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Correspondence Memorandum

Date: January 22, 2021

To: Group Insurance Board

From: Luis Caracas, Health Policy Advisor
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Office of Strategic Health Policy

Subject: Mental Health Parity and Access Report

This memo is for informational purposes only. No Board action is required.

Background

In November 2019, the Group Insurance Board (Board) approved several initiatives with the goal of improving the Group Health Insurance Program (GHIP) with an eye toward the Healthcare Triple Aim. The Healthcare Triple Aim is a framework developed by the Institute for Healthcare Improvement to capture the optimal balance of population health, patient experience, and cost in a healthcare setting. This memo addresses the initiative related to mental health and substance abuse treatment parity and access in the GHIP program and provides an initial review of strategies to assist GHIP members in accessing needed care and maintaining their health.

Problem Definition

Mental health includes emotional, psychological, and social well-being. Many factors can contribute to an individual's mental health, including genetics, brain chemistry, life experiences, trauma and abuse, and family history. According to HealthyPeople.gov, a health improvement initiative of the US Department of Health and Human Services' Office of Disease Prevention and Health Promotion, mental disorders are health conditions that are "characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning." Mental illness is the term that refers to all diagnosable mental disorders. Mental illness is among the leading causes of disability in the US; in any given year, 43.6 million Americans age 18 or older experience mental illness, and for 9.8 million of those people, the condition is seriously debilitating.[1]

[1] Office of Disease Prevention and Health Promotion. *HealthyPeople 2020: Mental Health and Mental Disorders.* https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders. Accessed January 19, 2021.

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy

Eileen K Mallow Electronically Signed 2/3/21

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Substance use disorder (SUD) is also a major problem in the United States. The abuse of drugs can have serious ramifications on a person's physical health, mental health, and overall well-being. Substance abuse not only affects the individual, but also can have far-reaching consequences that affect family, employment, personal health, health care systems, local communities, and society. SUD is a chronic condition, and like other chronic conditions, may be treated so that the patient can improve and maintain health.

Federal Legislative & Regulatory Landscape

The Mental Health Parity Act of 1996 (MHPA) was the first major federal initiative to address mental health coverage in group health plans. Under MHPA, group health plans could not impose lower lifetime coverage limits on mental health benefits than on medical benefits. While this law expanded coverage to some degree, insurers in many cases opted to change copays, coinsurance, and deductibles to reduce the amount of actual coverage provided. It also did not include SUD treatment coverage. The original law expired in 2001, but was extended several times, until 2007.[2]

The Mental Health Parity and Addiction Equity Act (MHPAEA) was passed in 2008 and went into effect in 2009. MHPAEA preserved the MHPA protections and added new protections that included the requirement to treat SUD benefits the same as mental health benefits, and the requirement for parity for all cost sharing levels, including copays, coinsurance, and deductibles, with medical benefits.

MHPAEA defined two different categories of coverage limitations: quantitative treatments limits (QTLs) and non-quantitative treatment limits (NQTLs). QTLs refer to a number or dollar limit placed on coverage, such as a limited number of visits, or maximum dollar amount of coverage. NQTLs refer to limitations on coverage such as prior authorization requirements, step therapy requirements, or other generally judgment-based limits on when a service might be covered.

MHPAEA also extended the parity requirements beyond group insurance plans to include issuers of non-group or individual plans (small group plans for employers with less than 50 employees remain exempt). However, MHPAEA did not require that plans cover mental health and SUD treatments; only that if a plan covers treatment, that treatment be covered at parity to other benefits.

The Patient Protection and Affordable Care Act (ACA) was passed in its final form in 2010.[3] ACA builds on MHPAEA and requires coverage of mental health and substance use disorder services as one of 10 essential health benefit (EHB)

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[2] United States Department of Labor. *Fact Sheet: The Mental Health Parity Act.* https://web.archive.org/web/20120416004526/http://www.dol.gov/ebsa/newsroom/fsmhparity.html. Accessed January 19, 2021.

[3] Department of Health and Human Services. *About the Affordable Care Act*. https://www.hhs.gov/healthcare/about-the-aca/index.html. Accessed January 19, 2021.

categories for small group and individual plans. Large group plans like the GHIP are not required by ACA to offer all 10 EHBs, but in instances where they do offer one of the 10 categories, benefit limits must be removed. In 2013, the Board elected to comply with offering EHBs as defined by the State of Pennsylvania's benchmark plan (Ref. GIB | 5.21.13 | 4B) due to similarities to the Board's existing benefits at that time, which included coverage of mental health and SUD services.

