

Texas Department of Insurance

# Mental Health Parity Annual Report

August 2023





# Mental Health Parity Annual Report

by the

**Texas Department of Insurance**

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A handwritten signature in black ink, appearing to read "C. Brown", with a long horizontal flourish extending to the right.

Cassie Brown

Commissioner of Insurance

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## Overview

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All fully insured health plans must include benefits for mental health and substance use disorder (MH/SUD) services. Federal law requires plans issued to individuals and small employers to cover 10 categories of essential health benefits, including MH/SUD. Texas law requires group health plans to cover autism spectrum disorder, serious mental illness, and treatment for chemical dependency. Both state and federal laws require health plans to include benefits for MH/SUD conditions at the same level as benefits provided for other illnesses, also known as "parity."

### What is mental health parity?

Parity requires health plans that cover MH/SUD services to provide the same level of benefits and access to coverage for MH/SUD as for medical and surgical benefits, with respect to:

- Annual and lifetime limits on coverage.
- Financial requirements:
  - Deductibles.
  - Copayments.
  - Coinsurance.
  - Out-of-pocket expense.
- Quantitative treatment limitations:
  - Frequency of treatment.
  - Number of visits.
  - Days of coverage.
  - Scope or duration of treatment.
- Non-quantitative treatment limitations:
  - Medical management standards.
  - Step therapy and fail first requirements.
  - Formulary design.
  - Availability of coverage for benefits provided by out-of-network providers and network tier design.
  - Standards for provider participation in a network.
  - Payment methodologies.
  - Plan processes that limit or restrict coverage or access to treatment.

Coverage terms that limit MH/SUD benefits must be comparable to, and applied no more stringently than, limits for medical benefits. This includes the processes and standards used to apply the limit.

## Consumer rights and protections

Consumers should be able to access the covered benefits they need, where and when they need them, from high-quality providers. They should be able to get care as easily as they can for other illnesses or injuries.

Health plans that use preferred provider networks, including PPOs, EPOs, and HMOs, must include enough providers within the plan's service area to allow enrollees reasonable access to in-network providers. These providers must be capable of providing all of the benefits covered under the plan, including:

- Specialty care, including MH/SUD, within 75 miles.
- Emergency care at all times.
- Urgent care within 24 hours.
- Routine care within two weeks for behavioral health conditions (three weeks for medical).
- Primary care within 30 miles (or 60 miles in rural areas for PPOs and EPOs).
- In areas where providers aren't available to contract, the health plan must set up a plan that says how enrollees can access needed services without paying more.

MH/SUD benefits should be equally accessible as benefits for other health conditions. Plans may not impose any limitations on MH/SUD benefits - whether quantitative or non-quantitative - that are more restrictive than the limits on medical or surgical benefits.

## Health benefit plan issuer responsibilities

Health benefit plan issuers design health plans - including benefits, formularies, networks, and internal standards and procedures. Plans must ensure consumers can effectively access benefits and coverage for MH/SUD under the same terms and conditions as the plan's medical and surgical benefits and coverage.

Issuers also have a responsibility to ensure that any limits on MH/SUD care are no more restrictive than the limits on medical or surgical care. Issuers must ensure parity both when designing benefits and limits (as written) and when applying the benefit design (in operation). This is true whether the issuer administers the benefits directly or has a third-party administer benefits for behavioral care.

Issuers must perform a comparative analysis and a mathematical analysis to show parity with medical and surgical benefits.

- The **comparative analysis** should show the processes, strategies, evidentiary standards, and other factors used to apply non-quantitative treatment limitations.
- The **mathematical analysis** must show compliance with quantitative parity requirements.

## Regulator responsibilities

The Texas Department of Insurance (TDI) is responsible for enforcing compliance with MH/SUD parity [laws](#) and [rules](#). These regulations require issuers to:

- [Submit comparative data](#) related to claims and utilization review for MH/SUD services and medical and surgical services, across specified classifications and subclassifications.
- [Use self-compliance tools](#) to ensure that quantitative and non-quantitative limits applied to MH/SUD benefits meet parity standards. Issuers must send these completed self-compliance analyses to TDI upon request.

