Mental Health Parity:

Enforcement by the New York State Office of the Attorney General

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Health Care Bureau

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New York state and federal law require that health insurance plans cover mental health and substance use disorder treatment the same way they cover all other medical treatment, ensuring "parity" between the coverage of mental health or substance use disorder and physical illness. In keeping with that mandate, the New York State Office of the Attorney General ("NYAG") has been deeply committed to ensuring that all New Yorkers have access to behavioral health services, including substance abuse treatment. To that end, in early 2013, the NYAG – based on a growing number of consumer complaints -- began an industry-wide investigation of health plans' compliance with state and federal mental health and addiction parity laws.

This report summarizes the results to date of the NYAG's industry-wide initiative, including the enforcement of eight agreements with seven health plans. Four of the settlements required plans to implement sweeping reforms in their administration of behavioral health benefits, in particular relating to medical management practices, coverage of residential treatment, and co-pays for outpatient treatment, and to submit regular compliance reports. Two of the settlements focused on coverage of particular services, and two more addressed the improper imposition of preauthorization requirements for medication-assisted treatment ("MAT"). Over the past five years, the NYAG has vigilantly monitored the health plans' compliance with these agreements, and the results, presented in this report, illustrate the degree to which these agreements have contributed to the transformation of plans' approach to behavioral health services. Some highlights include:

- Plans are imposing fewer barriers to necessary mental health treatment:
  - Covering the continuum of care, including residential treatment.
  - More consumers are able to access needed mental health care.
  - Plans are denying care at a lower frequency than in previous years.
- Plans reimbursed more than 300 consumers over ***$2 million*** for their out-of-pocket costs for previously denied claims.
- Plans paid a total of ***$3 million*** in penalties.
- Plans are letting providers prescribe – without preauthorization – medication-assisted treatment for patients suffering with substance abuse disorder.

The positive trends the NYAG has observed through its monitoring of these agreements has been reflected in other arenas as well. The NYAG's Health Care Bureau Helpline ("HCB Helpline") is a toll-free telephone line staffed by intake specialists and advocates trained to assist New York health care consumers in a range of complaints, including mediation of disputes to help protect their right to behavioral health services. Since 2014 the number of consumer complaints to the HCB Helpline regarding mental health and substance abuse issues diminished by nearly 60%. We strongly believe that health plans' compliance with the agreements described herein has resulted in increased access to behavioral health services, and therefore fewer consumer complaints. Moreover, over the past five years the HCB Helpline has provided individual resolutions for many New Yorkers that resulted in their accessing critical mental health and substance abuse services. For instance, a HealthNow member who had struggled with opioid addiction for years, was denied coverage for services from

an out-of-network psychiatrist. After intervention from a Helpline advocate, HealthNow agreed to process claims at the in-network rate. Similarly, through intervention of a Helpline advocate, a Cigna member was able to get in-patient psychiatric treatment covered by the health plan, after initially being denied. These are just a few examples of the many resolutions achieved on behalf of New York healthcare consumers.

A. **Background**

Timothy's Law mandates that New York group health plans that provide coverage for inpatient hospital care or physician services must also provide "broad-based coverage for the diagnosis and treatment of mental, nervous or emotional disorders or ailments, . . . *at least equal* to the coverage provided for other health conditions." (emphasis added).[1] Further, all group plans must cover, annually, a minimum of 30 days of inpatient care, 20 visits of outpatient care, and up to 60 visits of partial hospitalization treatment for the diagnosis and treatment of mental, nervous or emotional disorders or ailments.[2] Timothy's Law also requires that deductibles, copayments and co-insurance for mental health treatment be consistent with those imposed on other benefits,[3] and that utilization review for mental health benefits be applied "in a consistent fashion to all services covered by [health insurance and health maintenance organization] contracts."[4] Finally, New York law requires health plans to cover inpatient and outpatient treatment for substance use disorder ("SUD"), and to do so consistent with the federal Mental Health Parity and Addiction Equity Act (the "Federal Parity Act").[5]