In mid-2020, the Departments of Labor (DOL) and Health and Human Services (HHS) published a tool to help plan sponsors ensure that their benefits are compliant with MHPAEA. The tool is intended to provide a basic understanding of MHPAEA and help plans comply with the law. In particular, the tool is intended to assist plan sponsors in complying with the NQTL parity provisions of MHPAEA, which are the most challenging requirements to follow.[4] A few months later, the US Congress passed the Consolidated Appropriations Act of 2021 (CAA), which includes additional requirements that plan sponsors verify that benefit plans comply with MHPAEA. The bill allows DOL and HHS 18 months to establish final guidance for reporting, but also allows the agencies to request analyses as early as February 10, 2021. ETF is working with plans to verify their compliance approaches.

State Legislative & Regulatory Landscape

In addition to federal requirements related to parity, the State of Wisconsin has its own legislation that guides the coverage of mental health and SUD services by insurance carriers.

Wis. Stats. §632.89 addresses coverage of "mental disorders, alcoholism, and other diseases." Group health plans, under this statute, are required to cover inpatient, outpatient, and transitional treatment for both mental health and SUD. Transitional treatment includes services like day treatment programs, community support programs, and intensive outpatient programs for SUD. Wisconsin state law also requires that restrictions on qualitative and quantitative aspects of care be no more restrictive for mental health/SUD treatment than for all other coverage under the plan.

In addition to the coverage of services guaranteed by state law, Wis. Stats. §609.655 requires that plans also cover a limited set of mental health services and SUD assessment services for dependent students who are living outside of the plan's network.

The Office of the Commissioner of Insurance (OCI) includes requirements around mental health and SUD coverage in their administrative code language. INS §3.36 pertains specifically to coverage of autism spectrum disorders, the required levels of care, and minimum dollar values for coverage that plans must provide. INS §3.37

[4] US Department of Labor. *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA). https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf.* Accessed January 8, 2021.

includes requirements on transitional services and what types of transitional services should be covered under a health insurance plan. INS §3.375 provides further clarification on coverage requirements for mental health and SUD services, similar to those provided for by federal law.

The Wisconsin Legislature recently requested health plans voluntarily improve access to medication assisted therapy (MAT) for opioid use disorder. Some MATs must be administered by a provider in a clinic (e.g., Vivitrol) and would therefore not fall under the pharmacy benefit administered by Navitus. The request has not yet been made into a legal requirement.

Health, Quality, and Cost Impacts to the GHIP
ETF analyzed claims information on mental health and SUD claims using the Data Analytics and Insights (DAISI) data warehouse provided by the Board's vendor, IBM Watson Health. The following data analyzes claims from calendar years 2018 and 2019, the two most recent, complete years of claims data.

In 2019, GHIP members experienced 196.3 episodes related to mental health or SUD per 1,000 members. For all condition groups, members age 18 to 64 represented the largest cohort of claims. Depression and anxiety were the most reported conditions by far, occurring in 6.3% and 5.5% of all members, respectively. Table 1 below provides data on the most common patient episode groups.

