Families Pay the Price of False Hope in Parity Enforcement

Brian Morgan, DO, and Chris Rogers, MD

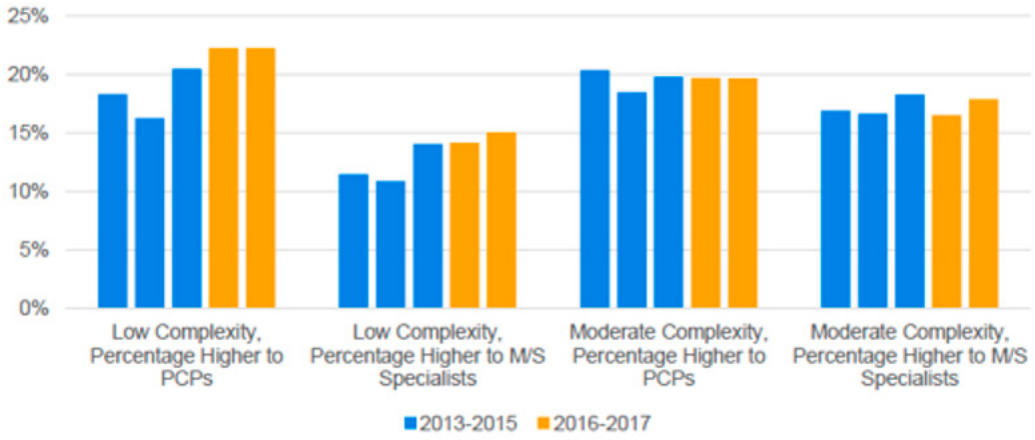
We all see it. The frustration. The fear. The loss of hope in a system that has let them down again and again. Words like "does not meet medical necessity" translate to "your child's suffering is not that important." Again. "Not taking new patients" begins to mean "you are on your own." Again. "Not a covered benefit" becomes "the safety of your children doesn't matter." Again. And again.

As child psychiatrists, we all see the hollow promise of true mental health parity on a personal level all too often. Now, we have a powerful tool outlining just how big the gap is nation-wide between coverage for physical and mental health. The Milliman Company, an independent actuarial firm founded in 1947, breaks down the data in painful detail in the 2019 Milliman Report. Spoiler alert: the news isn't good. Milliman Reports completed in 2017 and 2019 evaluated insurance companies' performance in providing affordable coverage to families following the enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. This federal law was designed to prevent insurers from imposing less favorable mental health or substance use disorder (MH/SUD) benefit limitations as compared to medical/surgical benefits. This law, also known as the Federal Parity Law, requires most insurers to cover psychiatric illness such as depression, anxiety, and substance use disorders commensurate with medical or surgical conditions. Today, 12 years later, there shouldn't be a difference in families' benefits for depression vs an appendectomy. Unfortunately, the law did not get fulfilled by many, and millions of Americans continue to remain without adequate mental health coverage.[1] This during an unprecedented time of increased deaths from suicide as well as drug and alcohol abuse.

Milliman researchers analyzed three years of claims data, 2013 to 2015, from 42 million US employees and family members. In December of 2019, the researchers updated that same study to include data from 2016 and 2017. The Milliman report simplifies data into 4 categories of treatment: (1) inpatient facility services, (2) outpatient facility services, (3) primary care office visits, and (4) specialist office visits. It then compares the level of out-of-network use for behavioral health vs physical health. In 2013, a family had a 2.8 times greater likelihood of paying for care at an "out of network" behavioral health facility than for care at a medical/surgical facility. This number increased by 85% over the five-year research period. The report notes that "disparities are particularly bad for children. In 2017, a behavioral health office visit was 10.1 times more likely to take place at an 'out of network' provider than 'in-network,' more than double the adult disparity." The Milliman research reports "insurers spent only 1% of their total health care dollars on treatment for substance use disorders and 2.4% for mental health in 5 years of 2012-2017."[1] Given the proportion of morbidity and mortality resulting from inadequate MH/SUD treatment this is inexcusable.

The story for the child and adolescent psychiatrist and the families they treat gets worse. The Milliman report demonstrates that insurers reimburse psychiatrists 20-30% less than they pay other doctors for treating the same illnesses, despite child and adolescent psychiatrists' extensive, specialized training in mental health treatment (Figure 1). For example, in 2015, primary care physicians in Colorado were paid 121% of the Medicare reimbursement rate for office visits while psychiatrists were paid just 85.9% of the rate (This is for low; 99213 and moderate complexity visits; 99214). In 11 states the report reflected that reimbursement rates for PCP office visits were >50% higher than behavioral health visits and in 13 others PCP reimbursements were 30-49% higher than behavioral health. Commercial insurers often pay less than Medicare reimbursement rates for mental

Figure 1. Percentage Higher Payments for Primary Care and Medical/Surgical Specialist Evaluation and Management (E&M) Visits Compared To Behavioral E&M Visits