For HMOs, PPOs, and EPOs, TDI performs exams once every three years, which provide an opportunity to evaluate parity compliance. Issuers must also file health plan documents and the associated provider networks with TDI for review before issuing coverage. TDI also regulates the utilization review agents that review preauthorization requests and determine medical necessity on behalf of health plans.

Finally, TDI receives complaints from consumers and providers, including referrals from the Texas Health and Human Services Commission's (HHSC) Ombudsman for Behavioral Health (OBH). Complaint reviews are an opportunity to evaluate the issuer and find any systematic compliance issues.

## Legislative requirement and agency collaboration

Texas [House Bill 2595](#), passed in 2021, directs TDI and the HHSC OBH to prepare and submit [a report](#) to the appropriate committees of the Texas Legislature and state agencies on:

- The status of the rights and responsibilities for mental health condition and substance use disorder benefits.
- Resolved and unresolved complaints sent through the parity complaint portal.

TDI and HHSC staff meet monthly to discuss complaints received and any parity issues. No parity violations have been identified as of May 31, 2023.

# Complaints

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If a patient or provider believes a state-regulated health plan is violating the law or isn't administering the health plan according to the terms of their policy or contract, they should file a complaint with TDI. TDI relies on complaints to learn of violations and identify issues that warrant enforcement actions. Consumers and providers may file a complaint with TDI regarding an insurer, HMO, or utilization review agent using [TDI's online Complaint Portal](#).

HHSC can help with concerns about access to behavioral health care through a Medicaid or self-funded health plan; answer questions about programs and providers; navigate a health plan's requirements to pay for services; find a way to solve problems with services; and help consumers understand their rights.

## Complaints received by TDI

TDI reviews complaints to find if an insurer or health plan violated any of the following:

- (1) A state insurance law or regulation.
- (2) A federal requirement that TDI has authority to enforce.
- (3) The term or condition of an insurance policy or certificate.

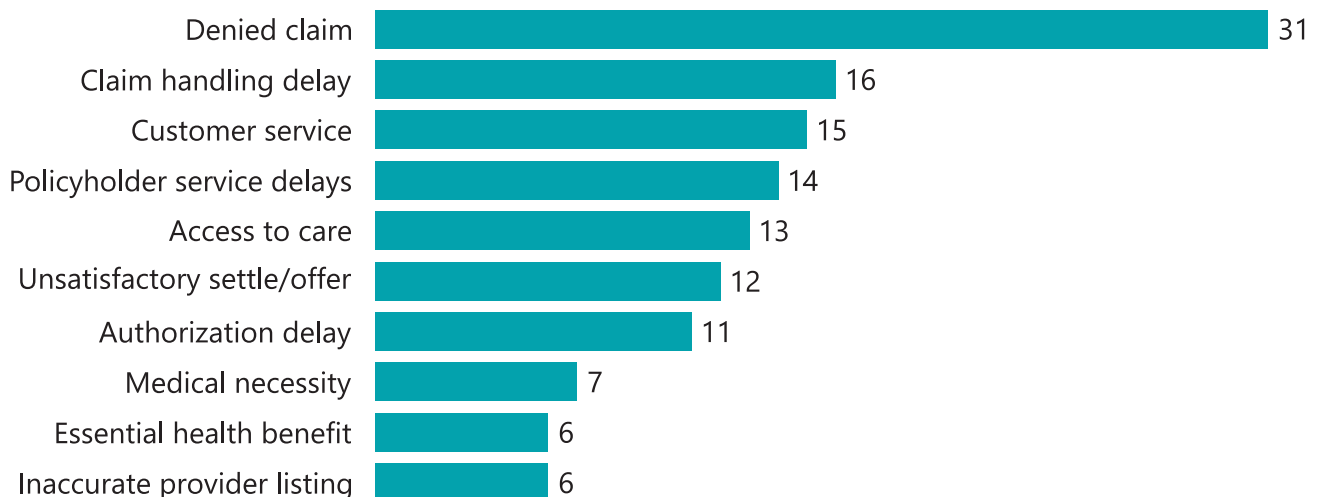
After reviewing a complaint and the insurer or health plan's response to it, TDI determines if a complaint is confirmed, or not confirmed.