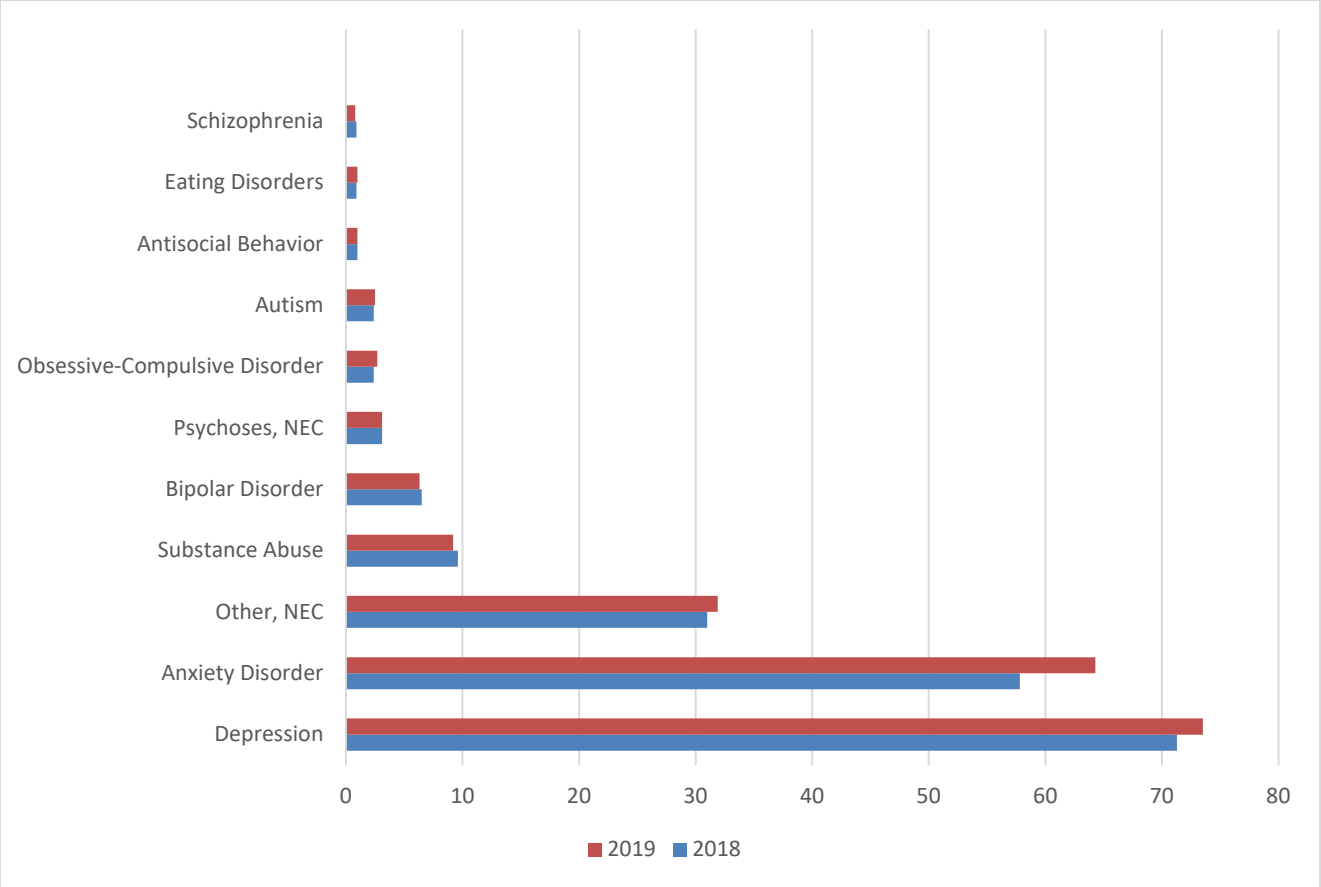
Table 1. Mental Health Utilization and Cost by Episode Group, 2019

Episode Group	Number of Episodes	Percent of Members with Episode	Allowed Amount per Episode
Depression	16,106	6.3%	$1,963.27
Anxiety Disorder	13,994	5.5%	$1,058.94
Other Disorders, NEC	6,733	2.6%	$1,455.36
Substance Abuse	1,882	0.7%	$5,368.54
Bipolar Disorder	1,294	0.5%	$3,950.20
Autism	585	0.2%	$14,601.20
Obsessive-Compulsive Disorder	563	0.2%	$2,295.52
Psychoses, NEC	548	0.2%	$1.551.43
Antisocial Behavior	232	0.1%	$2,753.18
Eating Disorders	222	0.1%	$11,481.42
Schizophrenia	193	0.1%	$6,672.69

Most mental health conditions are relatively low in cost to treat. Autism and eating disorders are outliers, costing over $10,000 each for treatment; this is likely due to the chronic nature and/or long-term treatment needs of these particular conditions.

The mental health service utilization of GHIP members increased between 2018 and 2019. The chart below shows the rates per 1,000 by each of the episode groups provided above in Table 1. For the top three reported conditions, rates increased in 2019 over 2018; for the remaining conditions, the rates remained steady.

Chart 1. Mental Health/SUD Episodes per 1,000 Rate Trends



GHIP members also experienced greater mental health service utilization than their peer groups. The following three charts compare the GHIP in 2019 to IBM's MarketScan benchmark data set of government workers. While GHIP members were slightly under the benchmark for bipolar disorder, they had substantially more episodes per 1,000 for depression and anxiety disorder. The blue bars in the charts below show the GHIP prevalence of the condition. The green bars represent the MarketScan benchmark.

