KANSAS MENTAL HEALTH COALITION

An Organization Dedicated to Improving the Lives of Kansans with Mental Illnesses

Testimony in Support of HB 2459 to the House Insurance Committee
February 10, 2020

Chairman Jene Vickrey and Members of the House Insurance Committee

The Kansas Mental Health Coalition supports HB 2459 to provide access to needed mental health and addictions treatment for Kansans through their state-regulated health insurance.

The members of the Coalition thank the families and legislative sponsors who have brought forward this legislation. It brings a valuable recommendation to address a devastating problem faced by many Kansans. It is time that Kansas joins other states in having a public conversation on this topic.

MENTAL HEALTH PARITY

What is Parity? Parity requires that financial requirements and treatment limitations that apply to Mental Health/Substance Use Disorder (SUD) benefits cannot be more restrictive than the predominant requirements and limitations that apply to substantially all of the medical/surgical benefits covered by an insurance plan.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. (https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet)

The federal regulation applies to non-Federal governmental plans with more than 50 employees, and to group health plans of private employers with more than 50 employees. It also applies to health insurance coverage in the individual health insurance market.

In addition, plans regulated by the Kansas Insurance Department must meet the requirements of the Kansas mental health parity statutes. The Kansas Mental Health Coalition was a central sponsor for passage of the Kansas mental health parity statute passed in 2001 and amendments in 2009. See the Act attached.

KANSANS SEE BARRIERS TO TREATMENT

Unfortunately, in spite of the intent of both the federal and the state parity laws, policyholders often encounter barriers to behavioral health treatment from their insurance provider and those barriers can be devastating. Last spring, the Coalition reinstated a Mental Health Parity Committee to investigate and pursue solutions to these barriers. The Committee is collaborating with our Coalition members and other partners, including social workers, community mental health centers, psychiatrists, psychologists, hospitals, residential treatment facilities, and advocates.

The Committee has met with Kansas Insurance Commissioner Vicki Schmidt and her staff, as well as representatives of national organizations. We are hopeful that the path forward includes future

collaboration with our organizations to develop a plan to hold regulated plans accountable to current law and to improve the ability of policyholders to access treatment. Passage of legislation that puts decision-making into the hands of treatment providers could be life-saving.

Insurance barriers to treatment come on the front end of providing care with denials for service as not "medically necessary" when authorizations are requested; when patients need access to psychiatric medications not covered or requiring fail first substitutions by the pharmacy benefit managers; and when the provider network is insufficient or providers are unwilling to accept insurance due to objectionable provider contracts.

There are endless stories of families frustrated by denials and faced with confusing communications and appeals requirements. What is the responsibility of an insurer to provide guidance to that policyholder? What is the hope for an individual suffering from suicidal ideation or buried in debilitating addiction? There is no end to the stories from the families who thought the hardest part would be getting their child to agree to treatment, not accessing that treatment. Providers attest to the coverage denials and often characterize them as inexplicable and seemingly arbitrary. Ultimately, delays and denials can be deadly.

We recognize that these challenges also exist outside of behavioral health in other parts of healthcare, and do not rest under the authority of any singular regulatory entity. What we are looking for is clarity, guidance, and to be treated in the same way as other healthcare sectors. Health Insurance Plans should be required to meet parity requirements and to cover treatment cited within their benefits plan.

Many of the challenges being experienced here in Kansas were addressed in the March 2019 class action *Wit v. United Behavioral Health* ("*UBH*"), United States District Court for the Northern District of California. In Wit the court found that UBH/Optum illegally denied mental health and substance use disorder benefits based on *faulty and arbitrary medical necessity criteria*. According to the court, United Behavioral Health failed to utilize "generally accepted standards of care" for medical necessity decisions:

- Duration of treatment for behavioral health disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment.
- Effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration.
- The determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made on the basis of a multidimensional assessment that takes into account a wide variety of information about the patient.
- Effective treatment requires treatment of the individual's underlying condition and is not limited to alleviation of the individual's current symptoms.
- Effective treatment requires treatment of co-occurring behavioral health disorders and/or medical conditions in a coordinated manner that considers the interactions of the disorders and conditions and their implications for determining the appropriate level of care.
- Patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective – the fact that a lower level of care is less restrictive or intensive does not justify selecting that level if it is also expected to be less effective. Placement in a less restrictive environment is appropriate only if it is likely to be safe and just as effective as treatment at a higher level of care in addressing a patient's overall condition, including underlying and co-occurring conditions.*
- The unique needs of children and adolescents must be taken into account when making level of care decisions involving their treatment for mental health or substance use disorders.