- **Confirmed complaint:** TDI finds the insurer in error.
- **Not confirmed complaint:** TDI finds that the insurer is not in error.

Between June 1, 2022, and May 31, 2023, TDI received 83 complaints about MH/SUD benefits through its online portal from Texans with state-regulated plans. Of the 83 complaints, 27 were confirmed. **No complaints were confirmed as mental health parity violations.**

## Top TDI mental health parity complaint categories

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Note: Complaints may have multiple concerns that fall into different categories.

Complaints that concerned denied or delayed payment of claims, or customer service matters involved issues related to:

- Psychotherapy/counseling sessions and applied behavioral analysis (ABA) treatment (in- and out-patient) provided by therapists and/or licensed clinical social workers.
- Number of days medically necessary for in-patient residential treatment for children or adolescents.
- A consumer's ability to find in-network behavioral health providers, including facilities.

Four of the complaints involved allegations of non-compliance with mental health parity requirements:

- One involved a dispute about the copay amount charged for a psychotherapy counselor visit. The benefits summary showed the company applied the correct copay for outpatient office visit to a physician or behavioral health provider.
- Two involved allegations that the plan denied ABA services to a child in a school setting based on the location. In both instances, services in a school setting were denied as not medically necessary because existing approved services in other care settings had shown to be effective in the management and treatment of the member's autism spectrum disorder.
- One involved denial of coverage for outpatient care for alcohol detox. The involved policy, bought in 2018, is an excepted benefit plan that's not required to provide coverage for mental health or chemical dependency.

### Complaints received by HHSC

OBH reviews complaints to see if there was a Health and Human Services (HHS) policy violation or if HHS expectations were unmet:

- **Substantiated complaint:** A complaint where research clearly shows a violation or unmet expectations.
- **Unable to substantiate a complaint:** A complaint where research does not clearly show a violation or unmet expectations.
- **Unsubstantiated complaint:** A complaint where research clearly shows there were no violations or unmet expectations.

Between June 1, 2022, and May 31, 2023, the HHSC OBH received 48 mental health parity contacts. **All complaints were unsubstantiated as mental health parity violations.**

### Types of HHSC mental health parity contacts

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The 23 complaints included:

- One from someone insured through a self-funded employer plan about the inability to continue to pay for an inpatient stay at a Residential Treatment Center (RTC). This complaint was determined to be unsubstantiated as a mental health parity violation because the consumer was able to access the appropriate level of care through their designated local mental health authority ([LMHA](#)).
- Two from consumers insured under a private insurance plan. OBH does not have the authority to consider a parity complaint that doesn't fall under Texas Medicaid and referred both cases to TDI.
  - One complaint was about a pharmacy not filling a prescription medication until the complainant paid the copayment amount.
  - One complaint had concerns about how the insurance company was paying for out-of-network mental health services compared to out-of-network medical services once they met their annual deductible.
- Twenty from consumers insured under Medicaid. OBH escalated these complaints to Managed Care Compliance & Operations, as needed, for health plan engagement.
  - Thirteen related to Medicaid not covering RTCs. Consumers contacting OBH requesting this benefit were connected to resources through the consumer's designated LMHA.
  - One about access to ABA services.
  - One about finding a funding source for a long-term behavior program, which Medicaid does not fund.
  - One about a denial for a previously prescribed medication.
  - One about someone in a skilled nursing facility experiencing mental health symptoms. They were self-pay until they obtained Medicaid and hadn't met the award period yet.
  - One about a Medicaid recipient denied behavioral healthcare coverage due to an out-of-network provider.
  - One about an out-of-state request to switch Medicaid plans but the timeline would take too long to get access to care. OBH does not have authority to speed up the plan change process.
  - One about a Medicaid plan not switching insurance plans faster to gain access to an RTC, which is not a covered Medicaid benefit.

The 24 inquiries included questions about access to RTC placement, ABA therapy, and Medicaid coverage of Partial Hospitalization Program.

OBH connected one legislative contact to resources through their LMHA to access RTC.



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