OFFICE OF THE
HEALTH INSURANCE COMMISSIONER

STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS

RI Behavioral Health Parity Implementation Report

November 2017

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RI Behavioral Health Parity Implementation Status Report to the General Assembly

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This patient's quote appears in the introduction to the November 2016 report, ***Out-of-Network, Out-of-Pocket, Out-of-Options,*** by the National Alliance on Mental Illness:

> *"I don't even try to use mental health benefits anymore provided by my insurance company. It requires pre-authorization by one of their providers. My psychiatrist isn't in any network. I have been going to her for over 20 years. She is part of the reason I am still on this earth…"*

Introduction

Behavioral health has long been considered a lesser important aspect of health care in the US, with a separate system of care and higher barriers to treatment as compared with general medical care. Even in that environment, our state has had a proud history of elected officials advocating for individuals with behavioral health disorders. These advocates include many current leaders and numerous former state legislators, such as former House HEW Chair Neil Corkery who championed the first state law to make certain that health insurance coverage for behavioral health is fairly applied through the Utilization Review Act, and former Senate HHS Chair Rhoda Perry who crafted Rhode Island's Mental Health Parity law to ensure equal treatment of mental disorders and other physical illnesses by health plans. These two twenty-five (25) year-old statutes combine with more recent state and federal requirements to form the legal foundation for this report.

The Office of the Health Insurance Commissioner was established by an act of the RI Legislature in 2004 RIGL Chapter 42-14.5. The Office's mandated purpose is to: (1) guard the solvency of health insurers; (2) protect the interests of consumers; (3) encourage fair treatment of health care providers; (4) encourage policies and developments that improve quality and efficiency of health care service delivery and

outcomes; and view the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

In July of 2013, the RI General Assembly passed a broad "Health Care Reform Act" which included the requirement that the Office of the Health Insurance Commissioner (OHIC) "monitor each health plan's compliance with the provisions of the federal mental health parity act." This OHIC responsibility pertains to the four health insurance carriers who provide health insurance in our state: Blue Cross & Blue Shield of RI, United HealthCare of New England, Tufts Health Plan, and Neighborhood Health Plan of RI. OHIC has utilized numerous regulatory tools to undertake this work.

OHIC's Health Insurance Advisory Council (HIAC) – a diverse group representing consumers, businesses, and healthcare providers – has raised its own concerns on matters relating to behavioral health parity. Council members include advocates for behavioral health patients and providers, serving as a vital source of ongoing guidance and public accountability for OHIC. HIAC's monthly meetings and quarterly public comment hearings have increasingly highlighted behavioral health care cost and quality issues, including access to substance use disorder treatment and mental health parity. (See Appendix #1 for a list of current HIAC members.)

This report comes at a time of an acute crisis in the field of mental health. Countless lives are being lost prematurely to suicide and drug overdoses. Each new obituary, Facebook post, or dreaded call from family or friends, offends our sensibilities. Inaction is not an option. The Governor has strongly committed to curb our overdose crisis, and has required all government agencies to participate. Indeed, research has demonstrated a link between opioid addiction and lack of health insurance[1]. OHIC recognizes that ensuring Rhode Islanders have access to stable, comprehensive, and affordable health insurance coverage is a critical component of our state's approach to addressing the public health crisis we are facing.

Compounding the issues of parity and comprehensive health insurance coverage for behavioral health is the significant amount of money spent on behavioral health care. According to the Truven Health Analytics Report published in 2015, Rhode Island spent about $853 million on behavioral health treatment in 2013, representing 1.6% of the state's GDP, which is higher than the national average of 1.2%[2]. The Advisory Board Company study dated October 31, 2013 Estimated Annual Allowed Costs of All Payers, revealed that for all RI insured persons $246 Million went toward Psychosis, Depression or Psychotherapy. This was by far, the highest cost condition group.

This report details the work OHIC is currently undertaking to promote behavioral health parity across several regulatory and reform functions within the Office. It is respectfully submitted to the General Assembly in accordance with RIGL 42-14.5-3 (j).

[1] Annals of Internal Medicine. Prescription Opioid Use, Misuse, and Use Disorders in U.S. Adults: 2015 National Survey on Drug Use and Health. 2017.
[2] Truven Health Analytics. Rhode Island Behavioral Health Project: Cost Report. 2015

Executive Summary

This report of the RI Office of the Health Insurance Commissioner (OHIC) is submitted to the General Assembly as a status update on the state's oversight of behavioral health (mental health and substance use disorder) parity implementation. Parity laws are intended to ensure equal treatment, by health insurance plans, of mental disorders with other physical illnesses. This report comes at a time of an acute crisis in the field of mental health as countless lives are being lost prematurely to suicide and drug overdoses.