Chart 2. Patients per 1,000 with Depression, GHIP v. MarketScan, 2019

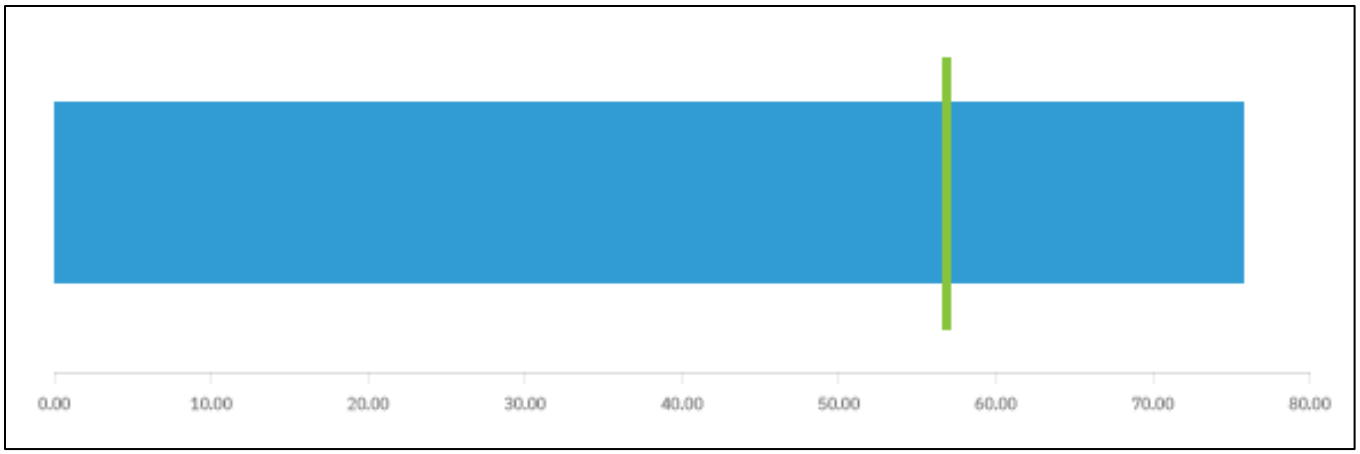


Chart 3. Patients per 1,000 with Anxiety Disorder, GHIP v. MarketScan, 2019

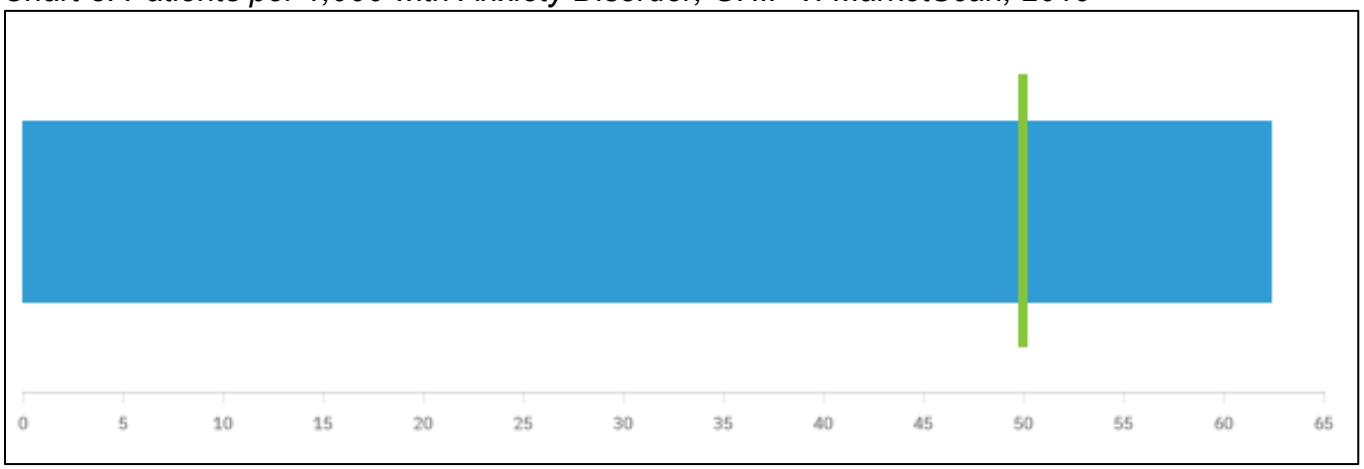
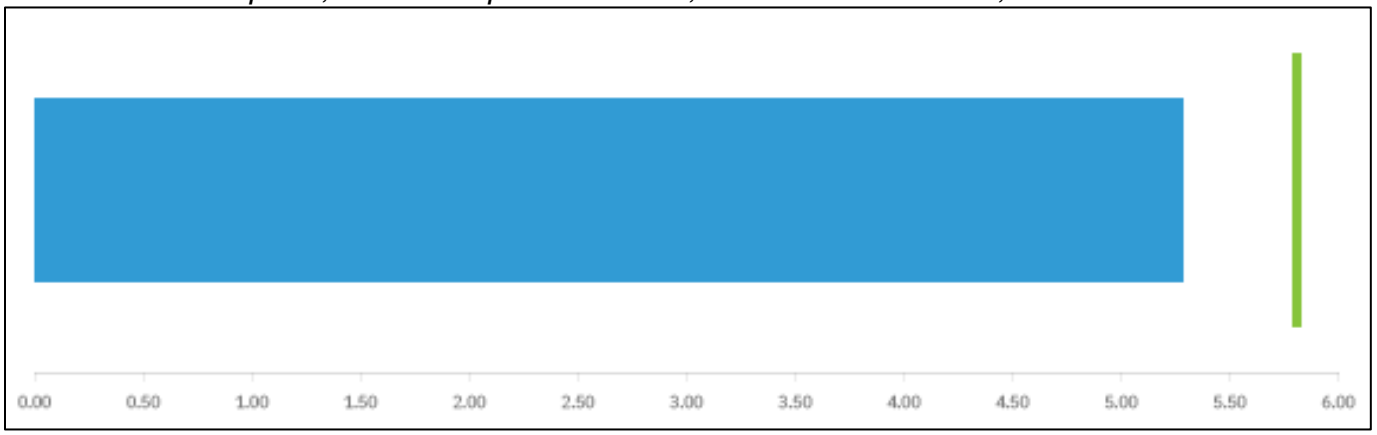


