# Compliance Actions Under State and Federal Mental Health and Substance Use Disorder Coverage and Parity Laws


## Joint Annual Report to the General Assembly

**Produced by:**

**Illinois Department of Insurance**

**Illinois Department of Healthcare and Family Services**

**January 2025**

January 1, 2025

To the Honorable Members of the General Assembly:

Section 370c.1(h)(3) of the Illinois Insurance Code requires the Department of Insurance, in conjunction with the Department of Healthcare and Family Services, to submit an annual report to the General Assembly regarding the agencies' respective activities in the enforcement of Sections 356z.23, 370c, and 370c.1 of the Illinois Insurance Code, as well as the Federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any Federal regulations or guidance relating to the compliance and oversight of the Federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and 42 U.S.C. 18031(j). *See* 215 ILCS 5/370c.1(h)(3).

In accordance with Section 370c.1(h)(3) of the Illinois Insurance Code, we are pleased to submit the January 2025 edition of the Joint Annual Report to the General Assembly on Compliance Actions Under State and Federal Mental Health and Substance Use Disorder Coverage and Parity Laws. The report contains significant information from a national and Illinois perspective regarding the current condition of regulated entities' compliance with these important laws.

Respectfully,

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Acting Director of Insurance

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Acting Director of Healthcare and Family Services

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## ***Methodology to Ensure Compliance***

### Illinois Department of Insurance

DOI utilizes market conduct examinations to verify a health insurance issuer's compliance with mental health and substance use disorder (MH/SUD) coverage and parity laws contained in Sections 356z.14, 356z.23, 370c, and 370c.1 of the Illinois Insurance Code and DOI regulations, which are interpreted consistently with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The scope of the examinations includes but is not limited to, activities as they pertain to parity in MH/SUD benefits within the company's health insurance business.

1. The objective of the examinations is to evaluate if the company designed, implemented, and managed MH/SUD benefits no less favorably than medical/surgical benefits. The specific review processes for the examination include, but are not limited to, the following:
2. Review the procedures and guidelines related to utilization review to ensure that such guidelines and utilization review processes on MH/SUD services are no more stringently applied than those applied to medical/surgical services.
3. Evaluate a sample of MH/SUD claims during the examination to compare services to medical/surgical and to ensure denials were appropriate based on medical necessity criteria.
4. Evaluate the universe of appeals during the examination to determine if the appeal decisions were based on appropriate clinical criteria and policies.
5. Evaluate the medical necessity criteria, policies, and procedures to ensure the company was not imposing more restrictive requirements and determination for MH/SUD treatments and services than on medical/surgical treatment and services.
6. Determine that the MH/SUD benefits provided in the classification identified by 45 CFR § 146.136(c)(2)(ii)(A) are paid in parity with benefits in the same medical/surgical classifications.
7. Evaluate financial requirements and quantitative treatment limitations (QTL) to ensure that any such requirements and limitations were consistently applied through MH/SUD and medical/surgical benefits and that any financial 4 requirements and QTLs imposed meet the two-thirds threshold of "substantially all" requirements outlined in 45 CFR § 146.136(c)(3)(i).
8. Evaluate non-quantitative treatment limitations (NQTL) to ensure that such limitations were consistently applied through MH/SUD and medical/surgical benefits and that the company was not being more restrictive as outlined in 45 CFR § 146.136(c)(4)(i)-(ii).
9. Evaluate pre-certification/prior-authorization, step therapy policies, and procedural requirements for MH/SUD treatments to ensure that any such requirements were no more restrictive than the comparable medical/surgical policies and procedural requirements.
10. Determine that the policies and procedures for the selection, tier placement, and quantity limitations of MH/SUD treatment drugs on the formulary were no less favorable to the insured than policies and procedures used for the selection, placement, and limitations of medical/surgical drugs.

Outside of market conduct examinations, since 2018, DOI has required every company to submit information in an MHSUD Supporting Documents Template for every major medical, HMO, or HMO Point-of-Service policy that the company files for approval, both on and off the ACA Health Insurance Marketplace. This template is designed to assist DOI when deciding whether to approve a policy to be sold in Illinois, and in performing an initial, high-level review of the policy for compliance with regulations under the Federal Mental Health Parity and Addiction Equity Act. In particular, it instructs companies to explain how their policy complies with parity requirements relating to aggregate lifetime and annual dollar limits, financial requirements, QTLs, NQTLs, and the ability of healthcare providers and insured individuals to access a company's medical necessity criteria.