The Federal Parity Act prohibits large group, individual, and Medicaid health plans that provide both medical/surgical benefits and mental health or SUD benefits, from: (i) imposing financial requirements (such as deductibles, copayments, co-insurance, and out-of-pocket expenses) on mental health or SUD benefits that are more restrictive than the predominant level of financial requirements applied to substantially all medical/surgical benefits; (ii) imposing treatment limitations (such as limits on the frequency of treatment, number of visits, and other limits on the scope or duration of treatment) on mental health or SUD treatment that are more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits, or applicable only with respect to mental health or SUD benefits; and (iii) conducting medical necessity review for mental health or SUD benefits using processes, strategies or standards that are not comparable to, or are applied more stringently than, those applied to medical necessity review for medical/surgical benefits.[6]

1 N.Y. Ins. Law §§ 3221(l)(5)(A); 4303(g)(1).
2 N.Y. Ins. Law §§ 3221(l)(5)(A)(i)&(ii); 4303(g)(1)(A)&(B).
3 N.Y. Ins. Law §§ 3221(l)(5)(A)(iii); 4303(g)(1)(C).
4 2006 N.Y. Laws Ch. 748, § 1.
5 N.Y. Ins. Law §§ 3221(l)(7)(A); 4303(l)(1); and 3216(i)(31).
6 42 U.S.C. § 300gg-26; 45 C.F.R. § 146.136(c)(4)(i). The essential health benefit regulations under the Affordable Care Act extend the Federal Parity Act's requirements to small and individual plans. 45 C.F.R. § 156.115(a)(3).

B. Investigations and Agreements by the New York Attorney General's Office

The NYAG launched our mental health parity initiative after receiving many complaints regarding health plans' coverage of behavioral health treatment.[7] The complaints fell into three categories: (1) plans were conducting frequent and stringent utilization review for behavioral health treatment, resulting in unwarranted medical necessity denials; (2) plans were excluding coverage of residential treatment for behavioral health conditions, while covering skilled nursing care, which is the equivalent level of care for medical/surgical conditions; and (3) plans charged consumers higher copayments for behavioral health treatment than for primary care medical visits.

Based on an abundance of consumer complaints, in 2013 the NYAG initiated investigations of MVP, EmblemHealth ("EmblemHealth" or "Emblem"), Excellus, Beacon Health Options (formerly ValueOptions), and Cigna, and in 2015, we initiated an investigation of HealthNow. The results of our investigations are as follows:

1. **MVP**: The NYAG determined that MVP violated the parity laws by imposing stricter utilization review for behavioral health services than medical services (evidenced in part by much higher denial rates for inpatient behavioral health treatment than for inpatient medical/surgical treatment), excluding residential treatment, and charging higher copays for behavioral health services than for medical services. In March 2014, the NYAG entered into an agreement with MVP, which required them to: (i) cover residential treatment; (ii) overhaul its behavioral health utilization review processes (including by providing detailed denial letters); (iii) charge the same co-pays for most outpatient behavioral health visits as for primary care visits; (iv) pay a penalty of $300,000; (v) appoint an internal compliance monitor that will submit quarterly compliance reports for a minimum of two years; and (vi) provide members who received medical necessity denials over a four-year period with an opportunity to file appeals, to be decided by an independent entity.

2. **EmblemHealth**: The NYAG determined that EmblemHealth violated the parity laws by imposing stricter utilization review for behavioral health services than medical services (evidenced in part by much higher denial rates for inpatient behavioral health treatment than for inpatient medical/surgical treatment), excluding residential treatment, and charging higher copays for behavioral health services than for medical services. In July 2014, the NYAG entered into an agreement with EmblemHealth, similar to the MVP agreement, which required Emblem to: (i) cover residential treatment; (ii) overhaul its behavioral health utilization review processes (including by providing detailed denial letters); (iii) charge the same co-pays for most outpatient behavioral health visits as for primary care visits; (iv) pay a penalty of $1.2 million; (v) submit to monitoring by an outside entity that issues quarterly compliance reports for

7 In 2011, the HCB handled almost 60 substantive complaints relating to insurance coverage of mental health/substance use disorder treatment. In 2012, the HCB handled almost 100 such complaints.

a minimum of two years; and (vi) provide members who received medical necessity denials over a four-year period with an opportunity to file appeals, to be decided by an independent entity.

