plan: Nov. 07, 2014; Date Issued to Public File: Nov. 18, 2014), *available at* http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303fsnr111814.pdf.

[278] *See* Ca. Dep't of Managed Health Care Help Center, Division of Plan Surveys Final Report: Non-Routine Survey of Blue Shield A Full Service Health Plan, at 3 (Date Issued to Plan: Nov. 07, 2014; Date Issued to Public File: Nov. 18, 2014), *available at* http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/043fsnr111814.pdf.

[279] *See* State of Conn., Office of the Healthcare Advocate, *The Office of the Healthcare Advocate launches its Behavioral Health Clearinghouse informational website* (Dec. 14, 2014), http://www.ct.gov/oha/cwp/view.asp?Q=558178&A=4571 (last visited Oct. 22, 2015).

[280] *See* State of Conn., Office of the Healthcare Advocate, *Connecticut's Behavioral Health Clearinghouse*, http://www.ct.gov/oha/cwp/view.asp?a=4363&q=556946 (last visited Oct. 22, 2015).

[281] *See 2017 Letter to Issuers*, supra note. 227, at 23.

[282] *See id.* at 23-24.

[283] *See id.* at 24.

legislation that requires any policy that provides hospital, major medical or similar comprehensive coverage to provide inpatient SUD coverage, including detoxification and rehabilitation.[284] In addition, UM of SUD treatment must use "recognized evidence-based and peer reviewed clinical review criteria."[285] Illinois specifically requires that medical necessity determinations for SUDs be made in accordance with American Society of Addiction Medicine's (ASAM) patient placement criteria and prohibits use of any additional criteria.[286]

Connecticut also requires carriers to use specific clinical review criteria identified by statute for the treatment of a SUD, child or adolescent mental disorder, and adult mental disorder, or to demonstrate in a document posted on its web site how its clinical review criteria are consistent with the prescribed criteria, justifying each deviation through citations to peer-reviewed medical literature generally recognized by the relevant medical community or to professional society guidelines.[287] In addition, Connecticut law requires carriers to use clinical peers to review all pre-authorizations or concurrent reviews, reviews of adverse determinations, and external review determinations.[288] It also specifies qualifications for clinical peer reviewers for reviews of certain MH/SUD services, such as requiring that a peer hold a national board certification in child and adolescent psychiatry or child and adolescent psychology and have training or clinical experience in treating child and adolescent SUDs or mental disorder, as applicable, when reviewing a benefit determination concerning SUD or mental disorder in a child or adolescent.[289] Similarly, for a review or benefit determination concerning SUD disorder or mental disorder in an adult, the clinical peer must be boarded in psychiatry or psychology, and have training or clinical experience in the treatment of adult SUDs or mental disorders, as applicable.[290]

A Connecticut statute also identifies specific BH services that plans must cover, including when such services must also be covered when they are provided by providers other than physicians, such as psychologists, clinical social workers, marriage and family therapists, licensed alcohol and drug counselor, and licensed professional counselors.[291] In addition, insurers are prohibited from requiring step therapy for more than sixty days if a treating provider deems the step therapy regimen "clinically ineffective for the insured."[292] There also must be a process in place for a provider to request an override of step therapy requirements at any time.[293] Connecticut further requires carriers to make preauthorization or

[284] *See* STATE OF N.Y., Senate Bill 7912, Assembly Bill A. 10164 (signed into law June 23, 2014), *available at* http://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=A10164&term=2013&Summary=Y&Actions=Y&Text=Y.

[285] *Id.*

[286] *See* Ill. General Assembly, Health Tech, HB0001, Public Act 099-0480, *available at* http://www.ilga.gov/legislation/billstatus.asp?DocNum=1&GAID=13&GA=99&DocTypeID=HB&LegID=83490&SessionID=88 (enacted Sept. 11, 2015).

[287] *See* Conn. Gen. Stat. § 38a-591c(a)(3)-(5).

[288] *See* STATE OF CONN. INS. DEP'T., *Bulletin HC-92: Sections 70-78 of Connecticut Public Act No. 13-3 – Behavioral Health Changes to Utilization Review, Grievance and Appeals*, at 3 (June 19, 2013), *available at* http://www.ct.gov/cid/lib/cid/Bulletin_HC-92_-_Public_Act_13-3_Behavioral_Health_Changes.pdf.

[289] *See id.*

[290] *See id.*

[291] *See* Conn. Gen. Stat. § 38a-488a.

[292] *Id.* § 38a-510(a)(2).

[293] *See id.* § 38a-510(b)(1).

concurrent review UM determinations within twenty-four hours for certain BH services that are deemed urgent, namely, "(1) substance use disorder or co-occurring mental disorder and (2) inpatient services, partial hospitalization, residential treatment, or intensive outpatient services needed to keep a covered person from requiring an inpatient setting in connection with a mental disorder."[294] The Office of the Healthcare Advocate also maintains an information and referral hotline that helps identify problems consumers are experiencing. A consistent problem for consumers, however, is that even if carriers provide information on criteria for both BH and med/surg services, parity is too complicated for the average consumer to assess. Advocates also point out the need for carriers to tie their denial letters to the specific criteria used.

Standardized health plans are another way states are seeking to minimize discretionary variations that may evade parity requirements. California's exchange was the first state exchange to define standardized health plan designs in 2013,[295] which include standardized drug tiers.[296] State exchanges in Connecticut, Massachusetts, New York, Oregon, and Vermont similarly have developed standardized benefit designs in each metal level that insurers participating in their exchanges must offer, and the District of Columbia's exchange began requiring carriers to offer standardized benefit plans in 2016.[297]

There also are efforts in several states to adopt caps on cost-sharing for prescription benefits,[298] including a bill introduced February 4, 2016 in New Jersey.[299] Carriers warn that these proposals would permit pharmaceutical companies to pass high costs for prescription drugs along to insurers, which then

[294] STATE OF CONN. INS. DEP'T., *Bulletin HC-92*, *supra* note 288, at 2.

[295] *See* California Healthline, California Sets Benefit Standards for Health Plans in Exchange (Feb. 14, 2013), *available at* http://www.californiahealthline.org/articles/2013/2/14/california-sets-standardized-rates-for-health-plans-in-exchange.

[296] *See* Covered California, 2016 Standard Benefit Designs and Medical Cost Shares, http://www.coveredca.com/PDFs/2016-Health-Benefits-table.pdf (last visited Oct. 22, 2015).

[297] *See* Lydia Mitts, *Standardized Health Plans: Promoting Plans with Affordable Upfront Out-of-Pocket Costs*, FAMILIES USA (Dec. 2014), *available at* http://familiesusa.org/product/standardized-health-plans-promoting-plans-affordable-upfront-out-pocket-costs; Massachusetts Health Connector, *Silver Plans for Individuals and Families*, http://bettermahealthconnector.org/wp-content/uploads/2014/01/Non-Group_Silver.pdf (last visited Oct. 22, 2015).

[298] *See* Patrick Connole, *States Target Prescription Drugs in 'Cap The Copay' Bills; Analysts Warn of Offsets*, HEALTH PLAN WEEK, vol. 25, issue 13 (Apr. 20, 2015), *available at* https://aishealth.com/archive/nhpw042015-02; *see generally* LEGISLATIVE BUDGET AND FINANCE COMMITTEE, A JOINT COMMITTEE OF THE PENNSYLVANIA GENERAL ASSEMBLY, *Prescription Drug Specialty Tiers in Pennsylvania*, at S-4-S-5 (Sept. 2014), *available at* http://lbfc.legis.state.pa.us/Resources/Documents/Reports/494.pdf (summarizing survey that found reductions of patient medication adherence at different copay levels).

[299] *See* State of New Jersey, 217th Legislature, Assembly Bill No. 2337 (introduced Feb. 4, 2016), *available at* http://www.njleg.state.nj.us/2016/Bills/A2500/2337_I1.PDF.

could result in higher premiums for consumers.[300] It would be prudent to subject these proposals to actuarial analysis to determine if they would negatively impact premiums or actuarial value. [301]

In general, it is in the best interest of consumers, advocates, insurers, and regulators alike to clarify the requirements of parity. Many of the stakeholders with whom we spoke agreed that we need clearer guidance from the federal government regarding how to implement MPHAEA.[302] A BH vendor, for example, cited the need for more specific examples of how to apply NQTL requirements to specific types of BH care that do not have clear med/surg analogues and where the clinical evidence on effectiveness differs. Advocates also expressed the need for more guidance regarding NQTLs. The Parity Implementation Coalition, for example, expressed the need for a quantitative benchmark, akin to the quantitative parity analysis, for NQTLs to facilitate monitoring whether NQTLs are applied more stringently to BH than to med/surg services. There may also be a role for federal regulation to resolve the debate between carriers and advocates, providers, and patients regarding which documents carriers must disclose, to whom, and when. A federal bill introduced in August 2015 would require the HHS Secretary, in cooperation with the Secretaries of Labor and the Treasury, to issue additional regulations or sub-regulatory guidance, "including an explanation of documents that are required to be disclosed, and analyses that are required to be conducted, including how non-quantitative treatment limitations are applied to mental health or substance use disorder benefits and medical or surgical benefits covered under the plan."[303] Some states like Oregon[304] and Washington[305] have also issued regulations or subregulatory guidance to help educate carriers regarding what parity compliance requires in practice. Among Illinois's parity implementation efforts is a legislative requirement that the state insurance

[300] *See* Susan K. Livio, NJ.com, N.J. lawmaker wants to limit how much you pay for prescription drugs (Feb. 23, 2016 at 8:38 AM, updated Feb. 25, 2016 at 8:39 AM), *available at* http://www.nj.com/politics/index.ssf/2016/02/nj_lawmaker_pushes_cap_on_high_rx_costs.html; Alex Wayne, BLOOMBERG NEWS, *Drugmakers Turn Heat on Insurers by Backing Copay Limits* (Mar. 12, 2015), http://www.bloomberg.com/news/articles/2015-03-12/drugmakers-turn-heat-on-insurers-by-backing-copay-limits-health.