Chart 4. Patients per 1,000 with Bipolar Disorder, GHIP v. MarketScan, 2019



Patients with mental illness or SUD may be particularly prone to issues with quality of care — often the very conditions that people seek treatment for make it difficult for them

to attend appointments regularly or even initiate treatment, and treatments that require multiple visits may be hard for people to accommodate in their schedules. This is particularly challenging for people who have limited access to transportation and people in rural areas who may have to drive farther to visit a counselor or psychiatrist in person. Adding to these challenges, there is often stigma surrounding mental illness that can make people less likely to seek care or disclose the condition to others who might be able to encourage them to find treatment and help remove other barriers to care.

In addition to the impacts to health and quality, mental illness — while not necessarily costly to treat on its own — can complicate other conditions. Individuals who have chronic conditions like diabetes are two to three times more likely to experience mental illness than people without a chronic condition[5]. Having a mental health condition as well as a chronic condition is also associated with greater costs of care, above just the costs of treating the mental illness. People who have chronic conditions and untreated mental illness are more likely to have poorly managed chronic conditions that are more costly to treat. The relationship between mental illness and physical illness may also be bidirectional; one study found that Type 2 diabetes increases the risk of onset of major depression and that a major depressive disorder could signal increased risk of diabetes.[6] A study published by the American Diabetes Association found that patients with diabetes and depression had expenses that were 4.5 times higher than for patients with diabetes and no depression noted.[7]

Another contributor to the likelihood that a person will experience a mental illness in their lifetime is trauma. Trauma can have a range of origins and given the nature of the work done by public employees (e.g., corrections officers, law enforcement, healthcare workers, etc.), certain employee groups may be at greater risk for experiencing traumatic events or other stressors as a part of their normal work duties. While ETF does not currently track employee classification within the DAISI data set, this may be an area of interest to consider when designing supportive programming for members.

Statewide Access

A key component of obtaining needed mental health services is provider availability; if there are not enough providers who are accepting patients and insurance reimbursement, members will not be able to receive the help they need. The Wisconsin Department of Health Services (DHS) tracks the numbers of certain provider types practicing in each county of the state and compares those numbers to the number of providers needed to provide adequate care. Figure 1 below shows their estimates of the number of psychiatrists needed to remediate shortages for Wisconsin's counties:

