Summary: New York Attorney General and Emblem Health Assurance of Discontinuance

Introduction

On July 9, 2014, the New York State Office of the Attorney General ("OAG") announced an Assurance of Discontinuance—similar to a settlement agreement—with New York-based EmblemHealth, Inc. ("Emblem"), which the OAG found had violated both state and federal laws that require health plans to provide mental health and substance use disorder benefits equally with medical and surgical benefits. The OAG also found that Emblem violated the Affordable Care Act's requirement that health plans allow members' treatment to be covered while their internal appeals of the health plan's denials are pending. The July 9 announcement marks the third time since January that the OAG has found a New York health plan to be in violation of state and federal parity laws.

Among other things, the Assurance of Discontinuance ("Assurance") fined Emblem a $1.2 million civil penalty, requires Emblem to overhaul its claims review process, and requires Emblem to reimburse its members who were improperly denied mental health and substance use disorder benefits since 2011, which could lead to more than $31 million in reimbursements.

This document provides background information on the federal parity law, a summary of the provisions of the Assurance, and next steps for providers and others.

Background: Federal Parity Law

In 2008, the Mental Health Parity and Addiction Equity Act ("federal parity law") was signed into law, requiring most types of health plans that choose to provide mental health and substance use disorder benefits to provide them equally—or at parity—with medical and surgical benefits. Final regulations implementing the 2008 law were released at the end of 2013, and are effective for health plan years beginning on or after July 1, 2014. The Legal Action Center ("LAC") worked successfully with the substance use disorder and mental health fields toward the passage of the federal parity law, and has worked as a co-leader of the Coalition for Whole Health to ensure that the law is implemented effectively.

The Affordable Care Act ("ACA"), passed in 2010, extends the requirements of the federal parity law to individual and small group health plans. The ACA also requires health plans to allow their members to receive coverage of treatment while members' internal appeals are pending. LAC and the Coalition for Whole Health have worked to ensure robust coverage of mental health and substance use disorder benefits under the ACA.

New York also has a state law, known as Timothy's Law, which requires health insurers who choose to provide mental health benefits to provide them equally with medical and surgical benefits. Timothy's Law ("state parity law") does *not* apply to substance use disorder benefits.

Highlights: NY OAG and EmblemHealth Assurance of Discontinuance

The OAG's investigation into Emblem—which looked at the period from 2011 through 2013—found widespread violations of both the state and federal parity laws by Emblem, which administered its mental health and substance use disorder ("SUD") benefits ("behavioral health benefits") through ValueOptions, as well as violations of the ACA. The violations include:

1) General:
    - Despite the passage of both state and federal parity laws, neither Emblem nor ValueOptions has been comparing their approvals and denials of behavioral health claims to their approvals and denials of medical and surgical claims.
    - Emblem's data showing that its overall spending on behavioral health care has "declined precipitously" from 2011 to 2013—a period that saw rising behavioral health care costs in the U.S.—suggests that Emblem may not be sufficiently covering behavioral health treatment.

2) Utilization Review:
    - Emblem & ValueOptions applied more rigorous and more frequent utilization review for behavioral health benefits than for medical and surgical benefits. (Utilization Review is the process by which a health insurer examines members' claims to determine whether they are medically necessary and thus eligible for coverage.) Specifically, in the case of Emblem & ValueOptions:
        - Emblem denied 18% of requests for preauthorization for behavioral health treatment from 2011 to 2013, compared with only 11% of those requests for medical surgical treatment.
        - Emblem denied 22% of members' behavioral health claims from 2011 to 2013, but only denied 13% of those claims for medical/surgical benefits during that period. Denials of claims for SUD treatment were even higher: Emblem denied 38% of those claims from 2011 to 2013. From January 2011 to March 2014, Emblem's denied $31 million worth of billed charges for members' behavioral health treatment.
        - Emblem's denial rates were even higher for more intensive levels of behavioral health care. From 2011 to 2013, Emblem denied 26% of requests for preauthorization for inpatient psychiatric treatment, and 36% of members' claims for that treatment. During the same period, Emblem denied 39% of requests for preauthorization for inpatient SUD rehabilitation, and 41% of members' claims for that treatment. In contrast, Emblem denied only 20% of requests for preauthorization and 29% of members' claims for inpatient medical/surgical treatment during that period.

- Emblem's own Senior Director of Behavioral Health described the approach taken by ValueOptions to utilization review for behavioral health benefits as "aggressive." In contrast, a senior Emblem medical director stated that it leaves decision planning for medical services to the provider's discretion.