3. **Beacon Health Options (formerly known as ValueOptions)**: The NYAG determined that Beacon Health Options, which administers behavioral health benefits for MVP and Emblem, as well as the Empire Plan, violated the mental health parity laws for the reasons set forth above in the summaries of the MVP and EmblemHealth settlements. In March of 2015, the NYAG entered into an agreement with Beacon, which requires the insurer to: (i) abide by the terms of the MVP and EmblemHealth agreements; (ii) cooperate with the compliance administrators for the MVP and EmblemHealth agreements; (iii) comply with additional terms, such as stopping its practice of discounting psychotherapy rendered by non-physician providers; (iv) appoint an external claims administrator for the EmblemHealth parity agreement appeal process; and (v) pay a $900,000 penalty.

4. **Excellus**: The NYAG determined that Excellus violated the parity laws by imposing stricter utilization review for inpatient SUD health services than medical services (evidenced in part by the imposition of "fail first" requirements for inpatient SUD rehabilitation treatment and much higher denial rates for that service than for inpatient medical/surgical treatment), excluding residential treatment for behavioral health conditions, and charging higher copays for behavioral health services than for medical services. In March of 2015, the NYAG entered into an agreement with Excellus, requiring them to: (i) eliminate the fail first requirements for inpatient SUD rehabilitation services; (ii) cover residential treatment for behavioral health conditions; (iii) charge the primary care copay for behavioral health visits for most of its plans; (iv) provide members who received medical necessity denials for inpatient SUD treatment over a four-year period with an opportunity to file appeals, to be decided by an independent entity; (v) appoint an internal compliance monitor that will submit quarterly compliance reports for a minimum of two years; and (vi) pay a penalty of $500,000.

5. **HealthNow**: The NYAG determined that HealthNow violated the parity laws by: (1) excluding coverage for nutritional counseling for eating disorders while covering this treatment for medical conditions such as diabetes and morbid obesity; and (2) requiring prior authorization for outpatient psychotherapy after members exceeded 20 visits, but not imposing a similar requirement for medical treatment. In August of 2016, the NYAG entered into an agreement with HealthNow, which requires the insurer to cover nutritional counseling for eating disorders and to remove its 20-visit threshold for reviewing outpatient behavioral health treatment. HealthNow will also reimburse individuals who received denials due to the nutritional counseling exclusion and the 20-visit threshold, and paid out of pocket for the treatment.

6. **Cigna**: The NYAG determined that Cigna violated mental health parity laws by applying a limit of three visits to a nutritional counselor per year for mental health conditions, but not for medical conditions. In January of 2014, the NYAG entered into an agreement with Cigna, which required them to eliminate the three-visit limit for mental health conditions, provide restitution to the members whose nutritional counseling claims were denied due to the limit, and pay a $23,000 penalty.

- **Medication-Assisted Treatment ("MAT"):** Over the last several years, the NYAG has received complaints that some health plans were restricting coverage of MAT for opioid use disorder (such as Suboxone) by requiring prior authorization for such drugs, and that plans' authorized provider networks are limited, such that people addicted to opioids must wait a long time before they can access this treatment. The NYAG's response to these complaints is reflected in the below agreements with Cigna and Anthem.

7. **Cigna:** In October of 2016, the NYAG entered into a second resolution with Cigna, in which the insurer agreed to remove prior authorization for MAT drugs for its non-federal beneficiaries, nationwide (including for self-insured plans). The pioneering agreement removed barriers to MAT medication for members in need of drug treatment.