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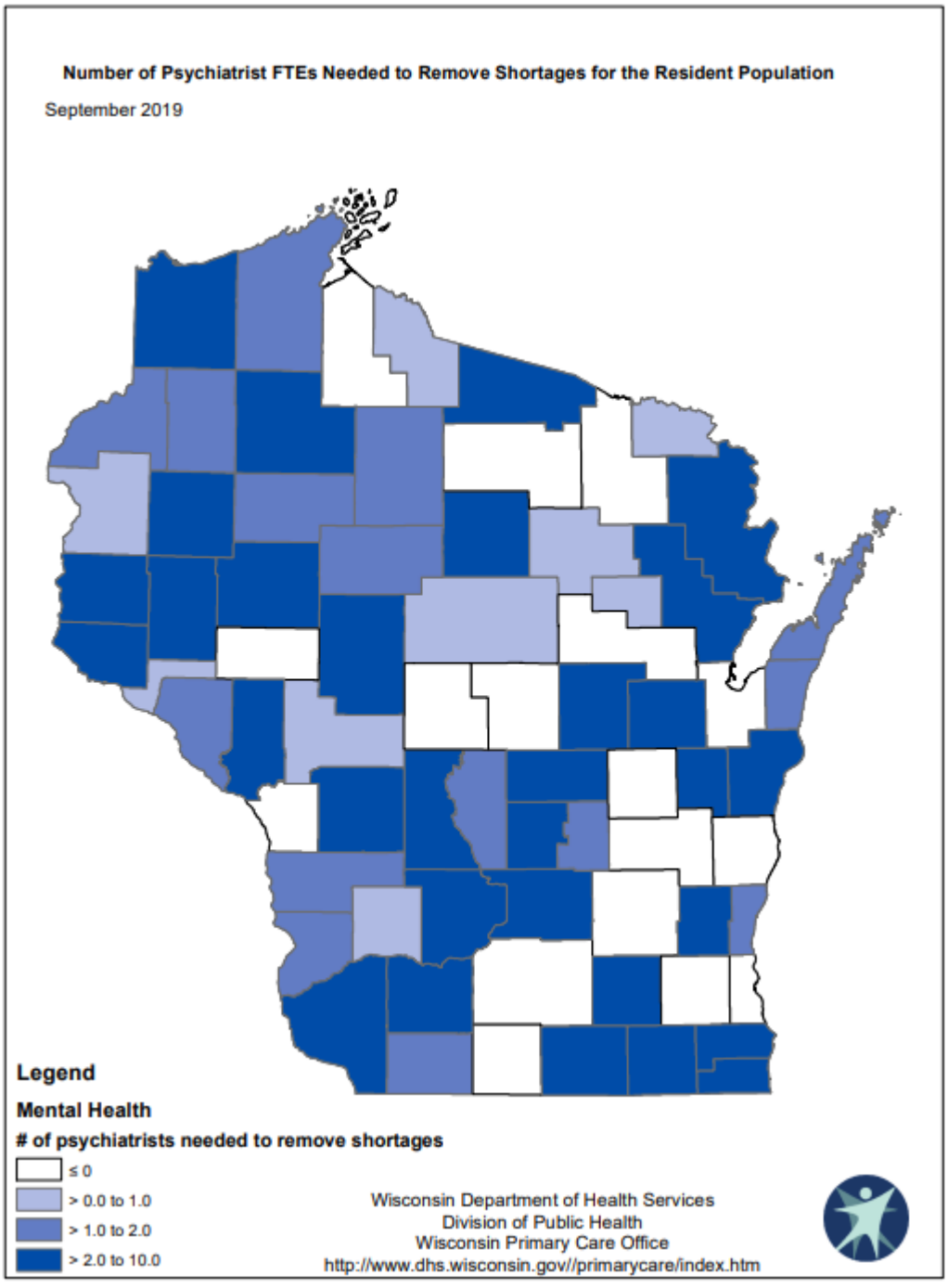
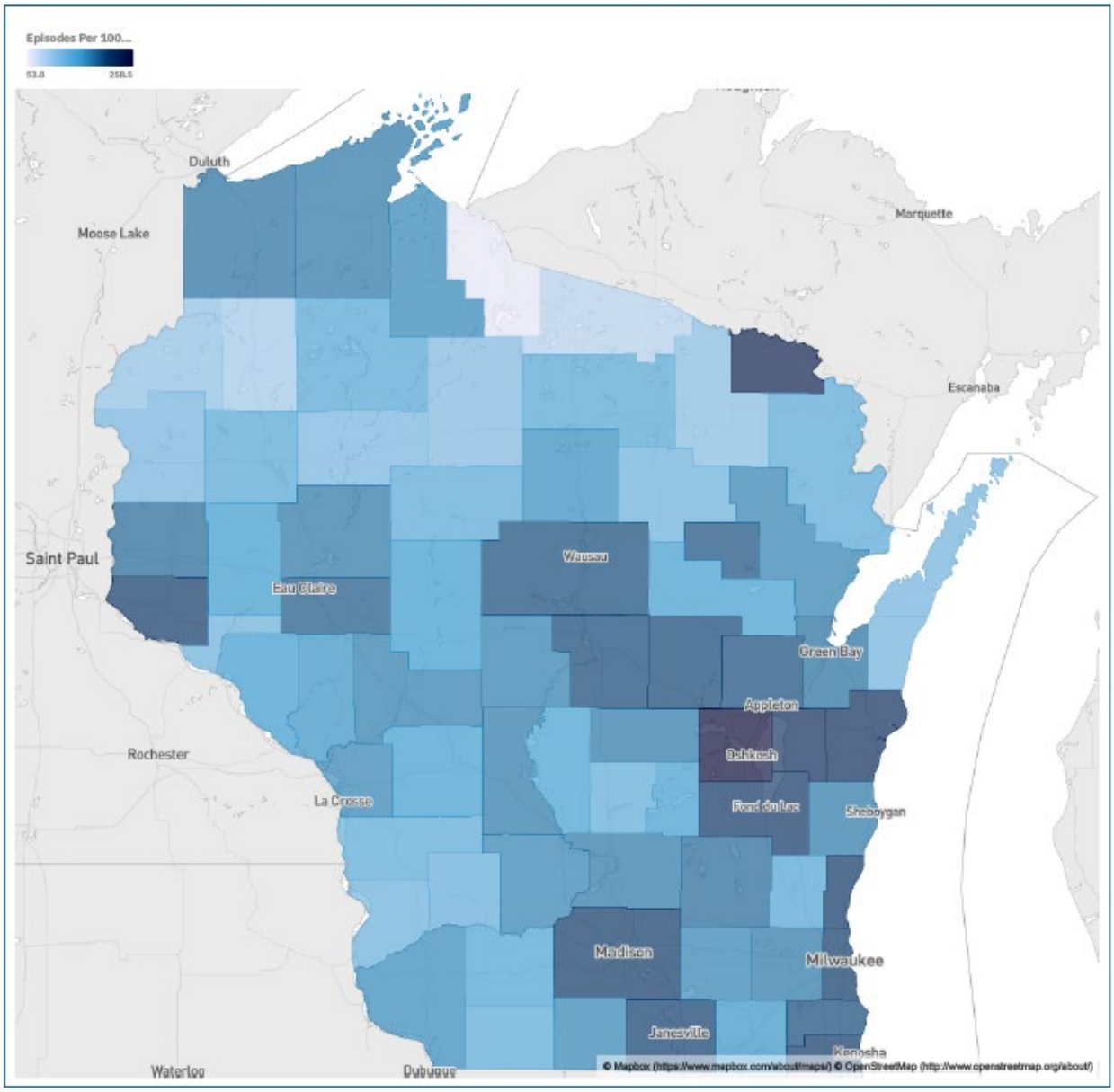
[5] Centers for Disease Control and Prevention. *Diabetes and Mental Health*. https://www.cdc.gov/diabetes/managing/mental-health.html. Accessed January 21, 2021.
[6] Ducat, L., Philipson, L.H., and Anderson, B.J. (2014). The mental health comorbidities of diabetes. *JAMA,* 312(7), 691—692. https://doi.org/10.1001/jama.2014.8040.
[7] Egede, L.E., Zheng, D., and Simpson, K. Comorbid Depression is Associated With Increated Health Care Use and Expenditures in Individuals with Diabetes. *Diabetes Care*. 2002 Mar; 25(3): 464-470. https://doi.org/10.2337/diacare.25.3.464.

