Texas Department of Insurance

Mental Health Parity Annual Report

August 2024

TDI | Texas Department of Insurance

Mental Health Parity Annual Report

by the

Texas Department of Insurance

Submitted August 2024

Cassie Brown
Commissioner of Insurance

First posting, August 2024
Publication ID: TDIMHP | 0824
This document is available online at tdi.texas.gov/reports.

Contents

Overview

The Texas Department of Insurance (TDI) is responsible for enforcing compliance with mental health and substance use disorder (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 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 gives the agency an opportunity to evaluate parity compliance. Issuers must 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 for health plans.

TDI gets 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 help consumers and evaluate issuers to find compliance issues.

Legislative requirement and agency collaboration

The Texas Insurance Code directs TDI and HHSC OBH to prepare and submit a report to the Texas Legislature and state agencies about:

- 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 talk about complaints and parity issues. There haven't been any parity violations identified as of May 31, 2024.

Background

All fully insured health plans must include benefits for MH/SUD services. Federal law requires individual and small employer plans 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 illnesses or injuries. This is called "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. This includes:

- Annual and lifetime limits on coverage.
- Financial requirements:
  - Deductibles.
  - Copayments.
  - Coinsurance.
  - Out-of-pocket expenses.
- 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 not more stringent 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 get covered benefits from high-quality providers where and when they need them. They should be able to get care as easily as they can for illnesses or injuries.

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

- Specialty care, including MH/SUD, within specified time and distance standards.
- Emergency care at any time.
- Urgent care within 24 hours.
- Routine care within two weeks for behavioral health conditions (three weeks for medical).
- Primary care within specified time and distance standards.
- 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 as 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 with benefits, formularies, networks, and internal standards and procedures. Plans must make sure consumers can access benefits and coverage for MH/SUD under the same terms and conditions as medical and surgical benefits and coverage.

Issuers must make sure any limits on MH/SUD care aren't more restrictive than the limits on medical or surgical care. Issuers must ensure parity both when designing benefits and limits and when applying the benefit design. 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 and 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.

Complaints

If a patient or provider thinks 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 using TDI's online Complaint Portal. TDI relies on complaints to learn about violations and identify issues that warrant enforcement actions.

Complaints received by TDI

TDI reviews complaints to learn if an insurance company or health plan violated:

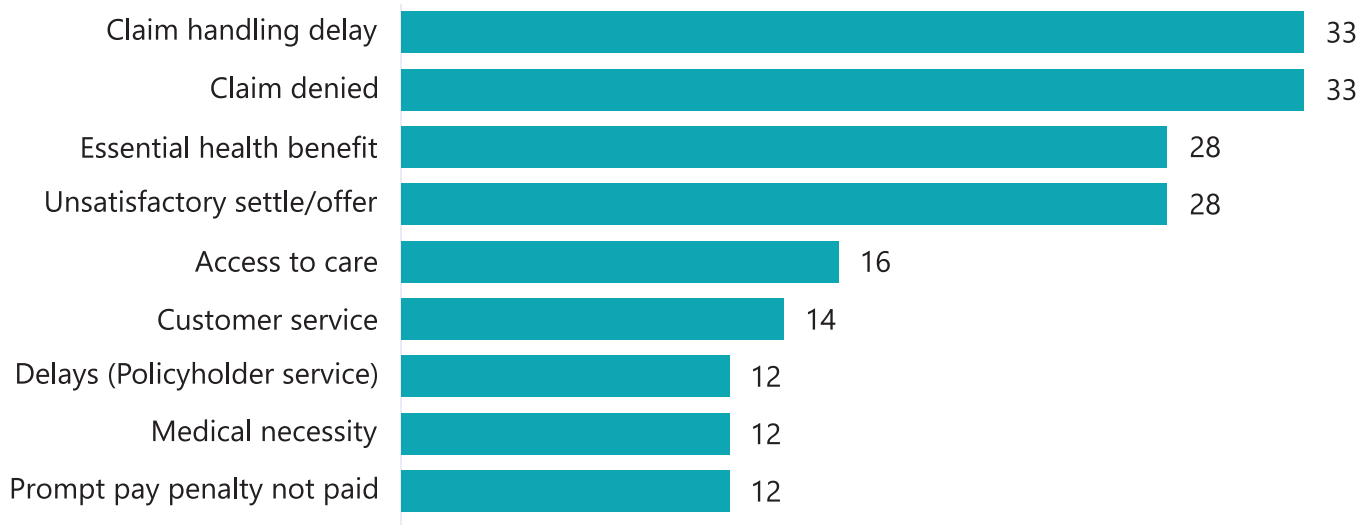
- A state insurance law or regulation.
- A federal requirement that TDI has authority to enforce.
- The term or condition of an insurance policy or certificate.

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

- **Confirmed complaint:** TDI finds the company in error.
- **Not confirmed complaint:** TDI finds that the company isn't in error.

Between June 1, 2023, and May 31, 2024, TDI received 62 complaints about MH/SUD benefits through its online portal from Texans with state-regulated plans. Of the 62 complaints, 29 were confirmed. **None of the confirmed complaints were mental health parity violations.**

Top TDI mental health parity complaint categories



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

Complaints about denied or delayed payment of claims or customer service matters were about:

- Psychotherapy/counseling sessions and applied behavioral analysis treatment (inpatient and outpatient) provided by therapists and licensed clinical social workers for children.
- Out-of-network inpatient residential treatment for children or adolescents.
- Consumers' ability to find in-network behavioral health providers and facilities.

None of the complaints were allegations of noncompliance with mental health parity requirements.

Complaints received by HHSC

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.
- Help consumers understand their rights.

OBH reviews complaints to see if there was a HHSC policy violation or unmet expectations. HHSC has three types of complaints:

- **Substantiated complaint:** A complaint where research clearly shows a violation or unmet expectations.
- **Unable to substantiate a complaint:** A complaint where research doesn't clearly show a violation or unmet expectations.
- **Unsubstantiated complaint:** A complaint where research clearly shows there weren't any violations or unmet expectations.

Between June 1, 2023, and May 31, 2024, the HHSC OBH received five mental health parity contacts. **All complaints were unsubstantiated as mental health parity violations.**

All five complaints were about Medicaid not covering residential treatment centers. Consumers who contacted OBH about these benefits were connected to their designated local mental health authority.

Types of HHSC mental health parity contacts

Complaints	4	80%
Legislative contacts	1	20%

Texas Department of Insurance
Mental Health Parity Annual Report

TDIMHP | 0824