## Illinois Department of Healthcare and Family Services

The Department of Healthcare and Family Services (HFS) is responsible for performing parity compliance audits for the Illinois Medicaid Managed Care Program (HealthChoice Illinois) to verify a Managed Care Organization (MCO) complies with mental health and substance use disorder (MH/SUD) coverage and parity laws contained in Sections 356z.23, 370c, and 370c.1 of the Illinois Insurance Code which are interpreted consistently with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

HealthChoice Illinois delivers fully integrated healthcare, inclusive of MH/SUD benefits, to Illinois Medical Assistance Program customers. HealthChoice Illinois MCO contracts require compliance with 42 CFR part 38, subpart K regarding parity in MH/SUD benefits, including but not limited to,

- Prohibition on aggregate lifetime or annual dollar limits on MH/SUD covered services,
- No financial requirement or treatment limitation on MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical (M/S) benefits in the same classification.
- Must provide MH/SUD benefits to an Enrollee in every benefit classification (inpatient, outpatient, emergency care, or prescription drugs) in which medical/surgical benefits are provided.
- No cumulative financial requirements for MH/SUD benefits in a classification that accumulates separately from any established for M/S benefits in the same classification.
- Prohibit non-quantitative treatment limitation (NQTL) for MH/SUD benefits in any classification unless, under the policies and procedures of the MCO, as written and in operation, those processes, strategies, evidentiary standards, or other factors used in applying the NQTL for MH/SUD benefits are applied no more stringently than those applied for M/S benefits in the same classification.

HFS utilizes three primary activities to monitor each health plan's compliance with contract requirements related to MHPAEA: 1) Monthly monitoring and tracking of MH/SUD Parity complaints submitted by providers to the HFS Managed Care Provider Resolution Portal 2) MCO Submission of Annual Comparative Analysis demonstrating that application of an NQTL as written and in operation is applied no more stringently to MH/SUD benefits, than when applied to M/S benefits. 3) Annual MH/SUD Parity Audit and analysis conducted by HFS' External Quality Review Organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

## Final Rules under the Mental Health Parity and Equity Act (MHPAEA)

On September 9, 2024, the U.S. Departments, of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) released new final rules implementing MHPAEA. The final rules amend certain provisions of the existing MHPAEA regulations and add new regulations to set forth content requirements and timeframes for responding to requests for nonquantitative treatment limitation (NQTL) comparative analyses required under MHPAEA, as amended by the Consolidated Appropriations Act, 2021 (CAA, 2021). The final rules reflect and address the thousands of comments received from the public during the comment period on the proposed rules that were published on August 3, 2023. The Departments appreciate the feedback and insight received through this process on this critically important issue.

The United States continues to experience a mental health and substance use disorder crisis. In the almost 16 years since the enactment of MHPAEA, disparities in coverage between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits have persisted and grown. These final rules aim to further MHPAEA's fundamental purpose – to ensure that individuals in group health plans or group or individual health insurance coverage who seek treatment for covered MH conditions or SUDs do not face greater burdens on access to benefits for those conditions or disorders than they would face when seeking coverage for the treatment of a medical condition or a surgical procedure. These final rules are critical to addressing barriers to access to MH/SUD benefits. Among other things, these final rules:

- Make clear that MHPAEA protects plan participants, beneficiaries, and enrollees from facing greater restrictions on access to MH/SUD benefits as compared to M/S benefits.
- Reinforce that health plans and issuers cannot use NQTLs that are more restrictive than the predominant NQTLs applied to substantially all M/S benefits in the same classification. Examples of NQTLs include prior authorization requirements and other medical management techniques, standards related to network composition, and methodologies to determine out-of-network reimbursement rates.
- Require plans and issuers to collect and evaluate data and take reasonable action, as necessary, to address material differences in access to MH/SUD benefits as compared to M/S benefits that result from the application of NQTLs, where the relevant data suggest that the NQTL contributes to material differences in access.
- Codify the requirement in MHPAEA, as amended by the Consolidated Appropriations Act of 2021, that health plans and issuers conduct comparative analyses to measure the impact of NQTLs. This includes evaluating standards related to network composition, out-of-network reimbursement rates, and medical management and prior authorization NQTLs.
- Prohibit plans and issuers from using discriminatory information, evidence, sources, or standards that systematically disfavor or are specifically designed to disfavor access to MH/SUD benefits as compared to medical/surgical benefits when designing NQTLs.
- Implement the sunset provision for self-funded non-Federal governmental plan elections to opt out of compliance with MHPAEA.