[301] *See, e.g.,* Bruce Pyenson, *et al.*, MILLIMAN, INC., *Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations*, at 1 (March 5, 2015) (Commissioned by the Leukemia & Lymphoma Society) (evaluating the potential effects of four possible benefit design changes for prescription drug cost sharing on premiums, compliance with actuarial value requirements, and member cost sharing), http://www.lls.org/sites/default/files/National/USA/Pdf/Milliman%20Report%20on%20Prescription%20Cost%20Sharing%20Limits%20for%20Exchange%20Plans.pdf.

[302] *See, e.g.,* Barry, Goldman, & Huskamp, *supra* note 14 (reviewing studies of effects of parity requirements and identifying need for additional guidance).

[303] S. 1945, Section 903 (114th Cong., 1st Sess.), https://www.congress.gov/bill/114th-congress/senate-bill/1945 (last visited Oct. 25, 2015).

[304] *See* Oregon Dep't of Consumer & Business Servcs., Oregon Insurance Division Bulletin INS 2014-1 (Nov. 14, 2014), *available at* http://www.oregon.gov/DCBS/Insurance/legal/bulletins/Documents/bulletin2014-01.pdf; *see also* ParityTrack, Regulatory Overview in Oregon, https://www.paritytrack.org/reports/oregon-parity-report-overview/regulation (last visited May 24, 2016).

[305] *See* Parity Implementation Coalition, *State Snapshot on Parity Implementation: Washington* (Jan. 2016) (reporting on Washington state's efforts to implement parity requirements, including adopting regulations to align federal and state parity laws and "to clarify how insurance companies ensure they are delivering mental health and substance use disorder services on par with medical and surgical benefits"), *available at* https://parityispersonal.org/media/photos/WA-state-snapshot.pdf.

department develop a consumer and provider parity education program, which will include live trainings and webinars.[306] Multiple avenues exist for states to partner with the federal government to work to realize parity's promise.

V. Next Steps

The ACA provides important, powerful tools that offer the promise of increasing access to comprehensive behavioral health care to millions of consumers. Many of these tools, however, are new, and their implementation is a work in progress. In particular, advocates, plans, state regulators, and consumers are engaged in an ongoing effort to assess the best methods to understand how plan behavior and the ACA's goals can come into harmony.[307]

In New Jersey, regulatory mechanisms seem poorly matched to the task of evaluating implementation of the ACA's behavioral health provisions. The information necessary to assess parity compliance, for example, is not readily available to consumers, providers, advocates, researchers, or even regulators. Regulatory resources also may not be sufficient to permit the granular analysis needed to assess parity compliance or otherwise monitor ACA implementation. Despite some of the most specific network adequacy regulations in the nation, for example, claims of phantom networks persist, suggesting that enhanced enforcement may be needed.

The Sentinel Project will continue to work with stakeholders to explore possible paths forward. Many states, including California, Connecticut, Maryland, Massachusetts, and New York are experimenting with a variety of legislative, regulatory, and enforcement approaches. These approaches include parity compliance filings and audits, standardized benefit plans, increased transparency, and partnerships with advocacy groups to help connect consumers to appropriate care. CMS is encouraging states to perform outlier analyses to help evaluate prescription tiering and UM. Carriers and advocates are calling for additional guidance from CMS regarding how to implement parity and non-discrimination requirements. President Obama in 2016 convened an interagency Mental Health and Substance Use Disorder Parity Task Force "to identify and promote best practices for executive departments and agencies (agencies), as well as State agencies, to better ensure compliance with and implementation of requirements related to mental health and substance use disorder parity, and [to] determine areas that

[306] *See* ParityTrack, Legislative Overview in Illinois, https://www.paritytrack.org/reports/illinois-parity-report-overview/legislation (last visited May 24, 2016).

[307] *See generally* Barry, Goldman, & Huskamp, *supra* note 14, at 1011-15 (reviewing literature evaluating effects of parity and identifying four areas of concern in the monitoring and enforcement of federal parity: parity in limitations on treatment; parity applied to certain diagnoses and treatment types, like autism and eating disorders; financial protection and parity; and multi-agency enforcement).

would benefit from further guidance."[308] The New Jersey Parity Coalition is working on legislation to improve parity implementation and monitoring in the State.[309]

We intend to work with stakeholders to evaluate the variety of policy options and distill best practices. The Sentinel Project will host a conference in fall 2016 that will bring together thought leaders to share early lessons and work collaboratively to plot a path forward that strives to realize the ACA's goals of improved access to quality BH health care at reasonable cost.

[308] THE WHITE HOUSE, OFFICE OF THE PRESS SECRETARY, Presidential Memorandum -- Mental Health and Substance Use Disorder Parity Task Force (Mar. 29, 2016), *available at* https://www.whitehouse.gov/the-press-office/2016/03/29/presidential-memorandum-mental-health-and-substance-use-disorder-parity.

[309] *See* New Jersey Parity Statement of Purpose, http://overdosepreventionagency.com/files/2015/10/New-Jersey-Parity-Coalition-Overview-and-Join.pdf (last visited May 24, 2016).

Appendix A

Individuals Interviewed or Consulted by the Sentinel Project during Preparation of Report

Lauren Alfred, Kennedy Forum
Barbara Andrews, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services
Diana Autin, Statewide Parent Advocacy Network, Inc. (SPAN)
Dr. Jeffrey Axelbank, New Jersey Psychological Association
Mishael Azam, Medical Society of New Jersey
Thomas Bane, Centers for Medicare & Medicaid Services
Carolyn Beauchamp, Mental Health Association in New Jersey, Inc.
Susanne Buchanan, Autism New Jersey
Adam Bucon, New Jersey Department of Human Services, Division of Mental Health and Addiction Services
Laura Budinick, Newark Beth Israel Medical Center
Robert Budsock, Integrity House
Marlana Cannata, Kennedy Health System
Joel C. Cantor, Rutgers Center for State Health Policy
Garry Carneal, The Kennedy Forum
Doreen Cavanaugh, Georgetown University McCourt School of Public Policy
Chuck Cerniglia, United Healthcare of New Jersey
Debbie Charette, Autism New Jersey
Tim Clement, ParityTrack
Maura Collinsgru, New Jersey Citizen Action
Mary Ellen Connington, Oscar Health
Jackie Cornell-Bechelli, U.S. Department of Health and Human Services
David Cusano, Georgetown University Center on Health Insurance Reforms
Ellen DeRosa, New Jersey Department of Banking & Insurance
Mary Ditri, New Jersey Hospital Association
Joseph Dobosh, Children's Specialized Hospital
Geraldine Doetzer, University of Maryland Carey School of Law Drug Policy Clinic
Adrienne Ellis, Maryland Parity Project
Emily Feinstein, CASAColumbia
Dr. Carl Erik Fisher, Columbia University
Holly Gaenzle, New Jersey Department of Banking & Insurance
Fran Gallagher, American Academy of Pediatrics, New Jersey Chapter
Patrick Gillepsie, Cigna
Janet Giordano, Children's Specialized Hospital
Laura Goodman, formerly of Health Law Advocates

Elena Graziosi, Autism New Jersey
Dr. Nilsa S. Gutierrez, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services
Randall Haggar, California Psychiatric Association
Barbara Hanlon, New Jersey Department of Banking & Insurance
Deborah Hartel, St. Joseph's Regional Medical Center
Dr. Barry Helfmann, New Jersey Psychological Association
Sarah Herbert, Parity Implementation Coalition
Carol Hertenstein, Christian Health Care Center
Dr. Russell Holstein
Mark Humowiecki, Camden Coalition of Healthcare Providers; working with the South Jersey Behavioral Health Innovations Collaborative
Doug Jacobs, Harvard School of Public Health
Cynthia Jay, Health Republic
Barbara Johnston, Mental Health Association in New Jersey, Inc.
Dr. Steve Kairys, American Academy of Pediatrics, New Jersey Chapter
Walter Kalman, National Association of Social Workers, New Jersey Chapter
Dr. Andrea Katz, American Academy of Pediatrics, New Jersey Chapter
Dr. James Korman, Summit Medical Group
Renee Koubiadis, National Association of Social Workers, New Jersey Chapter
Dennis Lafer, Consultant
Dr. Richard Lander, American Academy of Pediatrics, New Jersey Chapter
Sarah Lechner, Barnabas Health
Bradley Lerner, Beacon Health Options
Becky Levy, Summit Medical Group
Larry Lewis, Aetna
John Leyman, Horizon Blue Cross Blue Shield of New Jersey
Danielle Liss, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services
Ruth Lowenkron, Disability Rights New Jersey
Phillip Lubitz, National Alliance on Mental Illness New Jersey
Robert Lubran, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, Division of Pharmacologic Therapies
Amy Mansue, Children's Specialized Hospital
Ed Martone, National Council on Alcoholism and Drug Dependence, NJ state affiliate
Sally McCarty, Georgetown University Center on Health Insurance Reforms
Carol McDaid, Parity Implementation Coalition
Chanell McDevitt, New Jersey Department of Banking & Insurance
Brendan McEntee, American Society of Addiction Medicine
Clare McGorrian, Health Law Advocates
Christine Michaels, Integrity House
Russ Micoli, Kennedy Health System
David Moore, Inspira Health Network
Dave Mordo, National Association of Health Underwriters
Shauna Moses, New Jersey Association of Mental Health Agencies

