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Re: Follow-up on Blue Cross Blue Shield of Vermont and Mental Health Parity

Dear Jackie:

My optimism that Blue Cross Blue Shield of Vermont ("BCBSVT") was serious about its compliance with mental health parity waned as I waited to hear from you on this issue and have not. The lack of interest does not reflect well on BCBSVT's professed interest in treating patients with mental illness in Vermont – those whom Mr. Goddard said were neighbors and friends -- in a fair and reasonable manner. Nonetheless, below is our analysis as to why BCBSVT's practices of: (a) requiring prior authorization after 10 initial visits for mental health care; and (b) paying psychiatrists less for evaluation and management codes than they pay their non-psychiatric physician counterparts, violate the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA").

Background of MHPAEA

It is important to understand MHPAEA's history to appreciate its scope. MHPAEA is an antidiscrimination statute. In the spring of 1996, Senators Wellstone and Domenici proposed a comprehensive mental health parity bill that would have required full parity between mental health and medical/surgical benefits. *See* Health Insurance Reform Act of 1996, S. 1028, 104th Cong. § 305 (1996). Debates over the potential cost of parity resulted in passage of the Mental Health Parity Act of 1996 (the "1996 Act"), a much watered-down version of the original bill. The 1996 Act prohibited plans from imposing disparate annual and lifetime limits for mental health benefits compared to medical/surgical benefits. However, it contained many exceptions and other restrictions limiting its scope, no provision mandating access to out-of-network mental health benefits, and no protections for substance use disorder benefits. *See A Piecemeal, Step by Step Approach Toward Mental Health Parity,* Journal of Health & Biomedical Law, VII (2011), http://www.law.suffolk.edu/highlights/stuorgs/health/upload/d_Shamash_273-324.pdf at 280-82.

Not surprisingly, plans took advantage of the loopholes and found alternative ways to discriminate against mental health patients that did not violate the 1996 Act. These included: covering lower percentages of mental health costs than medical/surgical costs; imposing higher coinsurance rates on mental health benefits; restricting the number of outpatient visits and inpatient hospital days for mental health patients but not for medical/surgical patients, and manipulating medical management techniques and network admission standards in ways that discouraged treatment of mental illness. Indeed, 87% of plans reported imposing some restrictions on mental health coverage that were not imposed on medical/surgical benefits. U.S. Gen. Accounting Office, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited* 5 (2000), http://www.gao.gov/products/HEHS-00-95. As a result, mental health patients either had to pay higher health care costs or forgo treatment altogether. *Id.* Representative Barbara Lee's comments about the 1996 Act are particularly appropriate here: "companies can limit both the number of visits that a person makes to a mental health professional in a year and the network of doctors a patient can see, even when no such limit exists for medical or surgical benefits. That is ridiculous." Cong. Rec. 110th Congress (2007-08) at E 1915.

Over the following twelve years, many states adopted legislation governing mental health parity. Vermont adopted its own legislation in 1997, which like the 1996 Act focuses principally on discrimination in financial terms. Nonetheless, most mental health patients faced higher health care costs and discriminatory practices. *See generally A Piecemeal, Step by Step Approach Toward Mental Health Parity,* at 279, 287-91.

In 2008, Congress enacted comprehensive mental health parity legislation – MHPAEA. The purpose of the legislation was to close loopholes left by the 1996 Act and to eliminate discrimination in benefits against mental health patients, whether that discrimination was direct or indirect. Comments from the floor of the House of Representatives demonstrate the anti-discrimination purpose of the Act. For example, Representative Patrick Kennedy, the sponsor of the legislation, stated: "Access to mental health services is one of the most important and most neglected civil rights issues facing the Nation. For too long, persons living with mental disorders have suffered discriminatory treatment at all levels of society." 153 Cong. Rec. S 1864 (daily ed. Feb. 12, 2007). Representative James Ramstad said, "it is time to end discrimination against people who need treatment for mental illness and addiction. It's time to prohibit health insurers from placing discriminatory barriers to treatment." 154 Cong. Rec. H 8619 (daily ed. Sept 23, 2008). Representative Bill Pascrell called this "a civil rights issue. Parity removes the discrimination against a population that has been discriminated against and stigmatized. This a humanitarian issue; without parity, we allow those with illnesses to continue to suffer." *Id.* at H 8622. On October 3, 2008, the MHPAEA was enacted with broad bipartisan support in the House and the Senate.

Only two federal courts have considered this issue to date, and both agree that MHPAEA is designed end discrimination in the provision of coverage for mental health and substance use disorders as compared to medical and surgical conditions."

Coalition for Parity, Inc. v. Sebelius, 709 F. Supp. 2d 10, 13 (D.D.C. 2010); *C.M. v. Fletcher Allen,* 5:12-cv-00108 (D.VT 2013).