The Departments anticipate that these final rules will improve network composition by making mental health and substance use disorder provider networks more robust and making it easier for individuals seeking mental health and substance use disorder care to receive it by cutting red tape, with fewer and less restrictive prior authorization requirements and other medical management techniques to navigate. The final rules will also provide additional clarity and information needed for plans and issuers to meet their obligations under MHPAEA and for the Departments and States to enforce those obligations. The Departments intend to continue to provide guidance and compliance assistance materials in the coming months to assist plans and issuers in complying with MHPAEA and its implementing regulations, as well as informing participants, beneficiaries, and enrollees regarding their rights under MHPAEA.

## *Compliance Activities in 2024*

### Market Conduct Examinations: Illinois Department of Insurance

DOI completed two market conduct examinations evaluating compliance with MH/SUD coverage and parity laws for the following companies:

- Humana Health Plan Inc.
- Humana Insurance Company

Each market conduct examination where DOI has found violations of law has resulted in a stipulation and consent order requiring the company to correct all activities where violations were found, pay a civil forfeiture, and provide proof of compliance to DOI. The orders and the final reports are posted publicly on the DOI website. The following is a summary of findings by company for the recent round of examinations:

- The company imposed prior authorization and step therapy limitations for the treatment of substance use disorders other than those established under the American Society of Addiction Medicine.
    - Imposed prior authorization requirements on prescription medications approved by the FDA for substance use disorders.
    - Failed to follow the length of prior authorization approval durations of 12 months for treatment.
    - Failed to approve Drug Utilization Review requests after step therapy exceptions were satisfied.
    - Imposed more stringent and restrictive step therapy policies for mental health medications as compared to step therapy policies for medical/surgical medications.

- The company created barriers for consumers to access providers.
    - Failed to ensure there were enough mental health facilities in all network plans.
    - Failed to clearly identify the network plan and various naming conventions allowing consumers to determine which provider directly applies to which plan.
    - Failed to use maximum travel time and distance standards for plan beneficiaries.

- The company failed to provide coverage for medically necessary treatment of Pediatric Acute-onset Neuropsychiatric Syndrome (PANS)/Pediatric Autoimmune Neuropsychiatric Disorder Associated w/ Streptococcal Infections (PANDAS).

- Total Number of Combined Finable Violations: 21
- Posted final report and order: October 21, 2024
- Total Civil Forfeiture: $400,000.
- Mental health parity violations: $132,000

## Mental Health Parity Audits: Illinois Department of Healthcare and Family Services

Managed Care Provider Resolution Portal and Parity Tracking

Per Illinois statute (215 ILCS 5/370c(d)(2)), HFS is required to evaluate all consumer or provider complaints related to mental health (MH) or substance use disorder (SUD) coverage for possible parity violations. Effective January 1, 2022, the HFS Bureau of Managed Care (BMC) updated its Managed Care Provider Resolution Portal to include the ability to identify complaints that include an indication of potential parity violations and to track the outcome of those complaints. When a provider submits a complaint through the portal, they can indicate whether the complaint relates to MH/SUD parity. Complaints flagged as a potential parity violation are routed to staff within the HFS Bureau of Behavioral Health (BBH), for additional review and scrutiny to determine if the complaint is related to MH Parity and if there is evidence of a possible parity violation. Once a Complaint has been received by BBH staff, they have 30 days to review and respond with a determination. Data regarding the number of complaints identified as possible parity issues and the outcomes of the determinations are tracked and reported monthly.

From December 1, 2023, to November 30, 2024, a total of 2,814 provider complaints were received through the portal. Among these, 64 complaints were submitted by behavioral health providers. Five of these complaints were identified by the providers as potential mental health parity issues related to reimbursement rates, prior authorization, medical necessity, and concurrent review. BBH staff reviewed all five complaints and determined that they did not constitute a parity issue.

Mental Health Parity Audit and Comparative Analysis:

To meet Mental Health Parity (MHP) requirements in 42 CFR §438 Subpart K and Illinois statute 215 ILCS 5/370c.1, HFS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct a MH Parity Analysis of all HealthChoice Illinois health plans (health plans). The purpose of the review is to evaluate each health plan's processes, both written and in practice, to inform the Department and other policy makers regarding health plan compliance with MHPAEA requirements. All five Medicaid -contracted Managed Care Plans were reviewed, including:

- Aetna Better Health of Illinois
- Blue Cross Community Health Plans
- CountyCare
- Molina Health Care of Illinois
- Meridian (HealthChoice)
- YouthCare (Meridian)

To enable this review, HSAG developed a protocol and tools in alignment with the guidance outlined in the toolkit provided by the Centers for Medicare & Medicaid Services (CMS): *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.[1] The 2023 -2024 MH Parity Analysis report provides a summary across all health plans which consisted of:

1) Review of the health plans' NQTL Submission Form and comparative analyses of NQTL – Reimbursement. Comparative analyses were submitted to HFS prior to September 1, 2024.
2) An Administrative Data Profile review of claims.[2]
3) An attestation of continued compliance with MHP requirements and documentation of any related policy or procedural changes associated with the designated review period (calendar year 2023).