Mike Munoz, AmeriHealth of New Jersey
Sam Muszynski, American Psychiatric Association
Patrick Newsome, Children's Specialized Hospital
Alan Oberman, John Brooks Recovery Center
Ann O'Grady, Beacon Health Options
Bosede Ogunleye, New Jersey Department of Banking & Insurance
Brendan Peppard, United Healthcare of New Jersey
Ryan Petrizzi, AmeriHealth of New Jersey
Cathy Pilone, Christian Health Care Center
Belinda Doyle Puglisi, Children's Specialized Hospital
Dr. Tanya Pagán Raggio, U.S. Department of Health and Human Services
Dr. Jamie Reedy, Summit Medical Group
Michael Reisman, New York State Office of the Attorney General
Tom Renfree, County Behavioral Health Directors Association of California
Harry Ritter, Oscar Health
Dennis O. Romero, Substance Abuse and Mental Health Services Administration
Rosemarie Rosati, Rutgers University Behavioral Health Care
Dr. Elliot Rubin, American Academy of Pediatrics, New Jersey Chapter
Betsy Ryan, New Jersey Hospital Association
Nancy Ryan, Health Law Advocates
Wardell Sanders, New Jersey Association of Health Plans
John J. Sarno, Employers Association of New Jersey
Peter Saunders, Summit Medical Group
Catherine Ann Sauner, Health Republic
Dr. Michael Shore
Gale Simon, New Jersey Department of Banking & Insurance
Dr. Benjamin D. Sommers, Harvard School of Public Health
Susan L. Speranza, Inspira Health Network
Elizabeth Spring, California Department of Managed Health Care
Renée Steinhagen, New Jersey Appleseed Public Interest Law Center
Douglas A. Struyk, Christian Health Care Center
Trish Toole, Carrier Clinic
Jill Trachtenberg Stein, Oscar Health
Neil Vance, New Jersey Department of Human Services
Joel VandeVusse, Health Republic
Victoria Veltri, Connecticut Office of the Health Care Advocate
Marie Verna, Rutgers University Behavioral Healthcare's Center for Excellence in Psychiatry (CFEP)
Dr. Claire Vernaleken, New Jersey Psychological Association
Mary Watanabe, California Department of Managed Health Care
Ellen Weber, University of Maryland Carey School of Law Drug Policy Clinic
Debra Wentz, New Jersey Association of Mental Health Agencies
Deborah Wilson, New Jersey Psychiatric Association

Frank Winter, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services
Joe Young, Disability Rights New Jersey
Dr. Philip Yucht
Commander Jerry Zee , U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services

Appendix B: Tables

Table	**Page**
Table A: 58 Behavioral Health and Substance Use Disorder Medications Selected for Formulary Survey	84
Table B: Characteristics of Drug Coverage by Carrier in Formulary Survey	86
Table C-1: Carrier A – Drugs Not on Formulary or in High Cost-Sharing Tier	92
Table C-2: Carrier B – Drugs Not on Formulary or in High Cost-Sharing Tier	93
Table C-3: Carrier C – Drugs Not on Formulary or in High Cost-Sharing Tier	94
Table C-4: Carrier D – Drugs Not on Formulary or in High Cost-Sharing Tier	95
Table D: 2015 Smoking Cessation Coverage in Federal Marketplace Plans in New Jersey	96
Table E: Carrier Definitions of Formulary Tiers in 2015 Federal Marketplace Plans in New Jersey	99
Table F: Health Care Facility Expenses Reported in 2014 New Jersey HMO Annual Supplement Reports	100
Table G: Ambulatory Encounters Reported in 2014 New Jersey HMO Annual Supplement Reports	102

Table H:
Commercial Member Complaints Reported in 2014 New Jersey HMO Annual Supplement Reports 103

Table I:
Stage 1 Internal Utilization Management Appeals by Category Reported in 2014 New Jersey HMO Annual Supplement Reports 104

Table J:
Stage 2 Internal Utilization Management Appeals by Category Reported in 2014 New Jersey HMO Annual Supplement Reports 105

Table K:
External Utilization Management Appeals by Disposition and Category Reported in 2014 New Jersey HMO Annual Supplement Reports 106

Table L:
Utilization Management Requests and Denials Reported in 2014 New Jersey HMO Annual Supplement Reports 107

Table M:
Utilization of Inpatient Services Reported in 2014 New Jersey HMO Annual Supplement Reports 108

Table A: 58 Behavioral Health and Substance Use Disorder Medications Selected for Formulary Survey

Drug	Active Ingredient(s)	Notes
Schizophrenia (28)		
Abilify	aripiprazole	-Included Abilify Maintena, long-acting injectable formulation with no available therapeutic equivalent
Adasuve	loxapine	-no available therapeutic equivalent
aripiprazole	aripiprazole	
chlorpromazine hcl	chlorpromazine hcl	
clozapine	clozapine	
Clozaril	clozapine	
Fanapt	iloperidone	-no available therapeutic equivalent
Fazaclo ODT	clozapine	
fluphenazine	fluphenazine decanoate or fluphenazine hcl	
Geodon	ziprasidone hcl or ziprasidone mesylate	-no available therapeutic equivalent for 20 mg/ml injectable or 10 mg/ml oral suspension
haloperidol	haloperidol decanoate or haloperidol lactate	
Haldol	haloperidol decanoate or haloperidol lactate	
Invega	paliperidone and paliperidone palmitate	-therapeutic equivalent for paliperidone approved 8/2015[310] -Included Invega Sustenna (active ingredient paliperidone palmitate), a long-acting injectable formulation with no available therapeutic equivalent
loxapine succinate	loxapine succinate	
Navane	thiothixene	
olanzapine	olanzapine	
perphenazine	perphenazine	
quetiapine fumarate	quetiapine fumarate	
Risperdal	risperidone	-Included Risperdal Consta, a long-acting injectable formulation with no available therapeutic equivalent
risperidone	risperidone	
Saphris	asenapine maleate	-no available therapeutic equivalent
Seroquel	quetiapine fumarate	-Included Seroquel XR, an extended release formulation with no available therapeutic equivalent
thioridazine hcl	thioridazine hcl	
thiothixene	thiothixene	
trifluoperazine	trifluoperazine	
Versacloz	clozapine	-no available therapeutic equivalent

[310] We did not include paliperidone, Invega's active ingredient, in our survey because the FDA only approved it as a generic drug in August 2015. We note that Carrier A already had added it to its formulary by fall 2015.

Drug	Active Ingredient(s)	Notes
ziprasidone	ziprasidone	
Zyprexa	olanzapine and olanzapine pamoate	-Included Zyprexa Zydis (olanzapine) -Included Zyprexa Relprevv (olanzapine pamoate), an extended release injectable suspension with no available therapeutic equivalent
Bipolar Disorder (10)		
Depacon	valproate sodium	
Depakene	valproic acid	
Depakote	divalproex sodium	-Included Depakote ER, an extended release formulation with no available therapeutic equivalent
divalproex sodium	divalproex sodium	
Lamictal	lamotrigine	
lamotrigine	lamotrigine	
Lithium	lithium carbonate or lithium citrate	
Lithobid	lithium carbonate	
valproate sodium	valproate sodium	
valproic acid	valproic acid	
Drug Cessation (15)		
acamprosate calcium	acamprosate calcium	
Antabuse	disulfiram	
Bunavail	buprenorphine and naloxone	-no available therapeutic equivalent
buprenorphine hcl	buprenorphine hcl	
buprenorphine hcl-naloxone hcl	buprenorphine hcl and naloxone hcl	
Campral	acamprosate calcium	
disulfiram	disulfiram	
Dolophine	methadone hcl	-no available therapeutic equivalent for 10mg/ml injectable
methadone hcl	methadone hcl	-Included methadone hcl intensol oral concentrate
Methadose	methadone hcl	
naltrexone hcl	naltrexone hcl	
Revia	naltrexone hcl	
Suboxone	buprenorphine hcl and naloxone hcl	-no available therapeutic equivalent
Vivitrol	naltrexone	-no available therapeutic equivalent
Zubsolv	buprenorphine hcl and naloxone hcl	-no available therapeutic equivalent
Smoking Cessation (5)		
bupropion hcl	bupropion hcl	
Chantix	varenicline tartrate	-no available therapeutic equivalent
Nicotrol Inhalant	nicotine	-no available therapeutic equivalent
Nicotrol NS (nasal spray)	nicotine	-no available therapeutic equivalent
Zyban	bupropion hcl	

Table B: 58 Behavioral Health and Substance Use Disorder Medications Selected for Formulary Survey