In sum, the MHPAEA is first and foremost an anti-discrimination statute, and a major step forward in ending discrimination against those afflicted with mental health and substance use disorders, by eliminating differences in coverage between mental health and medical/surgical conditions. It is the differences in coverage, both direct and indirect, that BCBSVT continues between mental health and medical surgical benefits to which the Vermont and American Psychiatric Association object.

The Express Language of the Statute

The MHPAEA closed many of the loopholes left open in the 1996 Act. The MHPAEA makes unlawful a broad range of disparate treatment of mental health benefits, and mandates parity between mental health benefits and medical/surgical benefits with respect to aggregate lifetime limits, annual limits, and other financial requirements, including deductibles, copayments, coinsurance, and out-of-pocket expenses. *See* 29 U.S.C. §§ 1185a(a)(1), (2), and (3)(a)(i). Unlike the 1996 Act, however, MHPAEA also requires parity with respect to "treatment limitations":

> In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that: ... the treatment limitations applicable to such mental health or substance use disorder benefits are *no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits* covered by the plan (or coverage) *and* there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

29 U.S.C. § 1185a(a)(3)(a)(ii) (emphasis added). Thus, the Act imposes two standards with respect to treatment limitations – that the treatment limitations applicable to mental health benefits be "no more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits" *and* that there be "no separate treatment limitations that are applicable only" with respect to mental health benefits.

The Interim Final Regulations

The broad mandates of the MHPAEA have been fleshed out in detailed regulations. *See* Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 26 C.F.R. Part 54, 29 C.F.R. Part 2590, 45 C.F.R. Part 146, effective date April 5, 2010 (the "Regulations"). In particular, the Regulations elaborate on the "no more restrictive" requirement with respect to financial requirements and treatment limitations:

> A group health plan that provides both medical/surgical benefits and mental health or substance abuse benefits 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.*

Regulations, at § 2590.712(c)(2)(i) (emphasis added). In other words, the Regulations provide that financial requirements or treatment limitations must be compared within "classifications." The only classifications that may be used are: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs. Regulations, at § 2590.712(c)(2)(ii).

The regulations define "substantially all" as at least two thirds and "predominant" as more than one half. Thus, under the statute, if a treatment limitation does not apply to at least 2/3 of the medical surgical benefits under the plan, it may not apply to the mental health benefits under the plan. *Id.*

"Treatment limitations" 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." Regulations, at § 2590.712(a). Treatment limitations are either "quantitative" or "non-quantitative." *Id.* Quantitative treatment limitations are those that "are expressed numerically (such as 50 outpatient visits per year)." *Id.* Quantitative treatment limitations fall easily into the "predominant" "substantially all" analysis because they are numerical limits that easily can be compared.

Non-quantitative treatment limitations are those that "otherwise limit the scope or duration of benefits for treatment under the plan." *Id.* Non-quantitative treatment limitations – sometimes referred to as "NQTLs" and most relevant here – include, among other things, "medical management standards (such as prior authorization requirements) limiting or excluding benefits based on medical necessity," "standards for provider admission to participate in a network, including reimbursement rates," and "plan methods for determining usual, customary and reasonable charges." Regulations, at § 2590.712(c)(4)(ii). (FR 5436). NQTLs are generally not numeric, and therefore, the regulations provide an additional test to make a comparison between mental health and medical surgical NQTL's more meaningful.

> A group health plan may not impose a non-quantitative treatment limitation with respect 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 the non-quantitative 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, *except* to the extent that recognized clinically appropriate standards of care may permit a difference.

Regulations, at § 2590.712(c)(4)(i) (emphasis added). The burden of proving the compliance with MHPAEA is on the Plan. This test allows for differences in result and recognizes that NQTLs, because they are not numeric, are subject to a degree of interpretation. Thus, if the NQTL meets the "substantially all" test, it must then meet the "comparable to" and "no more stringent than" analysis. If the NQTL does not meet the "substantially all" test or the comparable to and no more stringent than analysis, the NQTL does not comply with MHPAEA. In other words, the statute and the Regulations create a two-part requirement, and allow a limited exception to determine whether the limitations are similar: a plan may not impose a non-quantitative treatment limitation on mental health benefits within a classification unless that NQTL is applied to substantially all medical surgical claims, and if it is then, the Plan must demonstrate that the factors used in applying that NQTL are (1) "comparable to," and (2) applied "no more stringently than," those used in applying the NQTL to medical/surgical benefits in the same classification. This latter test may not apply "to the extent that recognized clinically appropriate standards of care may permit a difference."