Figure 1.



The darker colored counties correspond to areas of greater need. ETF does not currently have complete, geo-coded provider data in DAISI; however, the map in Figure 2 shows where members live who are receiving care, which provides an approximation of access by county.

Figure 2. Mental Health Utilization by County, Calendar Year 2019



In the above map, the darker blue squares represent where mental health services utilization is the highest. While there are some counties where utilization does not appear to correspond with limited access (e.g., Winnebago County), other parts of the map with lower utilization also correspond with DHS's provider shortage maps. While ETF cannot state with certainty that provider access is the cause of lower use, it is a possible contributor. It is also important to note that the DHS maps only address psychiatrist availability, but that mental health services are provided by many different types of providers, including clinical social workers, psychologists, and primary care

providers. Table 2 provides a breakdown of the number and percentage of mental health and/or SUD episodes of care by the provider who provided services.

Table 2. Mental Health and SUD Episodes by Provider Type, Calendar Year 2019

Provider Type	Number of Patient Episodes	% of Total
Psychiatry	10,129	33.9%
Family Practice	7,792	26.1%
Internal Medicine (NEC)	2,685	9.0%
Nurse Practitioner	2,129	7.1%
Pediatrician (NEC)	1,602	5.4%
Medical Doctor – MD (NEC)	1,238	4.1%
Child Psychiatry	1,130	3.8%
Physician Assistant	922	3.1%
Emergency Medicine	573	1.9%
Neurology	258	0.9%

It is notable in Table 2 that encounters with a pediatrician are more common than with a child psychiatrist. Child psychiatrists are very challenging to find, particularly in rural areas of the state.

Coverage by the Board's Programs
Uniform Benefits (UB) has always included some level of coverage for mental health and SUD treatment, and that coverage has changed over the years to align with changes in legislation. UB covers inpatient, outpatient, and transitional services as required by state and federal law, as well as medications used to treat mental illness and SUD. UB does not govern prior authorization or other utilization management criteria that plans use to determine coverage of more complex services, and plans are allowed to determine which services require authorization and what criteria are used to adjudicate coverage. This means that member experience by plan may not always be consistent; some plans may authorize services others don't and may use different criteria to determine what is covered and when.

UB also contains an exclusion for residential treatment services, though that exclusion has been amended to allow for residential treatment as provided for under state and federal law. In the past, this has caused confusion as to coverage intent, and clarification may be warranted to ensure members are able to access needed benefits.