	Drugs Not on Formulary[311]	Drugs Subject to Step Therapy/Fail First Requirement	Drugs Subject to Prior Authorization Requirement	Drugs Subject to Quantity Limits[312]	Drugs Placed in a Specialty Tier
Carrier A	**Total: 5/58 (8.6%)** **Schizophrenia:** **2/28 (7.1%):** -Haldol -Navane **Bipolar: 1/10 (10%):** -Depacon **Drug Cessation:** **2/15 (13.3%):** -Campral -Vivitrol	**Total: 0/58 (0%)** **Schizophrenia:** **0/28 (0%)** **Bipolar: 0/10 (0%)** **Drug Cessation:** **0/15 (0%)**	**Total: 11/58 (19%)** **Schizophrenia:** **4/28 (14.3%)** -Adasuve -Fanapt -Invega -Saphris **Bipolar: 0/10 (0%)** **Drug Cessation:** **7/15 (46.7%)** -Bunavail -buprenorphine hcl -buprenorphine and naloxone -Dolophine -methadone hcl 5 mg and 10 mg tab and 40 mg for oral solution; methadone hcl 10 mg/5ml or 5 mg/5ml oral solution; Methadone Intensol 10 mg/ml oral concentrate -Methadose TBSO 40 mg and concentrate 10 mg/ml -Zubsolv	**Total: 10/58 (17.2%)** **Schizophrenia:** **0/28 (0%)** **Bipolar: 0/10 (0%)** **Drug Cessation:** **5/15 (33.3%)** -Bunavail 120 ea per 30 days -buprenorphine hcl 120 ea per 30 days -buprenorphine and naloxone 2 mg-10.5 ml: 120 ea per 30 days; 8mg-2mg: 90 per 30 days -Suboxone 12 mg: 60 per 30 days; 8 mg: 90 per 30 days; 2 mg and 4 mg: 120 per 30 days -Zubsolv 1.4 mg-0.36 mg and 2.9 mg-0.71 mg SL tab: 120 per 30 days; 5.7 mg-1.4 mg SL tab: 90 per 30 days; 8.6 mg-2.1 mg SL tab: 60 per 30 days; 11.4 mg-2.9 mg SL tab: 30 per 30 days	**Total: 0/58 (0%)** **Schizophrenia:** **0/28 (0%)** **Bipolar: 0/10 (0%)** **Drug Cessation:** **0/15 (0%)**

[311] There were numerous instances of a formulary including one of the 58 surveyed drugs in some dosage amount or format but not in others. We included in this category only drugs that were not included in the carrier's formulary for any dosage or form of the given drug.

[312] We were unable to find details of Carrier E's quantity limits on its web site.

	Drugs Not on Formulary[311]	Drugs Subject to Step Therapy/Fail First Requirement	Drugs Subject to Prior Authorization Requirement	Drugs Subject to Quantity Limits[312]	Drugs Placed in a Specialty Tier
	Smoking Cessation: **0/5 (0%)**	**Smoking Cessation:** **0/5 (0%)**	**Smoking Cessation:** **0/5 (0%)**	**Smoking Cessation:** **5/5 (100%)** -bupropion hcl tab sr 12 hr 150 mg: 60 per 30 days -Chantix: 60 ea per 30 days -Nicotrol inhalation: 300 ea per 30 days -Nicotrol NS: 80 ml per 30 days -Zyban: 60 ea per 30 days	**Smoking Cessation:** **0/5 (0%)**
Carrier B	**Total: 17/58 (29.3%)** **Schizophrenia:** **5/28 (17.9%):** -Adasuve -Clozaril -Haldol -Navane -Versacloz **Bipolar: 5/10 (50%):** -Depacon -Depakene -Depakote -Lamictal -Lithobid **Drug Cessation :** **6/15 (40%):** -Antabuse -Bunavail -Dolophine -Methadose -Revia -Zubsolv	**Total: 0/58 (0%)** **Schizophrenia:** **0/28 (0%)** **Bipolar: 0/10 (0%)** **Drug Cessation:** **0/15 (0%)**	**Total: 11/58 (19%)** **Schizophrenia:** **6/28 (21.4%)** -Abilify solution, ODT, Maintena -aripiprazole -Invega Sustenna -Risperdal Consta -Seroquel XR -Zyprexa Relprevv **Bipolar: 1/10 (10%)** -valproate sodium inj 100 mg/ml **Drug Cessation:** **4/15 (26.7%)** -buprenorphine hcl -buprenorphine and naloxone -Suboxone -Vivitrol	**Total: 7/58 (12.1%)** **Schizophrenia:** **4/28 (14.3%)** -Abilify ODT 30/30 days -aripiprazole 30/30 days -Fanapt 60/30 days -Invega 60/30 days **Bipolar: 0/10 (0%)** **Drug Cessation:** **3/15 (20%)** -buprenorphine hcl 90/30 days -buprenorphine and naloxone 90/30 days -methadone hcl 5 mg and 10 mg tab 180/30 days	**Total: 4/58 (6.9%)** **Schizophrenia:** **3/28 (10.7%)** -Abilify Maintena -Invega Sustenna -Risperdal Consta **Bipolar: 0/10 (0%)** **Drug Cessation:** **1/15 (6.7%)** -Vivitrol

	Drugs Not on Formulary[311]	Drugs Subject to Step Therapy/Fail First Requirement	Drugs Subject to Prior Authorization Requirement	Drugs Subject to Quantity Limits[312]	Drugs Placed in a Specialty Tier
	Smoking Cessation: **1/5 (20%):** -Zyban	**Smoking Cessation:** **0/5 (0%)**	**Smoking Cessation:** **0/5 (0%)**	**Smoking Cessation:** **0/5 (0%)**	**Smoking Cessation:** **0/5 (0%)**
Carrier C	**Total: 5/58 (8.6%)** **Schizophrenia :** **2/28 (7.1%):** -Adasuve -Navane **Bipolar: 1/10 (10%):** -Depacon **Drug Cessation:** **2/15 (13.3%):** -Campral -Vivitrol	**Total: 4/58 (6.9%)** **Schizophrenia:** **2/28 (7.1%)** -Geodon caps[313] -Zyprexa tabs and Zydis **Bipolar: 0/10 (0%)** **Drug Cessation:** **1/15 (6.7%)** -Dolophine	**Total: 8/58 (13.8%)** **Schizophrenia:** **2/28 (7.1%)** -Geodon caps -Zyprexa tabs and Zydis **Bipolar: 0/10 (0%)** **Drug Cessation:** **6/15 (40%)** -Bunavail -buprenorphine hcl -buprenorphine and naloxone -Dolophine -Suboxone sublingual film -Zubsolv	**Total: 9/58 (15.5%)** **Schizophrenia:** **0/28 (0%)** **Bipolar: 0/10 (0%)** **Drug Cessation:** **8/15 (53.3%)** -Bunavail 2.1 mg/0.3 mg buccal film: 3 films/day; 4.2 mg/0.7 mg buccal film: 2 films/day; 6.3 mg/1mg buccal film: 2 films/day -buprenorphine hcl 2 mg or 8 mg SL tab: 15 tabs/90 days -buprenorphine and naloxone 2 mg or 8 mg SL tab: 15 tabs/90 days -Dolophine 3 tabs/day -methadone hcl tab 40 mg for oral susp: 3 tabs per day; Methadone HCL solution 5 mg/5ml: 30 mls per day; Methadone HCL solution 10	**Total: 0/58 (0%)** **Schizophrenia:** **0/28 (0%)** **Bipolar: 0/10 (0%)** **Drug Cessation:** **0/15 (0%)**

[313] Carrier C had a policy that "requires the previous use of one or more medicines (usually a generic drug) before a different medicine (usually a brand name drug) is covered. The . . . process will automatically search for the previous use of one or more of the required generic drugs before the brand name drug will be covered. If that previous use history is present, the request for the brand name drug will be approved automatically." A doctor had to submit a prior authorization request to avoid this requirement. We classified drugs subject to this policy as requiring both step therapy and PA.

	Drugs Not on Formulary[311]	Drugs Subject to Step Therapy/Fail First Requirement	Drugs Subject to Prior Authorization Requirement	Drugs Subject to Quantity Limits[312]	Drugs Placed in a Specialty Tier
	Smoking Cessation: **0/5 (0%)**	**Smoking Cessation:** **0/5 (0%)**	**Smoking Cessation:** **0/5 (0%)**	mg/5ml: 15 mls per day; methadone hcl 10 mg/5ml: 15 mls/day; methadone hcl 5 mg/5ml: 30 mls per day -Methadose concentrate 10 mg/ml: 3 mls per day -Suboxone sublingual film 4mg: 1 film/day; 2 mg: 4 films/day; 8 mg: 2 films/day; 12 mg: 2 films/day -Zubsolv: 1.4/0.36 mg or 5.7/1.4 mg SL tab: 3 per day; 8.6/2.1 mg SL tab: 2 per day **Smoking Cessation:** **1/5 (20%)** -Chantix: 56 tablets/28 days, max of 168 days per lifetime	**Smoking Cessation:** **0/5 (0%)** -
Carrier D	**Total: 2/58 (3.4%)** **Schizophrenia :** **1/28 (3.6%):** -aripiprazole **Bipolar: 0/10 (0%):** **Drug Cessation:** **1/15 (6.7%):** -Bunavail	**Total: 2/58 (3.4%)** **Schizophrenia:** **2/28 (7.1%)** -Abilify solution and tabs -Seroquel XR **Bipolar: 0/10 (0%)** **Drug Cessation:** **0/15 (0%)**	**Total: 4/58 (7%)** **Schizophrenia:** **1/28 (3.6%)** -thioridazine hcl tabs **Bipolar: 0/10 (0%)** **Drug Cessation:** **3/15 (20%)** - buprenorphine and naloxone -Suboxone sublingual tab and film -Zubsolv	**Total: 3/58 (7.9%)** **Schizophrenia:** **0/28 (0%)** **Bipolar: 0/10 (0%)** **Drug Cessation:** **3/15 (20%)** -Dolophine 120 tabs per 25 days -Methadone HCL 5mg and 10 mg tabs: 120 tabs per 25 days; methadone hcl 10 mg tab: 3 tabs per day; Methadone TBSO 40 mg disp tab 9 tabs per 25 days; Methadone HCL solution 5 mg/5ml and 10 mg/5ml: 600 ml per 25 days; Methadone HCL	**Total: 1/58 (1.7%)** **Schizophrenia:** **0/28 (0%)** **Bipolar: 0/10 (0%)** **Drug Cessation:** **1/15 (6.7%)** -Vivitrol