10 Visit Limitations Violate MHPAEA

BCBSVT represents that the 10 visit limit is a threshold beyond which medical necessity review is done rather than a quantitative limitation *per se*. *See* Wheeler letter to Scully dated August 19, 2013 at 2. That concept, even if true, is not relevant to the analysis.[1] Further, BCBSVT suggests that because a similar limitation applies to chiropractic services, there is no discrimination under MHPAEA. *Id.* Under the express terms of the statute, if BCBSVT does not apply the same limitation to substantially all or at least 2/3 of its medical surgical benefits, BCBSVT is in violation of MHPAEA. Since BCBSVT concedes that it applies this limitation only to chiropractic services on the medical side, no further analysis is required.

Moreover, BCBSVT's claim that it uses a process to establish the thresholds for review, *(id.)* is not relevant to the analysis. The issue here is not whether 10, 20, or 30 visits should be the threshold, but whether, when the requirement of

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[1] Indeed, BCBSVT represented to us in our meeting that it almost never denies requests for more than 10 mental health visits. Merely because one combines a quantitative treatment limit (10 visits) with a non-quantitative treatment limit (medical management) does not mean that the limitation is not quantitative. Instead, it would depend on whether the evidence demonstrates that in practice this 10 visit limitation is not in fact a ceiling on mental health treatment. In other words, the evidence of how many requests for additional treatment are not granted is relevant to accurately defining this as a quantitative or non-quantitative limitation. We are most interested in seeing that data.

preauthorization after meeting an established visit limit --whatever number of visits that might be -- applies to all mental health visits and only to chiropractic visits, it is lawful under MHPAEA? The answer to that is "no." This is addressed by the Department of Labor in the following FAQ:

Q5: I am an employer considering several health insurance policy options. One health insurance policy requires prior authorization for all outpatient mental health benefits but only a few types of outpatient medical/surgical benefits (outpatient surgery; speech, occupational and physical therapy; and skilled home nursing visits.) Is this permissible?

> While some differences in plan requirements for prior authorization might be permissible based on recognized clinically appropriate standards of care, it is unlikely that the processes, strategies, evidentiary standards, and other factors considered by the plan in determining that those three (and only those three) outpatient medical/surgical benefits require prior authorization would also result in all outpatient mental health and substance use disorder outpatient benefits needing prior authorization.

http://www.dol.gov/ebsa/faqs/faq-aca7.html. In other words, BCBSVT's practice of comparing all of mental health to a small subset of medical surgical benefits is not permissible under the MHPAEA. Accordingly, BCBSVT should reconsider its approach to prior authorization for all mental health benefits regardless of who is providing the service and whether the provider participates or not in BCBSVT's network.

Discrimination in Reimbursement Rates Violates MHPAEA

All physicians, whether psychiatric, primary care, cardiologists, or otherwise, use Current Procedural Terminology ("CPT") codes to document the services provided. The evaluation and management codes (e.g. 90211-90215) are billed by all physicians, regardless of whether they are specialists or what their specialty is. The codes define the scope of work performed and one code represents the same work regardless of the physician's specialty. For example, a 99213 is an:

> Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

These requirements must be met regardless of whether the treating doctor is a surgeon, psychiatrist, family doctor or gynecologist. Likewise the relative value units (RVUs) assigned by CMS are the same for this code regardless of who is billing it – in this case 2.56. Accordingly, there is no reason other than discrimination to pay less for services of a psychiatrist than for another physician

performing the same work. Under the statutory analysis, only if BCBSVT is paying at least 2/3 of all physicians the same rate as it is paying psychiatrists for the 99213 code, can it meet the "substantially all" requirement of MHPAEA. I highly doubt that BCBSVT is paying 2/3 of its doctors rates equivalent to what psychiatrists are paid for E/M codes, but am willing to consider evidence otherwise.

Even if it were paying psychiatrists similarly to substantially all other physicians billing the 99213 code, BCBSVT would have to show that the processes or methodologies it used to determine the rate of payment for psychiatrists were comparable to those used to determine what the rate should be for those earning more than psychiatrists and that it applied those processes or methodologies no more stringently to psychiatrists. While we are confident that BCBSVT's current practice of paying psychiatrists less that it pays other doctors for the same work would not stand scrutiny under MHPAEA, we would be delighted to perform a detailed analysis for BCBSVT once it provides the details of how BCBSVT calculates rates for psychiatry and other physicians who bill E/M codes and the data on payment rates for particular CPT codes across specialties.

Not paying psychiatrists for the work they perform or not compensating them in a manner that encourages their participation in networks discriminates against mental health patients by limiting access to care. This is indeed one of the loopholes left open in the 1996 statute and closed in the 2008 statute and regulations which expressly recognize that reimbursement rates are indeed treatment limitations that cannot be discriminatory under MHPAEA.

I look forward to your analysis. Meanwhile, please do not hesitate to call me if you have any questions.

Sincerely,

Colleen M. Coyle,
General Counsel