

Texas Department of Insurance

Mental Health Parity Annual Report

August 2022





Mental Health Parity Annual Report

by the

Texas Department of Insurance

Submitted August 2022

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

First posting, August 2022

Publication ID: TDIMHP | 0822

This document is available online at tdi.texas.gov/reports.

Contents

- Overview..... 2**
 - What is mental health parity?..... 2
 - Consumer rights and protections..... 3
 - Health benefit plan issuer responsibilities 3
 - Regulator responsibilities 4
 - Legislative requirement and agency collaboration..... 4

- Complaints 5**
 - Complaints received by TDI 5
 - Complaints received by HHSC..... 6

- Complaint portal and website survey 8**
 - Assessment and action 8

Overview

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 provide 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 is provided 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.

Ultimately, 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 are responsible for designing 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 demonstrate 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 provide 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 are also required to 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 provide an opportunity to evaluate the issuer and identify 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 submitted through the parity complaint portal.

TDI and HHSC staff meet monthly to discuss complaints received and possible parity issues. No parity violations have been identified as of May 31, 2022.

Complaints

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.

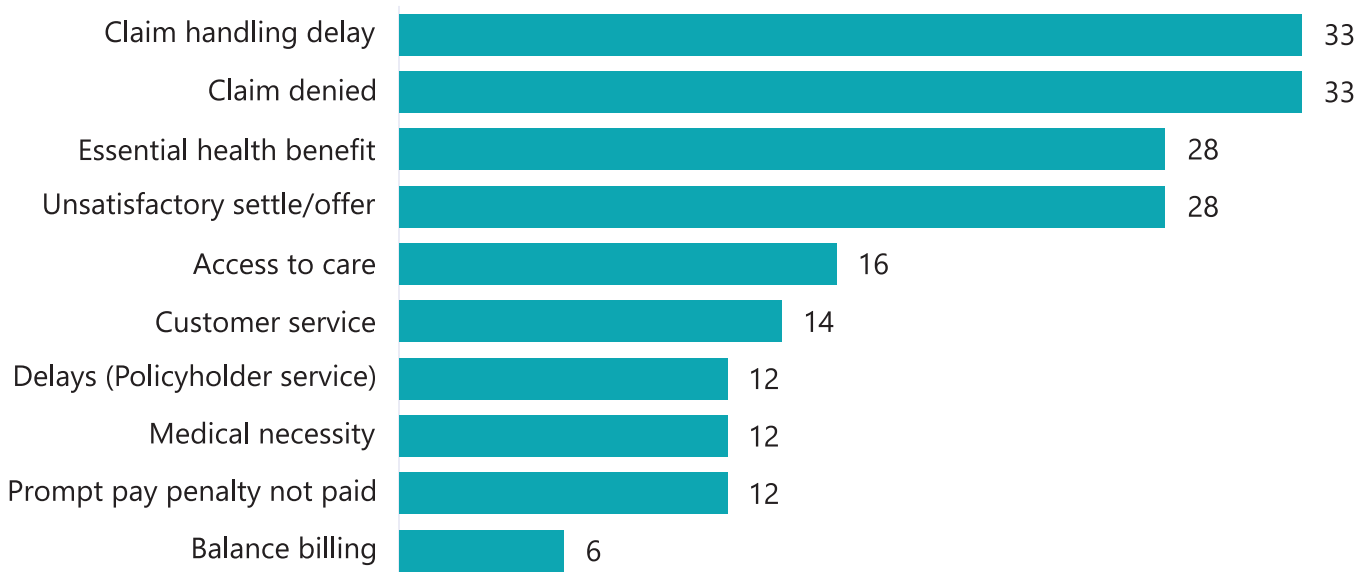
Complaints received by TDI

Between June 1, 2021, and May 31, 2022, TDI received 76 complaints about MH/SUD benefits through its online portal from Texans with state-regulated plans. Of the 76 complaints, 26 were determined to be confirmed. **No complaints were confirmed as mental health parity violations.**

TDI reviews complaints to find if an insurer or health plan violated: (1) a state insurance law or regulation, (2) a federal requirement that TDI has authority to enforce, or (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.

Top TDI MH/SUD complaint categories



Complaints that concerned disputes about the payment amount, denials, or the length of time taken to pay a submitted claim involved issues related to:

- Psychotherapy / counseling sessions (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.
- The consumers' ability to locate in-network behavioral health providers.

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

- One involved delayed payment of a claim that was missing the name of the physician who provided the service. It also was not sent directly to the behavioral health entity responsible for processing the claim.
- Two involved partial denial of direct applied behavior analysis (ABA) services. The number of hours requested were deemed more than what was medically necessary. Also, denials were reversed because the physician assigned for peer review was not licensed in Texas.
- One involved denial of an out-of-network, non-emergency, residential treatment. Authorization wasn't obtained on an EPO plan that didn't cover out-of-network benefits except in an emergency or when services aren't available in network.
- One involved denial of an ABA therapy assessment. There was no documentation of approved testing using a validated assessment tool for autism spectrum disorder based on behavioral health guidelines for outpatient ABA.