Note: This figure provides a detailed summary comparing in-network reimbursement rates related to Medicare-allowed amounts for office visits performed by different types of providers. In 2017, for example, behavioral healthcare providers were reimbursed by commercial PPO plans at 97.2% of Medicare-allowed amounts for office visit services, whereas primary care providers were reimbursed at 120.4% of Medicare-allowed levels, and medical/surgical specialists were reimbursed at 115.6% of Medicare-allowed levels. Republished with permission from Melek *et al.*[1] **https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p.**

health care – a direct reflection of the lack of value they perceive despite the clear evidence of the need for more providers within suppliers' networks. This contributes directly to the dire shortage of physicians who choose child and adolescent psychiatry as a specialty as well as to the alarming number of providers who have chosen to not accept insurance at all. This data provides a clear picture of the incentive of psychiatrists in private practice to not participate in networks. In doing so, not only do they earn more for the same care provided, but they are freed from the need to spend uncompensated time on unnecessary administrative burdens such as frequent utilization reviews or prior authorizations. What we need today is more child and adolescent psychiatrists' providing care to those who need our services now and to prepare for the likely deluge of care needed in the coming days.

Before anyone had ever heard of COVID-19, the US was already in the midst of a pandemic of overdoses and suicides. From 2016-2018, over 3 million (12%) adolescents ages 12 to 17, or more than one in ten, had depression and/or anxiety.[2] Suicide was the second leading cause of death for age groups 10 to 24 (19.2% of deaths in 2017). Suicidal thoughts and suicide rates among adolescents have increased over time; the crude rate of suicide deaths among adolescents was 7.0 per 100,000 in 2018 versus 3.7 per 100,000 in 2008,[3] Additionally, substance use is a concern among adolescents. Research shows that substance use among teens often occurs with other risky behaviors and can lead to substance use problems in adulthood.[4]

This was the grim challenge we faced at the beginning of 2020. Now, we face the single greatest challenge to the mental health of our nation in our lives as we grapple with the COVID-19 pandemic. Theodore Roosevelt once said, "The more you know about the past, the better prepared you are for the future." How does this apply to us today amid the COVID pandemic? For a preview of what may come, we can analyze the research available on mental health in the aftermath of the recession of 2008. "In 2008, the Great Recession ushered in a 13 percent increase in suicides attributable to unemployment with over 46,000 lives lost due to unemployment and income inequality in that year alone."[5] Logic tells us if such stark numbers occurred in 2008, then the current

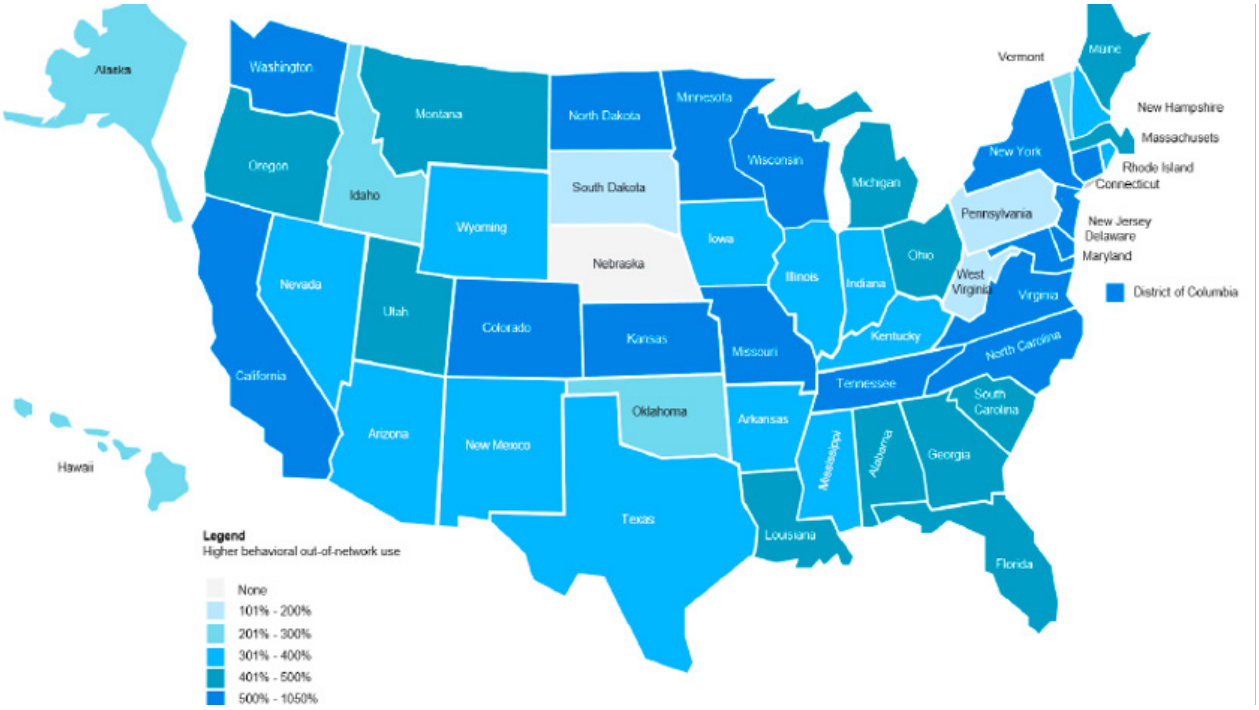
fallout from the COVID pandemic will likely mimic 2008 or worse.