	Drugs Not on Formulary[311]	Drugs Subject to Step Therapy/Fail First Requirement	Drugs Subject to Prior Authorization Requirement	Drugs Subject to Quantity Limits[312]	Drugs Placed in a Specialty Tier
				concentrate 10 mg/ml: 30 ml per 25 days; Methadone HCL solution 10 mg/ml: 1 multi-dose vial per 25 days; Methadone Intensol 10 mg/ml oral concentrate: 30 ml per 25 days -Methadose 10 mg tabs: 120 tabs per 25 days; TBSO 40 mg: 9 tabs per 25 days; concentrate 10 mg/ml: 30 ml per 25 days	
	Smoking Cessation: 0/5 (0%)	**Smoking Cessation: 0/5 (0%)**	**Smoking Cessation: 0/5 (0%)**	**Smoking Cessation: 0/5 (0%)**	**Smoking Cessation: 0/5 (0%)**
Carrier E	**Total: 14/58 (24.1%)** **Schizophrenia: 7/28 (25%):** -Abilify[314] -Geodon -Haldol -Navane -Risperdal -Versacloz -Zyprexa **Bipolar :1/10 (10%):** -Depacon	**Total: 5/58 (8.6%)** **Schizophrenia: 0/28 (0%)** **Bipolar: 2/10 (20%)** -Lamictal tabs, chewable, XR, ODT	**Total: 8/58 (13.8%)** **Schizophrenia: 0/28 (0%)** **Bipolar: 2/10 (20%)** -Depakote tabs, sprinkles, ER tabs	**Total: 11/58 (19%)** **Schizophrenia: 8/28 (28.6%)** -aripiprazole -Fanapt -Invega -olanzapine tabs & ODT -quetiapine fumarate tabs -Saphris 5 and 10 mg SL tab -Seroquel XR -ziprasidone hcl caps **Bipolar: 1/10 (10%)** -Depakote sprinkles and ER tabs	**Total: 0/58 (0%)** **Schizophrenia: 0/28 (0%)** **Bipolar: 0/10 (0%)**

[314] Carrier E's formulary included Abilify solution 1mg/ml, but this form of the drug was voluntarily discontinued in 2015, and the FDA estimated that it would not be available after May 15, 2015. *See* U.S. FOOD & DRUG ADMIN., Current and Resolved Drug Shortages and Discontinuations Reported to FDA, http://www.accessdata.fda.gov/scripts/drugshortages/dsp_ActiveIngredientDetails.cfm?AI=Aripiprazole+%28Abilify%29&source=govdelivery&st=d&tab=tabs-4&utm_medium=email&utm_source=govdelivery (last visited Oct. 7, 2015). Thus, in 2015, Carrier E's formulary did not include any formulation of Abilify that was being marketed at the time of the study.

	Drugs Not on Formulary[311]	Drugs Subject to Step Therapy/Fail First Requirement	Drugs Subject to Prior Authorization Requirement	Drugs Subject to Quantity Limits[312]	Drugs Placed in a Specialty Tier
	Drug Cessation: **5/15 (33.3%):** -acamprosate -buprenorphine and naloxone -Bunavail -Suboxone -Vivitrol **Smoking Cessation:** **1/5 (20%):** -Zyban	-lamotrigine disintegrating tabs and ER **Drug Cessation:** **0/15 (0%)** **Smoking Cessation:** **3/5 (60%)[315]** -Chantix -Nicotrol inhalation -Nicotrol NS	-Lamictal tab, chewable, XR, ODT **Drug Cessation:** **2/15 (13.3%)** -buprenorphine hcl -Zubsolv **Smoking Cessation:** **4/5 (80%)** -bupropion hcl tab sr 12 hr 150 mg -Chantix -Nicotrol inhalation -Nicotrol NS	**Drug Cessation:** **2/15 (13.3%)** -buprenorphine hcl -Zubsolv **Smoking Cessation:** **0/5 (0%)**	**Drug Cessation:** **0/15 (0%)** **Smoking Cessation:** **0/5 (0%)**

[315] Carrier E's formulary grid did not indicate that Chantix, Nicotrol inhalation, Nicotrol NS, or Zyban had step therapy requirements. But it disclosed on the third to the last page in the formulary that these drugs "are covered with Prior Authorization after members have tried: 1) One over-the-counter nicotine product and 2) Bupropion sustained-release (generic Zyban) separately." We thus classified these drugs as being subject to step therapy.

Table C-1: Carrier A - Drugs Not on Formulary or in High Cost-Sharing Tier[316]

Drugs Either Not on Formulary or in Tier with ≥ 50% Coinsurance for All Carrier A Plans Surveyed[317]	Drugs in Tier with ≥ 50% Coinsurance for Carrier A Median and Highest Premium Plans Surveyed[318]
Total: 26/53[319] (49.1%)	**Total: 27/53 (50.9%)**
Schizophrenia: 14/28 (50%) -Abilify -Adasuve -Clozaril -Fanapt -Fazaclo -Geodon -Haldol -Invega -Navane -Risperdal -Saphris -Seroquel -Versacloz -Zyprexa	**Schizophrenia: 14/28 (50%)** -aripiprazole -chlorpromazine hcl -clozapine -fluphenazine hcl -haloperidol -loxapine succinate -olanzapine -perphenazine -quetiapine fumarate -risperidone -thioridazine hcl -thiothixene -trifluoperazine -ziprasidone
Bipolar: 5/10 (50%) -Depacon -Depakene -Depakote -Lamictal -Lithobid	**Bipolar: 5/10 (50%)** -divalproex sodium -lamotrigine -lithium -valproate sodium -valproic acid
Drug Cessation: 7/15 (46.7%) -Antabuse -Bunavail -buprenorphine and naloxone -Campral -Dolophine -Vivitrol -Zubsolv	**Drug Cessation: 8/15 (53.3%)** -acamprosate calcium -buprenorphine hcl -disulfiram -methadone -Methadose -naltrexone hcl -Revia -Suboxone

[316] We note, however, that the Carrier A plans that we surveyed generally included a $125 maximum out-of-pocket cap per 1-30 day prescription filled (and a $250 maximum out-of-pocket cost for each 31-90 day prescription filled). This plan design feature helped to address the affordability concerns raised by high cost-sharing tiers.

[317] We included in this count drugs for which every dosage amount and form listed in the carrier's formulary was in a tier that had at least 50% coinsurance (or was excluded from the formulary). There were several instances where the formulary put certain dosages or forms of a drug into a high cost-sharing tier, but at least one dosage amount or form had less than a 50% coinsurance. We did not count these drugs, so our count understates the extent to which the surveyed drugs were in high cost-sharing tiers.

[318] Carrier A tiered at least some (but frequently not all) dosage amounts or forms of these drugs in Tier 1. The lowest and second lowest premium Carrier A plans surveyed had cost-sharing of $7 for Tier 1 drugs, which we did not categorize as high cost-sharing. But the median and highest premium plans required 50% coinsurance even for Tier 1 drugs.

[319] We did not include the tobacco cessation drugs in this count because they are supposed to be available with zero cost-sharing.

Table C-2: Carrier B - Drugs Not on Formulary or in High Cost-Sharing Tier

Drugs Not on Carrier B's Formulary	Drugs in Tiers with ≥ 40% Coinsurance for Carrier B Median and Highest Premium Plans Surveyed[320]
Total: 16/53[321] (30.2%)	**Total: 6/53 (11.3%)**
Schizophrenia: 5/28 (17.9%) -Adasuve -Clozaril -Haldol -Navane -Versacloz	**Schizophrenia: 3/28 (10.7%)** -Fazaclo -Saphris -Seroquel
Bipolar: 5/10 (50%) -Depacon -Depakene -Depakote -Lamictal -Lithobid	**Bipolar: 0/10 (0%)**
Drug Cessation: 6/15 (40%) -Antabuse -Bunavail -Dolophine -Methadose -Revia -Zubsolv	**Drug Cessation: 3/15 (20%)** -buprenorphine hcl -buprenorphine and naloxone -Suboxone

[320] Carrier B tiered at least some (but frequently not all) dosage amounts or forms of these drugs in Tier 3. The lowest and second lowest premium Carrier B plans surveyed had a copayment of $75 retail or $187.50 for mail order for Tier 3 drugs, which we did not categorize as high cost-sharing. But the median and highest premium plans required 40% coinsurance for Tier 3 drugs after the deductible.

[321] We did not include the tobacco cessation drugs in this count because they are supposed to be available with zero cost-sharing.

Table C-3: Carrier C - Drugs Not on Formulary or in High Cost-Sharing Tier

Drugs Either Not on Formulary or in Tiers with ≥ 30% Coinsurance for All Carrier C Plans Surveyed[322]	Drugs in Tiers with ≥ 30% Coinsurance for Carrier C Lowest, Second Lowest, and Highest Premium Plans Surveyed[323]
Total: 28/53[324] (52.8%)	**Total: 25/53 (47.2%)**
Schizophrenia: 14/28 (50%) -Abilify -Adasolve -Clozaril -Fanapt -Fazaclo -Geodon -Haldol -Invega -Navane -Risperdal -Saphris -Seroquel -Versacloz -Zyprexa	**Schizophrenia: 14/28 (50%)** -aripiprazole -chlorpromazine hcl -clozapine -fluphenazine hcl -haloperidol -loxapine succinate -olanzapine -perphenazine -quetiapine fumarate -risperidone -thioridazine hcl -thiothixene -trifluoperazine -ziprasidone
Bipolar: 5/10 (50%) -Depacon -Depakene -Depakote -Lamictal -Lithobid	**Bipolar: 5/10 (50%)** -divalproex sodium -lamotrigine -lithium -valproate sodium -valproic acid
Drug Cessation: 9/15 (60%) -Antabuse -Bunavail -Campral -Dolophine -Methadose -Revia -Suboxone -Vivitrol -Zubsolv	**Drug Cessation: 6/15 (40%)** -acamprosate calcium -buprenorphine hcl -buprenorphine and naloxone -disulfiram -methadone -naltrexone hcl

[322] We included in this count drugs for which every dosage amount and form listed in Carrier C's formulary was in a tier that had at least 30% coinsurance (or was excluded from the formulary). There were several instances where the formulary put certain dosages or forms of a drug into a high cost-sharing tier, but at least one dosage amount or form had less than a 30% coinsurance. We did not count these drugs, so our count understates the extent to which the surveyed drugs were in high cost-sharing tiers.