- Emblem not only applied more stringent utilization review to behavioral health benefits, it also applied medical necessity criteria incorrectly when reviewing behavioral health claims and requests. For example, Emblem incorrectly classified SUD rehabilitation as acute care, and then denied requests for coverage of such treatment on the grounds that the member was not experiencing "life-threatening withdrawal," which is not a requirement for SUD rehabilitation.
- Although Emblem's medical necessity criteria do not officially contain any "fail first" requirement, in practice Emblem sometimes denied requests for coverage of SUD rehabilitation based on "fail first" requirements. For example, Emblem denied a request for coverage of inpatient SUD rehabilitation because the member had not recently failed at an outpatient SUD rehabilitation program. Emblem does not apply any "fail first" requirement to medical/surgical benefits.
- When Emblem does approve more intensive levels of care, it often approves only a few days or visits at a time, a practice that the OAG says requires "members to focus on health coverage rather than treatment." For example, Emblem sometimes approves just one day of SUD rehabilitation at a time, even though it is not possible to complete such treatment in one day. The OAG found that Emblem's utilization review for behavioral health benefits "is so intensive and frequent that it often interferes with treatment, because providers and members must spend a great deal of time justifying each day or visit, or because the member cannot get treatment when a claim is denied."
- Emblem requires behavioral health providers (even at the outpatient level) to develop treatment and discharge plans, and denies coverage if such plans are not filed. In contrast, such plans are typically not required of medical/surgical providers.
- Emblem applies a utilization review tool for outpatient behavioral health benefits known as the Outpatient Outlier Model, whereby a certain number of outpatient psychotherapy visits triggers a special form of intensive utilization review. The Outpatient Outlier Model is not based on any clinical evidence, and has no counterpart in medical/surgical benefits. Furthermore, Emblem does not even have a written policy and procedure stating how the Outpatient Outlier Model is performed.

3) Denial Letters:
   - Emblem's denial letters were generic, and failed to sufficiently explain the basis for the denials—including what medical criteria were used and why the member failed to meet those criteria—thus depriving members of the ability to lodge meaningful appeals. Emblem's denial letters also often mischaracterized the level of treatment requested. According to the OAG, "such flawed letters call into question the accuracy of Emblem's adverse decisions." In contrast, Emblem's denial letters for medical/surgical benefits are more detailed.

- Emblem's denial letters for SUD benefits were especially deficient. Until at least 2012, Emblem neither cited medical necessity criteria in its denial letters for SUD benefits, nor did it provide the criteria to members upon request, as it is legally required to do.

4) Medical Criteria:
   - Although SUD treatment programs in New York State are required to use level of care criteria approved by the New York Office of Alcoholism and Substance Abuse Services ("OASAS"), Emblem uses different criteria created by ValueOptions to determine the medical necessity of SUD treatment. This results in further denials of SUD benefits, since providers are required by law to use criteria that differ from the criteria used by Emblem.

5) Denial Classification:
   - Although Emblem classifies denials of medical/surgical benefits due to lack of preauthorization or clinical information as medical necessity denials, it classifies those denials as "administrative" in the behavioral health context, thereby depriving members with behavioral health conditions of appeal rights.

6) Residential Treatment:
   - Many of Emblem's plans do not cover residential treatment for behavioral health conditions.

7) Cost Sharing:
   - Some of Emblem's plans charge higher co-payments for outpatient mental health visits than for outpatient primary care visits. In some plans, the mental health co-payments are twice as high as the primary care co-payments.

After the OAG determined that Emblem violated both state and federal parity laws, as well as the ACA, the OAG and Emblem signed the Assurance, which specifies how Emblem will remedy its violations of the law. Going forward, Emblem will implement the following changes:

1) Cost Sharing:
   - Emblem will apply members' primary care co-payment requirements to members' outpatient behavioral health visits. (This requirement applies to Emblem's fully-insured health plans, but its self-funded health plans may opt out.)

2) Utilization Review:
   - Emblem will no longer use the Outpatient Outlier Model.
   - If Emblem uses any utilization review tool that is based on quantity or frequency of outpatient visits, the tool must be developed and updated annually based on clinical evidence, and must be approved by a physician specializing in psychiatry or addiction medicine. Utilization review with such a tool will only be conducted if the quantity or frequency of visits is inconsistent with clinical evidence.