Complaints received by HHSC

Between June 1, 2021, and May 31, 2022, the HHSC OBH received 52 mental health parity contacts.

Complaints are reviewed and are determined to be:

- **Substantiated complaint:** A complaint where research clearly indicates a Health and Human Services (HHS) policy was violated or HHS expectations were not met.
- **Unable to substantiate a complaint:** A complaint where research does not clearly indicate if an HHS policy was violated or HHS expectations were met.
- **Unsubstantiated complaint:** A complaint where research clearly indicates an HHS policy was not violated or HHS expectations were met.

All complaints were unsubstantiated as mental health parity violations.

Twenty-three complaints were about access to MH/SUD covered benefits:

- One was about a consumer who is insured through a self-funded employer plan. This was a non-quantitative complaint about network adequacy issues. This complaint was escalated to the U.S. Department of Labor. It was found 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](#)).

- Twenty-two were from consumers insured under Medicaid. These complaints were received through the Ombudsman for Managed Care Team and were escalated to Managed Care Compliance & Operations, as needed, for health plan engagement.
 - Twenty-one of these complaints were related to access to residential treatment centers (RTC) for children ages 8 to 17. RTC placement is not a Medicaid covered benefit. Consumers contacting OBH requesting this benefit were connected to resources through the consumer’s designated LMHA.
 - One non-quantitative complaint was related to access to applied behavior analysis (ABA) therapy for a minor child. HHSC considers ABA therapy to be a service addressing neuro-developmental conditions.

Twenty-seven were about access to benefits for consumers insured through Medicaid:

- Thirteen were related to access to RTC placement.
- Thirteen were submitted on behalf of a provider that was not in-network with a Medicaid health plan inquiring about coverage for a Partial Hospitalization Program (PHP). Similar to RTC placement, the PHP is not covered by Medicaid. These individuals were contacted by OBH and connected to local in-network resources.
- One inquiry was related to an individual asking about ABA therapy for their minor child.

Two were legislative contacts about mental health parity concerns from consumers covered under Medicaid health plans. The consumers were connected to the appropriate resources for their respective level of care:

- One was related to a parent of a minor child trying to access RTC placement.
- One was related to a network adequacy complaint for a minor trying to access mental health services.

HHSC MH/SUD contact topics



Provider	Legislative inquires	Medicaid complaints	Medicaid inquires	Self-funded complaints
Access to RTC placement	1	21	13	0
Access to PHP	0	0	13	0
Access to ABA therapy	0	1	1	0
Network adequacy	1	0	0	1

Complaint portal and website survey

As [required](#), TDI conducted a survey and assessment of the consumer complaint portals and websites of nine state insurance departments: California, Colorado, Maine, Maryland, New Jersey, New York, Pennsylvania, Virginia, and Washington.

The survey found:

- All states surveyed allow enrollees to submit a complaint multiple ways.
- Seven states allow for complaint status updates.
- Five states provide approximate time frames for complaint processing.
- New Jersey is the only state that doesn't include educational materials about health plan benefits for MH/SUD.
- None of the states include educational materials about:
 - An enrollee's rights and responsibilities under a health plan concerning MH/SUD.
 - When a claim may be denied.
 - The complaint review process.

State insurance department website and portal survey

Does the portal or website:	TX	CA	CO	MA	MD	NJ	NY	PA	VA	WA
Allow the enrollee to submit a complaint multiple ways?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Allow for complaint status updates?	✓	✓	✓	✓			✓	✓	✓	✓
Provide information about the insurance complaints process time frame?	✓			✓	✓			✓	✓	✓
Include educational materials about:										
MH/SUD benefits?	✓	✓	✓	✓	✓		✓	✓	✓	✓
An enrollee's rights and responsibilities under a health benefit plan concerning MH/SUD?	✓									
When a claim may be denied?	✓									
The agency's complaint review process?	✓									
Total yes responses	9	3	3	4	3	1	3	4	4	4

Assessment and action

TDI determined best practice standards for a complaint portal should include each feature listed in the survey above. TDI has educational materials, resources, and information about the complaint process on its [website](#), and uses social media to inform consumers monthly about mental health parity.

TDI uses its [complaint portal](#) for all complaints, including complaints about MH/SUD benefits. The portal allows enrollees and other consumers to submit complaints multiple ways, upload relevant documents, update the complaint status, and communicate directly with TDI staff.



Texas Department of Insurance
Mental Health Parity Annual Report

TDIMHP | 0822