[323] Carrier C tiered at least some (but frequently not all) dosage amounts or forms of these drugs in Tier 1. The median premium Carrier C plan surveyed had a copayment of $15 for retail and $30 for mail for Tier 1 drugs, which we did not categorize as high cost-sharing. But Carrier C's lowest, second lowest, and highest premium plans required 30% coinsurance even for Tier 1 drugs.

[324] We did not include the tobacco cessation drugs in this count because they are supposed to be available with zero cost-sharing.

Table C-4: Carrier D - Drugs Not on Formulary or in High Cost-Sharing Tier

Drugs Either Not on Formulary or in Tiers with ≥ 30% Coinsurance for All Carrier D Plans Surveyed[325]	Drugs in Tiers with ≥ 50% Coinsurance for Carrier D Median Premium Plan Surveyed[326]
Total: 29/53[327] (54.7%)	**Total: 24/53 (45.3%)**
Schizophrenia: 16/28 (57.1%) -Abilify -Adasuve -aripiprazole -chlorpromazine hcl -Clozaril -Fanapt -Fazaclo -Geodon -Haldol -Invega -Navane -Risperdal -Saphris -Seroquel -Versacloz -Zyprexa	**Schizophrenia: 12/28 (42.9%)** -clozapine -fluphenazine hcl -haloperidol -loxapine succinate -olanzapine -perphenazine -quetiapine fumarate -risperidone -thioridazine hcl -thiothixene -trifluoperazine -ziprasidone
Bipolar: 5/10 (50%) -Depacon -Depakene -Depakote -Lamictal -Lithobid	**Bipolar: 5/10 (50%)** -divalproex sodium -lamotrigine -lithium -valproate sodium -valproic acid
Drug Cessation: 8/15 (53.3%) -Antabuse -Bunavail -Campral -Dolophine -Revia -Suboxone -Vivitrol -Zubsolv	**Drug Cessation: 7/15 (46.7%)** -acamprosate calcium -buprenorphine hcl -buprenorphine and naloxone -disulfiram -methadone -Methadose -naltrexone hcl

[325] We included in this count drugs for which every dosage amount and form listed in Carrier D's formulary was in a tier that had at least 30% coinsurance (or was excluded from the formulary). There were several instances where the formulary put certain dosages or forms of a drug into a high cost-sharing tier, but at least one dosage amount or form had less than a 30% coinsurance. We did not count these drugs, so our count understates the extent to which the surveyed drugs were in high cost-sharing tiers.

[326] Carrier D tiered at least some (but frequently not all) dosage amounts or forms of these drugs in Tier 1. The lowest, second lowest, and highest premium Carrier D plans surveyed had no cost-sharing for Tier 1 drugs, which we did not categorize as high cost-sharing. But Carrier D's median premium plan required 50% coinsurance for all of its tiers.

[327] We did not include the tobacco cessation drugs in this count because they are supposed to be available with zero cost-sharing.

Table D: 2015 Smoking Cessation Coverage Federal Marketplace Plans in New Jersey

	Carrier A	Carrier B	Carrier C	Carrier D	Carrier E
bupropion hydrochloride (hcl) (smoking deterrent) Tab SR 12 hour	-**Tier 1** – Formulary Generic -**Quantity Limit**: 60 tablets per 30 days **Related Cost-sharing:** -Lowest premium plan: $7 copay -2nd Lowest premium plan: $7 copay -Median premium plan: 40% coinsurance -Highest premium plan: 50% coinsurance	-**Tier 0** Preventive	-**Tier A** - Preventive	-**Tier 0** Preventive	-**HCR Preventive Care** -**Notification/Prior Authorization**
Chantix (varenicline tartrate)	-**Tier 3** – Non-Formulary Brand -**Quantity Limit**: 60 each per 30 days **Related Cost-sharing:** -50% coinsurance for all plans surveyed	-**Tier 0** Preventative	-**Tier A** – Preventive -**Quantity Limit**: 56 tabs/28 days, max of 168 days per lifetime	-**Tier 0** Preventive	-**HCR Preventive Care** -**Step Therapy and Notification/Prior Authorization:** first must try OTC nicotine product and bupropion hcl; if fail, will be covered with prior authorization

	Carrier A	Carrier B	Carrier C	Carrier D	Carrier E
Nicotrol Inhaler (nicotine inhalation system)	-**Tier 3** – Non-Formulary Brand -**Quantity Limit**: 300 EA per 30 day(s) **Related Cost-sharing:** -50% coinsurance for all plans surveyed	-**Tier 0** Preventative	-**Tier A** - Preventive	-**Tier 3** Non-Preferred Brands **Related Cost-sharing:** -Lowest premium plan: 30% coinsurance -2nd Lowest premium plan: 30% coinsurance -Median premium plan: 50% coinsurance -Highest premium plan: 50% coinsurance	-**HCR Preventive Care** -**Step Therapy and Notification/Prior Authorization:** first must try OTC nicotine product and bupropion hcl; if fail, will be covered with prior authorization
Nicotrol NS (nicotine nasal spray)	-**Tier 3** – Non-Formulary Brand -**Quantity Limit**: 80 ML per 30 day(s) **Related Cost-sharing:** -50% coinsurance for all plans surveyed	**-Tier 0** Preventative	-**Tier A** - Preventive	-**Tier 3** Non-Preferred Brands **Related Cost-sharing:** -Lowest premium plan: 30% coinsurance -2nd Lowest premium plan: 30% coinsurance -Median premium plan: 50% coinsurance -Highest premium plan: 50% coinsurance	-**HCR Preventive Care** -**Step Therapy and Notification/Prior**

	Carrier A	Carrier B	Carrier C	Carrier D	Carrier E
					Authorization: first must try OTC nicotine product and bupropion hcl; if fail, will be covered with prior authorization
Zyban Tablet ER (bupropion hydrochloride sustained release)	-**Tier 3** – Non-Formulary Brand -**Quantity Limit**: 60 EA per 30 day(s) **Related Cost-sharing:** -50% coinsurance for all plans surveyed	(**Not on Formulary)**	-**Tier A** - Preventive	-**Tier 0** Preventive	(**Not on Formulary)**

Table E: Carrier Definitions of Formulary Tiers in 2015 Federal Marketplace Plans in New Jersey

	Lowest Tier	Second Lowest Tier	Third Lowest Tier	Fourth Lowest Tier	Other Tiers or Designations
Carrier A	Tier 1 - Formulary Generic	Tier 2 - Formulary Brand	Tier 3 - Non-Formulary Brand		-Specialty Pharmacy designation - Access may be limited to the preferred specialty vendor[328]
Carrier B	Tier 1 - Preferred Generics	Tier 2 - Preferred Brands	Tier 3 - Non-Preferred Generic & Brand Names		-Tier 0 – Preventative -Specialty Drugs: Specialty drugs are high-cost drugs used to treat complex or rare conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia
Carrier C	Tier 1 – Lowest Copayment/Cost-share – Generic Drugs	Tier 2 – Middle Copayment/Cost-share – Preferred Brand Drugs	Tier 3 – Highest Copayment/Cost-share – Non-Preferred Brand Drugs		-Tier A – Preventive -Specialty designation: requires PA and use of specialty pharmacy
Carrier D	Tier 1 – Generics	Tier 2 - Preferred Brand Drugs	Tier 3 - Non-Preferred Brand Drugs	Tier 4 - Specialty Drugs	-Tier O – Preventive Drugs
Carrier E	Tier 1 Lowest Cost: Lower-cost drugs. Some low-cost brands are also included.	Tier 2 Mid-Range cost: Mix of brands and generics.	Tier 3 Highest Cost: Mostly higher-cost brand as well as select generic drugs.		-HCR Preventive Care -Specialty Medication designation

[328] Carrier A's SBCs listed a fourth tier for Specialty Drugs, although its formulary noted specialty drugs with a special notation in the table of covered drugs. Because the cost-sharing was the same in the SBC for Tier 3 and the Specialty Tier, we followed the formulary and described Carrier A's coverage in terms of three tiers.