*It is also a significant barrier to treatment if referrals to residential treatment are denied in order to prefer outpatient treatment, but such outpatient treatment is not available to that individual due to inadequate provider networks.

Kansas should not wait to see the positive impacts of this case trickle down to Kansas policyholders.

WHY IT MATTERS

The fact is: these failures also occur in Kansas and are a significant barrier for Kansas policyholders seeking treatment for behavioral health needs. When treatment is out of reach, individuals and families feel helpless and hopeless.

As we talk about solutions for Kansas families, we need to also talk about the use of restrictive utilization review practices in Medicaid and within the State Employees Health Plan. Utilization review practiced by government sponsored plans and private commercial plans must be based on research supported medical standards of care, not simply the financial considerations.

There has been a lot of work done by the Kansas Legislature and state government to address the mental health and addictions crisis that exists in this state. New programs have been funded within Medicaid, the Mental Health in Schools Pilot is showing positive outcomes, the expansion of crisis stabilization services is showing positive outcomes, and KDADS has finally put forward a plan to end the moratorium on voluntary admissions at Osawatomie State Hospital.

It is vitally important that individuals with private health insurance are able to access treatment for mental health and addictions without the barriers experienced by so many families. Please support HB 2459.

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40-2,105a. Kansas mental health parity act; insurance coverage for services rendered in the treatment of mental illnesses, alcoholism, drug abuse or substance use disorders; limitations. (a) (1) Any group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization that provides medical, surgical or hospital expense coverage shall include coverage for diagnosis and treatment of mental illnesses and alcoholism, drug abuse or other substance use disorders. Reimbursement or indemnity shall be provided for treatment in a medical care facility licensed under the provisions of K.S.A. 65-429, and amendments thereto, treatment facilities licensed under K.S.A. 65-4605, and amendments thereto, a community mental health center or clinic licensed under the provisions of K.S.A. 2019 Supp. 39-2001 et seq., and amendments thereto, a psychiatric hospital licensed under the provisions of K.S.A. 2019 Supp. 39-2001 et seq., and amendments thereto, or by a physician or psychologist licensed to practice under the laws of the state of Kansas. Such coverage shall be subject to the same deductibles, copayments, coinsurance, out-of-pocket expenses, treatment limitations and other limitations as apply to other covered services.

(2) The coverage shall include treatment for in-patient care and out-patient care for mental illness, alcoholism, drug abuse or substance use disorders.

(b) For the purposes of this section, "mental illness, alcoholism, drug abuse or substance use" means any disorder as such terms are defined in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association.

(c) The provisions of this section shall be applicable to health maintenance organizations organized under article 32 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

(d) The provisions of this section shall not apply to any small employer group policy, as defined under K.S.A. 40-2209, and amendments thereto, providing medical, surgical or hospital expense coverage or to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation.

(e) The provisions of this section shall be applicable to the Kansas state employees health care benefits program and municipal funded pools.

(f) The provisions of this section shall not apply to any policy or certificate that provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 40-2227, and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, any coverage issued as a supplement to liability insurance, workers compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

(g) Treatment limitations include limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment.

(h) There shall be no coverage under the provisions of this section for any assessment against any person required by a diversion agreement or by order of a court to attend an alcohol and drug safety action program certified pursuant to K.S.A. 8-1008, and amendments thereto, or for evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody or child visitation proceedings.

(i) Utilization review for mental illness shall be consistent with provisions in K.S.A. 40-22a01 through 40-22a12, and amendments thereto.

History: L. 2001, ch. 178, § 1; L. 2009, ch. 136, § 8; L. 2018, ch. 71, § 13; July 1.