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[1] The CMS *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* and additional CMS resources related to MHP are available at https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/parity/index.html. Accessed on: October 16, 2024.

[2] Claims data excluded non-emergency medical transportation (NEMT) and pharmacy (Rx) claims.

Mental Health Parity Attestation and NQTL Submission Form Review

For each health plan, HSAG compared the health plan's design and application of nonquantitative treatment limitations (NQTLs) for MH/SUD benefits with those for medical and surgical (M/S) benefits. For its review of the attestation and NQTL Submission forms, HSAG assessed each health plan's responses across two evaluation domains:

- The comparability of the processes, strategies, evidentiary standards, and other factors (in writing and in operation) used in applying treatment limitations to MH/SUD benefits and M/S benefits.
- The stringency with which the processes, strategies, evidentiary standards, and other factors (in writing and operation) were applied to MH/SUD benefits and M/S benefits.

Based on the information submitted by the health plans for desk review and during the webinar review, all health plans received a rating of *Compliant*.

Administrative Data Profile/Claims Data Assessment

For the Administrative Data Profile, parity between MH/SUD and M/S benefit administration was evaluated for inpatient (IP), outpatient (OP), and emergency service (ER), across three domains:

- Comparison of overall paid and denied ratios for in-network (INN) and out-of-network (OON) claims.
- Difference of INN versus OON paid ratios for MH/SUD and M/S services, analyzed at both the header and detail level.
- Difference of header-level versus detail-level paid ratios for MH/SUD and M/S services, analyzed at both the INN and OON level.

The health plans were required to submit CY 2023 claims data with a claim adjudication date of September 1, 2024, or prior. HSAG analyzed the health plans' data to assess for parity between M/S and MH/SUD claims counts. HSAG used deviation ratings of ***Minimal*** *(difference of less than 5 percentage points)*, ***Moderate*** *(difference of 5 or more percentage points but less than 10 points)*, and ***Substantial*** *(difference of 10 or more percentage points)*, to indicate the degree to which each health plan's reported metrics differed across MH/SUD and M/S services.

HSAG used the ratings of *Compliant, Partially Compliant, and Not Compliant*, as defined in Table 1, to indicate the degree to which each health plan's performance was compliant with parity requirements, based on whether the organization's procedures and results affected the comparability and stringency of processes, strategies, or evidentiary standards used in administering MH/SUD and M/S benefits. This scoring methodology aligned with CMS' Parity Compliance Toolkit.

**Table 1—Rating Definitions of Compliance to MHP**

| Rating | Definition |
|---|---|
| Compliant | Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was comparable with equivalent stringency. |
| Partially Compliant | Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was:<br>• Comparable, but were applied with different stringency, or<br>• Not comparable but were applied with equivalent stringency. |
| Not Compliant | Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was not comparable and applied with different stringency. |

Conclusion

Based on the review of the MHP attestation form, NQTL submission form, and claims analysis, of each MCO, HSAG assigned each MCO an overall rating of *Compliant.* While all MCOs were found *Compliant* based on comparability and stringency of the information assessed, additional analysis of data would allow for greater examination of the MCOs' administration of MH/SUD and M/S benefits to determine whether opportunities for improvement exist.

## *Educational Actions Taken in 2024*

### Illinois Department of Insurance

The Illinois Department of Insurance (DOI) announced its second annual ad campaign highlighting mental health parity that kicked off in May 2024 and continued throughout the summer of 2024. The radio, digital, out-of-home, and social media ads aim to raise awareness about mental health parity to help Illinoisans better understand their rights related to health insurance coverage for mental health and substance use disorders, under the Mental Health Parity and Addiction Equity Act (MHPAEA). MHPAEA requires health insurers to provide coverage for mental health and substance use disorders that are no more restrictive than coverage for physical health conditions. As the state's insurance regulator, DOI is tasked with ensuring companies' compliance with MHPAEA and other parity laws to protect Illinois insurance consumers. The Department's enforcement includes conducting market conduct examinations to investigate the practices of health insurance companies, and when parity law violations are found, companies are fined.

DOI's mental health parity ad campaign also directs consumers to file a complaint with the Department if they believe their health insurer's mental health and substance use disorder coverage has more restrictive requirements than those for physical health coverage.