8. **Anthem**: In January of 2017, Anthem/Empire Blue Cross Blue Shield ("Empire BCBS") executed an agreement in which the health insurer agreed to remove prior authorization for MAT drugs nationally, including self-funded plans. In addition, Empire BCBS agreed not to require authorization for injectable naltrexone in New York. Empire BCBS also agreed to launch a MAT initiative to increase its network provider base capacity to provide MAT to its members.

C. Effects of NYAG's Enforcement of Parity Laws

1. **MVP**: The plan is compliant with the prospective measures of the agreement. MVP reimbursed 101 members a total of $645,000 for their out-of-pocket costs for previously denied treatment. MVP reports that spending and utilization for behavioral health increased since 2014. In its most recent report submitted in May of 2017, MVP reported that, in contrast to earlier periods (in particular, in the "pre-agreement" first quarter of 2014), denial rates are declining, as follows:

Denial Rates from 2014-2018									
Level of Care	**1Q 2014 (overall)**	**2015 Q1-Q3 (commercial)**	**2015 Q1-Q3 (Medicaid)**	**Q1-Q3 2016 (commercial)**	**Q1-Q3 2016 (Medicaid)**	**Q1-Q3 2017 (commercial)**	**Q1-Q3 2017 (Medicaid)**	**1Q 2018 (commercial)**	**1Q 2018 (Medicaid)**
Inpatient Psychiatric	22.00%	7.00%	2.00%	10.00%	1.00%	8.00%	Less than 1%	4.00%	Less than 1%
Psychiatric Residential	N/A	11.00%	N/A	30.00%	N/A	5.00%	N/A	6.00%	N/A
SUD Detoxification	33.00%	12.00%	3.00%	13.00%	0%	1.00%	Less than 1%	8.00%	0.00%
SUD Rehabilitation	59.00%	17.00%	6.00%	32.00%	2.00%	13.00%	4.00%	8.00%	1.00%
SUD Residential	N/A	24.00%	N/A	23.00%	N/A	15.00%	0.00%	7.00%	1.00%

2. **EmblemHealth**: The plan is compliant with the prospective measures of the agreement. EmblemHealth reimbursed 131 members a total of $782,000 for their out-of-pocket costs for previously denied treatment. Emblem's denial letters show greater specificity and the review process has produced more accurate results. As of a report issued in April of 2017, there were positive trends, which have continued. In that report, a much lower percentage of Emblem's denials were reported to be "inappropriate" (only 28%, versus 62% in the prior reporting period). In particular, Emblem's denial rates in 2017 were much lower than in prior years, which is quite positive:

Denial Rates from 2014-2017				
Level of Care	**2014**	**2015**	**2016**	**2017**
Inpatient MH	16.78%	9.51%	6.42%	4.87%
MH Residential	23.38%	12.43%	13.73%	6.25%
SUD Detoxification	31.01%	11.92%	4.08%	2.19%
SUD Rehabilitation	26.22%	15.44%	5.27%	4.58%
SUD Residential	26.37%	16.95%	9.98%	10.78%

3. **Excellus**: The plan is compliant with the prospective measures of the agreement. The NYAG has worked with Excellus to ensure greater specificity in their denial letters and to address their high denial rates for more intensive levels of SUD care. In June 2016, the NYAG began to require that Excellus: (1) automatically approve coverage of SUD inpatient detoxification, inpatient rehabilitation and residential treatment in New York facilities for members with moderate or severe opioid use disorder ("automatic approval process"); (2) use criteria issued by the New York State Office of Alcoholism and Substance Abuse Services; (3) further improve their utilization review procedures; and (4) exercise greater quality control over their denial letters. The "auto approval" policy has resulted in a marked decrease in the denial rate for more intensive SUD services. In its most recent compliance report, supplied in March of 2018, Excellus reported that its denial rates for more intensive levels of SUD treatment have declined to almost zero, as shown by these charts from the report:

Denial Determination Rates from 2015-2017					
Level of Care	**Q4 2015**	**Q3 2016**	**Q4 2016**	**Q3 2017**	**Q4 2017**
SUD Detox	20.20%	1.50%	1.00%	1.00%	1.00%
SUD Rehab	25.00%	2.00%	1.00%	0.40%	1.00%
SUD Residential	50.00%	6.00%	6.00%	1.00%	1.00%

In the fourth quarter of 2016, Excellus approved more than 650 episodes of care under the automatic approval process set forth in the amendment to the agreement. As shown in the following tables, that positive trend has continued through 2017:

Denial Rates Under Automatic Approval Process 2016-2017					
Level of Care	**Q4 2016**	**Q1 2017**	**Q2 2017**	**Q3 2017**	**Q4 2017**
SUD Detox	0.00%	0.50%	0.00%	0.00%	0.80%
SUD Rehab	0.00%	3.00%	0.30%	0.33%	1.00%
SUD Residential	0.00%	3.00%	1.00%	0.00%	0.00%

While Excellus' mental health residential treatment denial rate remains high, the below table demonstrates that progress has been made in this area as well:

Denial Rates for Mental Health Residential Treatment 2015-2017				
Q4 2015	**Q3 2016**	**Q4 2016**	**Q3 2017**	**Q4 2017**
33.00%	29.00%	30.00%	8.40%	18.00%

4. **Beacon Health Options**: The company has been compliant with the prospective measures of the agreement with the NYAG. In 2016, Beacon confirmed that it:

- will no longer manage outpatient behavioral health benefits in New York using set thresholds for reviewing cases (i.e., it has eliminated the "outpatient outlier model" in New York).
- is covering treatment pending decisions on internal appeal for all levels of care.
- removed an element of its provider rating program that evaluated providers based on their level of agreement with Beacon's review decisions.
- removed its prior authorization requirements for medication-assisted treatment for opioid use disorder.
- revised its residential treatment medical necessity criteria to not require imminent danger, to self/others. In response to a complaint prior to these revisions, Beacon reported that it will reimburse 15 members a total of $250,000 for inappropriate denials of coverage for residential treatment, and will retrain its staff on the criteria.
- is tracking modifications (days requested by providers vs. days approved).
- has removed preauthorization requirements for MAT on their end.

5. **HealthNow**: The plan has implemented the terms of the agreement with the NYAG and sent notice to members regarding their ability to file new claims for previously improperly denied behavioral health services.

6. **Cigna**: The plan removed the visit limit for nutritional counseling for mental health conditions and paid a total of $29,000 in reimbursement to a total of 52 members for previously denied claims.

MAT: In an effort to expand its network of MAT providers, and pursuant to an agreement with the NYAG, Empire BCBS launched an initiative to identify in-network MAT providers, and post the names of these providers on its website. As a result of this effort, members are now able to search for a MAT-authorized provider in the Empire BCBS directory and on its public website. Empire BCBS continues its efforts to expand its network of MAT-certified providers.

RESTITUTION IN MENTAL HEALTH PARITY SETTLEMENTS

In addition to changing the landscape for member access to critical mental health services going forward, a hallmark of the mental health parity agreements has been that health plans reimburse members for out of pocket expenses for behavioral health services that should have been covered by the health plan. In this regard, the NYAG efforts have reaped very tangible benefits for nearly 500 members – totaling over $2 million in restitution.

TOTAL RESTITUTION	Members	Dollars
Cigna	52	$28,908
MVP	93	$652,377
Emblem	127	$801,094
Excellus	31	$236,347
Beacon	15	$254,656
HealthNow	179	$62,852
	497	**$2,036,234**

D. **Other Efforts**

The NYAG continues to actively monitor health plans' compliance with mental health and addiction parity laws, and has undertaken substantial outreach with consumers, providers, and health plans to provide information about the laws and our enforcement work. In addition, the NYAG HCB Helpline continues to help individual consumers gain access to much needed behavioral health services.


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