Table F: Health Care Facility Expenses Reported in 2014 New Jersey HMO Annual Supplement Reports

		Carrier A – Contracting Facility	Carrier A – Non-Contracting Facility	Carrier C – Contracting Facility	Carrier C – Non-Contracting Facility	Carrier E – Contracting Facility	Carrier E – Non-Contracting Facility
Total Inpatient Services (excluding ER)[329]		$155,886,749	$13,129,729	$212,259,540	$7,977,055	$59,016,799.57	$9,081,300.60
	BH Services	$378,112	$50,307	$92,587	$0	$973,609.04	$625,555.15
	SUD Treatment Services	$440,324	$21,238	$13,421	$0	$225,522.34	$412,722.68
	% of Total Inpatient – BH	**0.24%**	**0.38%**	**0.04%**	**0%**	**1.6%**	**6.9%**
	% of Total Inpatient – SUD	**0.28%**	**0.16%**	**0.006%**	**0%**	**0.38%**	**4.5%**
Total Outpatient Services (excluding ER) [330]		$94,050,320	$9,253,463	$104,601,184	$306,461	$36,553,298.30	$2,449,278.53
	BH Services	$0	$0	$62,142	$1,080	$11,849.76	$0
	SUD Treatment Services	$0	$0	$8,852	$0	$0	$54,835.57
	% of Total Outpatient – BH	**0%**	**0%**	**0.06%**	**0.35%**	**0.03%**	**0%**
	% of Total Outpatient – SUD	**0%**	**0%**	**0.008%**	**0%**	**0%**	**0.24%**
Total Hospital Expenses		$264,373,755	$23,776,704	$342,118,967	$8,530,755	$112,041,828.87	$31,138,242.13
Total BH Hospital Expenses		$378,112	$50,307	$154,729	$1,080	$985,458.80	$625,555.15
Total SUD Hospital Expenses		$440,324	$21,238	$22,273	$0	$225,522.34	$467,558.25

[329] Included General Acute Care Hospital Services, Comprehensive Rehab Services, and Skilled Nursing Facility Services, in addition to Behavioral Health and Substance Abuse Treatment Services.

[330] Included Outpatient General Acute Care Hospital Services and Comprehensive Rehab Services, in addition to Behavioral Health and Substance Abuse Treatment Services.

% of Total Hospital – BH		**0.14%**	**0.21%**	**0.045%**	**0.01%**	**0.9%**	**2%**
% of Total Hospital – SUD		**0.17%**	**0.09%**	**0.007%**	**0%**	**0.2%**	**1.5%**

Table G: Ambulatory Encounters Reported in 2014 New Jersey HMO Annual Supplement Reports

	Carrier A	Carrier C	Carrier E
Total Ambulatory Encounters[331]	1,158,048	1,441,420	534,833
Non-BH Medical Care Ambulatory Encounters (PCPs and Specialists)	658,382	847,909	433,776
Ambulatory Encounters – BH	6,638	9,518	45,901
Ambulatory Encounters – SUD Referral and Treatment	5,304	317	3,606
% of Total Ambulatory Encounters – Non-BH Medical Care	**56.9%**	**58.8%**	**81.1%**
% of Total Ambulatory Encounters – BH	**0.6%**	**0.7%**	**8.6%**
% of Ambulatory Encounters – SUD	**0.5%**	**0.02%**	**0.7%**

[331] Included, in addition to medical care, behavioral health, and substance use referral and treatment ambulatory encounters, other direct services, namely home health, emergency department, or "other," which included hospital, extended care facilities/skilled nursing facilities, among others; and ambulatory surgery.

Table H: Commercial Member Complaints Reported in 2014 New Jersey HMO Annual Supplement Reports

		Carrier A	Carrier C	Carrier E
Complaints (except BH and SUD)		**191**	**963**	**1832**
Behavioral Health Complaints		**16**	**5**	**1**
	Appointment Availability – Other	2 (12.5%)		
	Dissatisfaction with Quality of Medical Care – Other Type of Provider	6 (37.5%)	1 (20%)	
	Dissatisfaction with Provider Office Administration	5 (31.3%)	2 (40%)	
	Dissatisfaction with Provider Network		1 (20%)	1 (50%)
	Reimbursement Problems – Unpaid Claims	3 (18.8%)	1 (20%)	
	Member Not Covered at Time of Service			1 (50%)
Substance Abuse Treatment Complaints		**10**	**0**	**5**[332]
	Appointment Availability – Other	1 (10%)		
	Dissatisfaction with Quality of Medical Care – Inpatient			2 (33.33%)
	Dissatisfaction with Quality of Medical Care – Other Type of Provider	4 (40%)		1 (16.67%)
	Dissatisfaction with Plan Benefit Design	2 (20%)		
	Dissatisfaction with Marketing, Member Services or Handbook			1 (16.67%)
	Dissatisfaction with Utilization Management Appeal Process			2 (33.33%)
	Reimbursement Problems – Unpaid Claims	3 (30%)		
Total # of Complaints		**217**	**968**	**1838**
% of Complaints – BH		**7.4%**	**0.5%**	**0.1%**
% of Complaints – SUD		**4.6%**	**0%**	**0.3%**

[332] We believe this was a typographical error and should be 6, to match the number of complaints itemized in Table I(c) of Carrier's E's annual supplement.

Table I: Stage 1 Internal Utilization Management Appeals by Category Reported in 2014 New Jersey HMO Annual Supplement Reports[333]

	Carrier A - BH	Carrier A - SUD	Carrier A – Non-BH/SUD	Carrier C - BH	Carrier C - SUD	Carrier C – Non-BH/SUD	Carrier E - BH	Carrier E - SUD	Carrier E – Non-BH/SUD
Total Appeals	3	11	142	69	38	270	20	12	739
Denial of Inpatient Admissions	0 (0%)	0 (0%)	0 (0%)	24 (34.8%)	5 (13.2%)	7 (2.6%)	6 (28.6%)	0 (0%)	197 (27%)
Denial of Inpatient Hosp. Days	2 (66.7%)	6 (54.5%)	28 (19.7%)	2 (2.9%)	2 (5.3%)	0 (0%)	0 (0%)	0 (0%)	3 (0.4%)
Reduction of Acuity Level	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	12 (57.1%)	11 (100%)	0 (0%)
Denial of Emergency Services	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	6 (1%)
Denial of Outpatient Medical Treatment/Diagnostic Testing	n/a	n/a	26 (18.3%)	N/a	n/a	215 (76.6%)	n/a	n/a	397 (54%)
Denial of Outpatient Rehab Therapy (PT, OT, ST, Cardiac)	n/a	n/a	1 (0.7%)	n/a	n/a	6 (2.2%)	n/a	n/a	5 (1%)
Denial of Skilled Nursing Facility	n/a	n/a	2 (1.4%)	n/a	n/a	14 (5.2%)	n/a	n/a	3 (0.4%)
Denial of Referral to Out-of-Network Specialist	0 (0%)	0 (0%)	12 (8.5%)	0 (0%)	0 (0%)	6 (2.2%)	2 (9.5%)	0 (0%)	4 (1%)
Denial of a Covered Medication	n/a	n/a	0 (0%)	n/a	n/a	1 (0.4%)	n/a	n/a	42 (6%)
Service Not a Covered Benefit	0 (0%)	0 (0%)	6 (4.2%)	0 (0%)	0 (0%)	4 (1.5%)	1 (4.8%)	0 (0%)	0 (0%)
Service Considered Experimental/Investigational	n/a	n/a	33 (23.2%)	n/a	n/a	4 (1.5%)	n/a	n/a	6 (1%)
Other (Define)	1 (33.3%)	5 (45.5%)	7 (4.9%)	43 (62.3%)	31 (81.6%)	0 (0%)	0 (0%)	0 (0%)	2 (0.3%)

[333] Did not include all categories.

Table J: Stage 2 Internal Utilization Management Appeals by Category Reported in 2014 New Jersey HMO Annual Supplement Reports [334]

	Carrier A - BH	Carrier A - SUD	Carrier A – Non-BH/SUD	Carrier C - BH	Carrier C - SUD	Carrier C – Non-BH/SUD	Carrier E - BH	Carrier E - SUD	Carrier E – Non-BH/SUD
Total Appeals	0	3	19	6	8	22	9	4	67
Denial of Inpatient Admissions	0 (0%)%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (4.5%)	0 (0%)	0 (0%)	9 (13%)
Denial of Inpatient Hosp. Days	0 (0%)	2 (66.7%)	7 (36.8%)	1 (16.7%)	1 (12.5%)	0 (0%)	0 (0%)	0 (0%)	4 (6%)
Reduction of Acuity Level	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	5 (55.6%)	4 (100%)	0 (0%)
Denial of Emergency Services	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Denial of Outpatient Medical Treatment/Diagnostic testing	n/a	n/a	1 (5.3%)	n/a	n/a	4 (40.9%)	n/a	n/a	25 (37%)
Denial of Skilled Nursing Facility	n/a	n/a	1 (5.3%	n/a	n/a	2 (9.1%)	n/a	n/a	1 (1%)
Denial of Referral to Out-of-Network Specialist	0 (0%)	0 (0%)	1 (5.3%)	0 (0%)	0 (0%)	5 (22.7%)	3 (33.3%)	0 (0%)	0 (0%)
Denial of Covered Medication	n/a	n/a	0 (0%)	n/a	n/a	3 (13.6%)	n/a	n/a	0 (0%)
Service Not a Covered Benefit	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (11.1%)	0 (0%)	1 (1%)
Service Considered Experimental/Investigational	n/a	n/a	4 (21.1%)	n/a	n/a	1 (4.5%)	n/a	n/a	1 (1%)
Other (Define)	0 (0%)	1 (33.3%)	0 (0%)	5 (83.3%)	7 (87.5%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)

[334] Did not include all categories.