A new report released by the Wellbeing Trust is projecting substantially increased mortality as a result of the pandemic, termed as additional "deaths of despair." Their analysis suggests as many as 75,000 more people will die from drug or alcohol misuse and suicide in the coming years as a result of primarily economic impacts alone. They calculate a range of potential increased mortality but even their most optimistic prediction estimates over 27,000 more people will lose their life in the next decade.[6]

The importance of this information cannot be stressed enough after reading the conclusions of the Milliman report. Those at risk for these additional deaths of despair will need greater access to affordable care. Yet there already exists widespread disparities in how often behavioral office visits are provided out of network compared to PCP visits. For example, in Connecticut, Maine, Maryland and New York behavioral healthcare office visits were at least 10x more likely to be out of network than primary care office visits in 2017 pushing families away from care that is needed (Figure 2).

This has significant implications for communities such as New York or Florida which have already been hit hard with coronavirus infections and deaths. Families in or around a hot spot will not only have to deal with losing a job, wages, and insurance but also limited access to much needed mental health services. The hard facts are most families can't pay for out-of-network services for mental health and this is only going to worsen. This can be further impacted as families are not likely to seek mental health treatment after losing a job and income. Shouldn't mental health services be provided less stringently during high-risk situations?

Figure 2. Higher Proportion of Behavioral Out-of-Network Care: Behavioral Office vs Primary Care Office Visits in 2015



Note: The observed differences between out-of-network utilization rates for behavioral and medical/surgical services points to inequitable design and standards for behavioral services. Republished with permission from Melek *et al.*[1] **https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p**.

Looking at the data in the Milliman Report can be daunting and even overwhelming; however, the news isn't all bad. Some plans have recently taken steps towards substantive changes such as Blue Cross Blue Shield of Massachusetts (BC/BS of MA) which recently acknowledged, "Access to mental health services is a serious issue across the country and has become even more pronounced during the COVID-19 pandemic."[7] This past July BC/BS of MA established an incentive program to increase reimbursements to child psychiatrists by 50% with hopes of expanding their network of providers, as well as committing to adding 2,000 more clinicians to their mental health network. Unfortunately, concrete efforts to address the mounting need for mental health services are rare and not likely to happen without pressure from providers and customers alike.

More likely, insurers will make changes only when they are forced to or the financial penalties of not providing parity are compelling. In the last 2 years, a few major private insurance companies have had to pay penalties and fines for noncompliance with the Federal Parity Act. Aetna was fined $190,000 in 2019 for their lack of compliance. More impressively, United Behavioral Healthcare was fined $1 million for failure to pay, or sometimes denial of care for customer's claims relating to mental health in 2019. In the latter case, the Pennsylvania Insurance Department, whose main function is to audit insurance companies, found that United Behavioral Healthcare was using flawed medical review criteria and rejected claims on more than 50,000 people who were attempting to obtain coverage for mental health. Blue Cross Blue Shield were not fined, but were audited. During the audit, Blue Cross Blue Shield agreed to pay $5 million in 2018 to expand mental health services. These serve as templates for action that can be encouraged in states across the nation.

The time is now! Physicians and patients need to demand equality and accountability from health insurance companies. Along with our patients, psychiatrists can be the trailblazers for a more proactive process in correcting the disparities in mental health care coverage. Lawmakers and insurance companies have to be made aware of and accountable for this noncompliance. Psychiatrists have too many families seeking mental health services just to find out they are out-of-network, not covered, and ultimately, denied. After being told that they are not covered the next step is a protracted process of appealing insurance determination and filing a complaint. Given how COVID-19 has disrupted more than just mental health, consumers are less likely to follow through with such a process that can take months to complete not to mention the average consumer won't have the legal knowledge required to complete such a parity complaint. The other option for the consumer is to contact their state insurance commissioner to ensure mental health parity. These state insurance commissioners have the ability with their position to enforce the law by ensuring plan compliance before being sold to consumers. Unfortunately, too few of the State insurance commissioners are living up to this obligation. No family should ever have to endure their child's suffering due to red tape and lack of enforcement of the Final Rule. We must lead the way to both empower the families we serve to seek justice and to hold our own state governments accountable for this lack of parity. The costs are too high to wait any longer.

Take Home Summary

Physicians and patients need to demand equality and accountability from health insurance companies. The Federal Parity Law was supposed to close the gap between mental health or substance use disorder benefits when compared to medical/surgical benefits. The disparities continue to be a problem for psychiatrists and families.

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