- The OAG and Emblem will agree on measures to promote the integration of administration of medical/surgical and behavioral health benefits. These measures will include regularly scheduled meetings attended by individuals responsible for administering Emblem's medical/surgical and behavioral health benefits.
- Emblem, and any entity administering behavioral health benefits on its behalf, must follow a specific protocol (laid out in the Assurance) when collecting information during utilization review.
- Emblem will not apply any "fail first" requirement for SUD rehabilitation treatment.
- Emblem will provide coverage of outpatient SUD treatment received in office settings, including, but not limited to, medication-assisted treatment for opioid addiction.
- Emblem will work to secure approval from OASAS of its criteria for determining medical necessity for SUD treatment.
- When an Emblem member transitions between levels of treatment (e.g., from inpatient to outpatient), utilization review for the second level of treatment will be conducted as concurrent review.
- When Emblem denies coverage of behavioral health services due to lack of clinical information and/or lack of preauthorization, the denial will be processed as a medical necessity denial (this affords appeal rights to members receiving such denials).
- Emblem will not approve only one day or one visit for a behavioral health benefit; rather, the number of days or visits approved will be based on the treatment needs of the member.

3) Visit Limits:
    - There will be no day or visit limits for behavioral health services in any Emblem plan, except for family counseling services.

4) Compliance:
    - The OAG will appoint an independent parity compliance administrator, who will serve for a minimum of three years.
    - For three years, Emblem will provide the OAG and the independent parity compliance administrator with a quarterly summary of complaints received regarding Emblem's behavioral health coverage.

5) Denials:
    - Emblem's denials (known as adverse determination notifications) will be changed in a number of ways, including providing members with clear and specific information, both telephonically and in writing, about the medical necessity criteria used and why the member did not meet those criteria, and about how to appeal the denial.

6) Behavioral Health Advocates:
    - Emblem will designate a minimum of five full-time employees to serve as Behavioral Health Advocates, who will assist members who have received denials of behavioral health benefits with complaints and appeals. Behavioral Health Advocates will also be accessible to providers.

7) Appeals:
    - Emblem will offer members the assistance of Behavioral Health Advocates in pursuing internal appeals, and will continue coverage of treatment pending the completion of internal appeals.
    - Emblem will make a number of changes to its external appeals process, including increasing eligibility for expedited external appeals, permitting providers to file external appeals on behalf of their member patients, and continuing coverage of treatment pending the completion of expedited external appeals.

8) Residential Treatment:
    - Emblem will cover medically necessary residential treatment for behavioral health conditions.

9) Training:
    - Emblem will train its utilization review and customer relations staff on the requirements of the federal and state parity laws as well as New York State Insurance Law provisions regarding substance use disorder and eating disorder treatment.

The Assurance also requires Emblem to remedy the impact of its illegal practices between 2011 and 2013. Emblem must:

1) Review and Reimbursement of Denials:
    - Members whose behavioral health treatment claims (or requests for preauthorization) were denied by Emblem between 2011 and 2014 on the grounds of lack of medical necessity will be eligible to have their denials reviewed by an independent entity and, if the independent entity determines that the denied treatment was medically necessary, Emblem will reimburse the member for any out-of-pocket costs the member incurred in paying for the denied treatment. The OAG estimates that this will apply to, at a minimum, 15,000 denials or requests for preauthorization, with accompanying billed charges of $31 million.
    - Emblem will reimburse members who incurred out-of-pocket costs paying for residential treatment for behavioral health services between January 1, 2011 and March 31, 2014 (the date on which Emblem began covering residential treatment), if those members incurred the costs because Emblem denied their claims on the grounds that residential treatment was not a covered service, or because they did not submit the claims to Emblem.
    - The Behavioral Health Advocates established under the Assurance will be made available to members who are seeking these types of review and reimbursement.

2) Fine:
   - Emblem must pay a $1.2 million civil penalty to the OAG.

What's Next

The OAG has made clear that it is committed to enforcing both New York State and federal parity laws. The OAG entered into two other settlements with health plans earlier this year for violating state and federal parity laws: one against Cigna in January, and one against MVP Health Care in March. In its Assurance with Emblem, the OAG noted that Emblem's unlawful practices served to place, "yet another obstacle in front of members who, suffering from addiction, may have a small window of opportunity to access treatment and embark on the path to recovery." When health insurers violate parity laws, they create very real barriers to treatment for people with mental health and substance use disorders, often leading to grave consequences for patients and their families.

Providers or patients in New York State who are concerned that their rights under the state or federal parity laws are being violated are encouraged to call the OAG's Health Care Bureau Helpline at 1-800-428-9071. Providers and patients can also contact the U.S. Department of Labor, the U.S. Department of Health and Human Services, or the U.S. Department of the Treasury to report violations of the federal parity law. Finally, when appealing adverse decisions by health insurers that seem to violate the parity laws, providers and patients should consider citing to both the Emblem Assurance and the MVP Assurance to demonstrate what types of policies and practices have been found to be illegal.