Table K: External Utilization Management Appeals by Disposition and Category Reported in 2014 New Jersey HMO Annual Supplement Reports

		Carrier A	Carrier C	Carrier E
% of External UM Appeals Modified or Reversed		**25%**	**33.3%**	**37.5%**
	Denial Upheld	3	10	8
	Denial Reversed	0	5	3[335]
	Denial Modified	1	0	0
Categories of Appeals	Denial of Inpatient Admissions	0	5 (33.3%)	3 (13.6%)
	Denial of Inpatient Hosp. Days	1 (25%)	1 (6.7%)	5 (22.7%)
	Reduction of Acuity Level	0	0	0
	Denial of BH/SUD – inpatient and outpatient[336]	1 (25%)	Not provided	Not provided
	Denial of Surgical Procedure	0	0	3 (13.6%)
	Denial of Emergency Services	0	0	3 (13.6%)
	Denial of Outpatient Medical Treatment/Diagnostic Testing	0	1 (6.7%)	0
	Denial of Outpatient Rehab Therapy (PT, OT, Cardiac, Speech, etc.)	0	0	0
	Denial of Home Healthcare	1 (25%)	0	1 (4.5%)
	Denial of Hospice Care	0	0	0
	Denial of Skilled Nursing Facility	0	2 (13.3%)	1 (4.5%)
	Denial of Medical Equipment (DME) and/or Supplies	0	0	0
	Denial of Referral to Out of Network Specialist	1 (25%)	3 (20%)	0
	Denial of a Covered Medication	0	0	6 (27.3%)
	Service Not a Covered Benefit	0	2 (13.3%)	0
	Service Considered Experimental/Investigational	0	0	0
	Service Considered Cosmetic, Not Medically Necessary	0	1 (6.7%)	0
	Service Considered Dental, Not Medically Necessary	0	0	0
	Other (Define)	0	0	0

[335] We suspect that this was a typographical error and should be 13, based on the total number of appeals and the breakdown of appeals provided in the report. If we are correct, then the percentage of external UM appeals modified or reversed for Carrier E would be 61.9% rather than the 37.5% reported in the table, based on the numbers reported by the carrier.

[336] Note that this category was not included in the 2014 HMO Annual Supplement Report template from DOBI. It appears that Carrier A added this category to its report.

Table L: Utilization Management Requests and Denials Reported in 2014 New Jersey HMO Annual Supplement Reports

	Carrier A	Carrier C	Carrier E
General Medical UM Requests	37,489	19,232	23,047
Formulary UM Requests	16,163	1,875	9,372
BH/SUD Treatment Services UM Requests	685	2,813	577
Total UM Requests	54,337	23,920	32,996
% UM Requests – Formulary	29.7%	7.8%	28.4%
% UM Requests – BH/SUD	1.3%	11.8%	1.7%
General Medical UM Denials	1,441	2,364	908
General Medical UM Denials/General Medical UM Requests	3.8%	12.3%	3.9%
Formulary UM Denials	6,173	710	1,635
Formulary UM Denials/Formulary UM Requests	38.19%	37.9%	17.4%
BH/SUD UM Denials	87	188	114
BH/SUD UM Denials/BH/SUD UM Requests	12.7%	6.7%	19.8%

Table M: Utilization of Inpatient Services Reported in 2014 New Jersey HMO Annual Supplement Reports

		Carrier A	Carrier C	Carrier E[337]
Hospital Admissions (Contracting/Non-Contracting)				
	BH Admissions	89 (82/7)	192 (189/3)	301 (127/54)
	BH Admissions Denied	12 (12/0)	13 (8/5)	37 (15/22)
	BH Admissions Sought	101 (94/7)	205 (197/8)	338 (142/76)
	BH Admissions Denied / BH Admissions Sought	**11.9% (12.8%/0%)**	**6.3% (4.1%/62.5%)**	**10.9% (10.6%/28.9%)**
	SUD Admissions	17 (15/2)	19 (17/2)	297 (81/97)
	SUD Admissions Denied	2 (2/0)	2 (1/1)	22 (2/20)
	SUD Admissions Sought	19 (17/2)	21 (18/3)	319 (83/117)
	SUD Admissions Denied / SUD Admissions Sought	**10.5% (11.8%/0%)**	**9.5% (5.6%/33.3%)**	**6.9% (2.4%/17.1%)**
	Med/Surg Admissions	3,358 (3,287/71)	2,464 (2,107/357)	5,202 (2,558/359)
	Med/Surg Admissions Denied	34 (24/10)	107 (97/10)	335 (252/83)
	Med/Surg Admissions Sought	3,392 (3,311/81)	2,571 (2,204/367)	5,537 (2,810/442)
	Med/Surg Admissions Denied / Med/Surg Admissions Sought	**1% (0.7%/12.3%)**	**4.2% (4.4%/2.7%)**	**6.1% (9%/18.8%)**
	Obstetrical Admissions	761 (754/7)	329 (287/42)	1,686 (1,041/41)
	Obstetrical Admissions Denied	0 (0/0)	8 (6/2)	18 (17/1)
	Obstetrical Admissions Sought	761 (754/7)	337 (293/44)	1,704 (1,058/42)
	Obstetrical Admissions Denied / Obstetrical Admissions Sought	**0% (0%/0%)**	**2.4% (2%/4.5%)**	**1.1% (1.6%/2.4%)**
	Newborn Admissions	21 (21/0)	42 (40/2)	1,480 (931/45)
	Newborn Admissions Denied	0 (0/0)	1 (1/0)	24 (22/2)
	Newborn Admissions Sought	21 (21/0)	43 (41/2)	1,504 (953/47)
	Newborn Admissions Denied / Newborn Admissions Sought	**0% (0%/n/a)**	**2.3% (2.4%/0%)**	**1.6% (2.3%/4.3%)**
	Comprehensive Rehab Admissions	7 (6/1)	47 (45/2)	149 (69/3)

[337] We did not evaluate the data in this table for Carrier E because there were numerous mathematical errors in the total inpatient admissions numbers, which render any calculations based on these numbers suspect. For example, Section M(i) in Carrier E's 2014 HMO Annual Supplement Report reports 127 behavioral health admissions to a contracting facility, and 54 to a non-contracting facility, which totals 181 behavioral health admissions. Yet the report indicates a total of 301 behavioral health admissions.

		Carrier A	Carrier C	Carrier E[337]
	Comprehensive Rehab Admissions Denied	0 (0/0)	3 (3/0)	2 (2/0)
	Comprehensive Rehab Admissions Sought	7 (6/1)	50 (48/2)	151 (71/3)
	Comp. Rehab Adm. Denied / Comp. Rehab. Adm. Sought	**0% (0%/0%)**	**6% (6.3%/0%)**	**1.3% (2.8%/0%)**
	All Other Admissions	0 (0/0)	4 (1/3)	0 (0/0)
	All Other Admissions Denied	0 (0/0)	0 (0/0)	0 (0/0)
	All Other Admissions Sought	0 (0/0)	4 (1/3)	0 (0/0)
	All Other Adm Denied / All Other Adm Sought	**n/a**	**0% (0%/0%)**	**n/a**
	BH Avg Length of Stay	6.33	8.82	12.22
	SUD Avg Length of Stay	8.71	5.58	8.10
	Med/Surg Avg Length of Stay	4.10	4.11	5.74
	Obstetrical Avg Length of Stay	2.8	2.87	3.88
Other Facilities (Contracting/Non-contracting)				
	Psychiatric Hospital Admissions	121 (119/2)	165 (158/7)	13 (3/5)
	Psychiatric Hospital Adm Denied	23 (23/0)	13 (4/9)	7 (1/6)
	Psychiatric Hosp. Adm. Sought	144 (142/2)	178 (162/16)	20 (4/11)
	Psych. Hosp. Denied / Psych. Hosp Adm. Sought	**16% (16.2%/0%)**	**7.3% (2.5%/56.3%)**	**35% (25%/54.5%)**
	Residential/SUD Admissions	297 (218/79)	268 (266/3)	0 (0/0)
	Residential/SUD Denied	35 (35/0)	39 (29/10)	0 (0/0)
	Residential/SUD Adm. Sought	332 (253/79)	297 (295/13)	0 (0/0)
	Residential/SUD Adm Denied / Resid/SUD Adm Sought	**10.5% (13.8%/0%)**	**13.1% (9.8%/76.9%)**	**n/a**
	Skilled Nursing Facility Admissions	140 (132/8)	17 (15/2)	8 (5/10)
	Skilled Nursing Facility Adm. Denied	1 (1/0)	0 (0/0)	7 (7/0)
	Skilled Nursing Facility Adm. Sought	141 (133/8)	17 (15/2)	15 (12/10)
	Skilled Nursing Facility Adm Denied / Skilled Nursing Facility Adm Sought	**0.7% (.8%/0%)**	**0% (0%/0%)**	**46.6% (58.3%/0%)**
	Comprehensive Rehab Admissions	37 (37/0)	111 (92/19)	1 (3/0)
	Comprehensive Rehab Admissions Denied	5 (5/0)	0 (0/0)	2 (2/0)
	Comprehensive Rehab Admissions Sought	42 (42/0)	111 (92/19)	3 (5/0)
	Comp. Rehab Adm. Denied / Comp. Rehab. Adm. Sought	**11.9% (11.9%/n/a)**	**0 (0%/0%)**	**66.7% (40%/n/a)**
	All Other Admissions	74 (45/29)	0 (0/0)	0 (0/0)

		Carrier A	Carrier C	Carrier E[337]
	All Other Admissions Denied	9 (9/0)	0 (0/0)	0 (0/0)
	All Other Admissions Sought	83 (54/29)	0 (0/0)	0 (0/0)
	All Other Adm Denied / All Other Adm Sought	**10.8%** **(16.7%/n/a)**	**n/a**	**n/a**
	Psychiatric Hospitals Avg Length of Stay	9.08	15.32	78
	Resid/SUD Avg Length of Stay	7.96	10.06	n/a
	Skilled Nursing Facility Avg Length of Stay	27.10	92.88	124.73
	Compreh Rehab Avg Length of Stay	15.4	16.27	34
	All Other Avg Length of Stay	6.38	0	n/a

THE CENTER FOR HEALTH &
PHARMACEUTICAL LAW & POLICY

Seton Hall University School of Law
One Newark Center
Newark, NJ 07102
Tel: 973-642-8871
law.shu.edu/health-law/