Opportunities for Improvement
Following a review of available literature and coverage issues, ETF has identified the following opportunities for improving access to mental health and SUD services for GHIP members:

1. **Continue investigation of provider adequacy and consider contract requirements.** While the maps provided by DHS are helpful, ETF's actual, available network and relative levels of access could differ from what DHS has provided. ETF intends to continue to work on obtaining provider data with worksite location, and to compare that data to where members live to better understand where there may be gaps in available care. If gaps are substantial, ETF may propose requiring a provider access threshold for behavioral health, similar to the current thresholds required for primary care and hospital access, during the annual rate negotiation process. This could encourage plans to contract with more providers who are not already included in their networks, though requirements would need to be carefully drafted to allow for areas of the state where providers are simply not available.

2. **Require and promote telehealth access to behavioral health services.** The Board approved adding telehealth as a formal benefit with its own benefit coverage category to UB in 2019 and is currently working to establish guidelines for plans on what should be covered as telehealth. The COVID-19 pandemic has further accelerated the development of telehealth offerings and coverage in the market at large, and now more providers than ever are offering telehealth services, including behavioral health providers. ETF proposes including specific requirements that behavioral health services continue to be covered via telehealth, and that plans ensure these services are available as they structure their networks. This should include SUD treatment, as appropriate.

3. **Develop communications and educational materials regarding benefits available.** Members in general are often unsure of how coverage works, and the fear of unexpected medical bills may act as a further barrier to receiving treatment. ETF intends to create educational materials, as well as pieces that employers can use, to clarify what mental health benefits are available and how members can start care. ETF plans to work with the Department of Administration (DOA) on this outreach to coordinate benefits available through DOA's employee assistance program vendor.

4. **Develop communication related to stigma reduction**. As addressed earlier, the stigma surrounding mental illness and SUD can drive people to hide both their conditions and their need for help. ETF also proposes working with DOA and other employers to promote different ways to reduce stigma around mental illness and help members talk about these sensitive topics. ETF would leverage existing campaigns available from MakeItOK.org and hopes to establish community partnerships that can help further develop outreach.

5. **Promote Mental Health First Aid (MHFA) training access through GHIP enrolled employers.** MHFA and similar trainings provide skills for lay people to use to help others address mental health and SUD issues as they arise. MHFA provides a framework for individuals to respond to someone who may be experiencing mental illness and to help that person consider treatment. MHFA does not make the first aider a counselor; rather, it helps them to ask questions and support someone who may need help. Like physical health first aid, MHFA can help bridge the gap between crisis and care. ETF has made MHFA trainings available to its own staff internally, and response has been very positive so far. ETF would work with employers and DOA to explore how they might provide similar access to their employees. This would contribute both to stigma reduction and promoting care access.

6. **Using the MHPAEA Parity Tool created by DOL and DAISI, analyze overall plan parity.** Following the increased transparency requirements issued under the CAA, ETF plans to use the Parity Tool to ensure that the GHIP complies with parity. The Parity Tool provides suggestions on benefit design and prior authorization review, as well as some flags that can indicate whether a plan might be out of compliance. ETF will provide the results of this review at a future Board meeting.

7. **Encourage plans to promote behavioral health access and develop programming.** ETF typically limits the content that health plans can communicate during open enrollment in order to reduce member confusion about what is within the scope of UB, versus what is plan marketing or a limited feature not available to the GHIP. Given the Board's interest in supporting member mental health (as well as other Board initiatives identified in November 2019), ETF suggests encouraging plans to promote their innovative strategies to address mental health during open enrollment and as a part of other promotional materials. ETF would also support plans developing innovative approaches to behavioral health case management, such as creating behavioral health medical homes, creative case management strategies, and other programming or educational outreach. ETF could also ask plans to offer changes to benefit design that promote behavioral health access and support these programs, bringing them to the Board for consideration. It will be important to consider, though, how these changes might impact members with different access to technology, transportation, or other barriers to care, resultant disparities in health, and how those disparities might be addressed.

8. **Consider ways to support access to peer support workers.** Peer support workers are individuals with lived experience who have recovered from a mental illness or SUD. They may also have specific life experience that can help them

relate to different populations, such as military veterans. Wisconsin DHS promotes and provides financial reimbursement for peer support to help Medicaid members in recovery. ETF could explore ways to encourage access to appropriate services for GHIP members.

9. **Consider coverage of marriage and/or family therapy.** The GHIP does not currently cover marriage and family therapy visits. Members may invite a spouse or partner to their individual therapy session to discuss challenges, but the focus of the session is on supporting the member, not the relationship. Social relationships are foundational to mental health, however, and access to support in repairing family relationships could help promote individual health and wellbeing. ETF could investigate the specific costs of adding this benefit for the Board's consideration.

Next Steps

ETF is seeking Board feedback on the above initiatives, as well as any other supportive services it can facilitate to improve member mental health. Following this meeting, ETF will continue outreach to relevant experts and will further define any recommended changes to the benefits and services offered by the Board, for the Board's consideration at the May 2021 meeting.

Staff will be available at the Board meeting to answer any questions.