The primary laws used for the regulatory oversight of parity implementation include the Federal Mental Health Parity and Addiction Equity Act (MHPAEA) and the State Mental Health Parity law (RIGL §27-38.2-1) which require that a health insurance plan provide coverage for the treatment of mental health and substance-use disorders under the same terms and conditions as that coverage is provided for other illnesses and diseases. Oversight and encouragement of insurer compliance with these laws has taken many forms, reflected in a multi-pronged approach to ensuring behavioral health parity in Rhode Island. With an emphasis on the OHIC comprehensive market conduct examination (MCE), the report discusses ten categories of behavioral health parity activities that OHIC has employed to-date:

1. Participation in the federally-organized Commercial Insurance Parity Policy Academy
2. Review of Insurer Forms for Consumers
3. Fulfillment of the state's goals in OHIC's Enforcement and Consumer Protection Grant
4. Leading Delivery System Improvements through Policy
5. State Innovation Model (SIM) Test Grant
6. Encouraging Fair Treatment of Providers
7. Consumer Assistance, Complaint Resolution and Advocacy
8. Transition of Utilization Review Authority to OHIC
9. Responsiveness to State and National Reform Efforts
10. Parity Market Conduct Examination

Based upon these ten categories of activities, OHIC has identified the following general issues of concern and action plans. These items focus primarily on non-quantitative insurer practices and requirements that may pose barriers to achieving behavioral health parity:

- Issue: More detailed examinations are needed to measure the level of compliance with many non-quantitative parity requirements, such as provider reimbursement, network adequacy, and patient cost-sharing necessities.
  Action Plan: OHIC will continue to carry out market conduct examination-related activities.

- Issue: OHIC has worked with the insurers to measure the value of certain "medical management tools," such as prior authorization.
  Action Plan: OHIC will continue to work cooperatively with the insurers on opportunities to remove prior authorization requirements that are not productive or are contrary to achieving parity.

- Issue: Utilization Review processes --obtaining specific approvals for certain services to be paid for—may impede medically necessary care, impact care transitions, and interrupt continuity of care during the decision/approval process.
  Action Plan: As of January 1, 2018, OHIC will become the state authority for "Utilization Review Agent" oversight. New regulations must be drafted, a revised patient/provider appeals process must be implemented, and monitoring of compliance must be integrated into the OHIC consumer protection and insurer regulatory processes.

OHIC is uniquely situated-- through legislative authority, federal grant opportunities, and health system reform priorities—to encourage and ensure parity implementation in Rhode Island. OHIC will continue to integrate behavioral health parity into its regulatory and policy efforts, employing multiple strategies to improve access, quality, and coverage of behavioral health services.

OHIC's Multi-Pronged Approach to Ensuring Behavioral Health Parity Implementation

The major focus of this report is on the areas of concern that have been identified and focused on during the course of the 2015-2017 OHIC Market Conduct Examination of Parity Implementation, which has reviewed patient case handling by the four (4) major commercial insurers in the state.[3] However, OHIC has made behavioral health parity a priority integrated into its ongoing regulatory and system reform activities. These include:

1. Participation in the federally-organized Commercial Insurance Parity Policy Academy
2. Review of Insurer Forms for Consumers
3. Fulfillment of the state's goals in OHIC's Enforcement and Consumer Protection Grant
4. Leading Delivery System Improvements through Policy
5. State Innovation Model (SIM) Test Grant
6. Encouraging Fair Treatment of Providers
7. Consumer Assistance, Complaint Resolution and Advocacy
8. Transition of Utilization Review Authority to OHIC
9. Responsiveness to State and National Reform Efforts
10. Parity Market Conduct Examination

1. Commercial Insurance Parity Policy Academy

Nationally, 22 states' insurance departments were selected to participate in a 2017 federal effort to enhance state-level enforcement of federal and state-mandated behavioral health parity. The effort was designed to learn and share best practices for reviewing insurance forms, policies, formularies, networks, administrative and reimbursement procedures to measure the parity of treatment for patients with behavioral health needs as compared with other health concerns. Policy Academy participants received technical expert assistance, and developed plans and strategies to utilize each state's regulatory authority toward improved implementation of parity. The goals of the Policy Academy are to:

a. Access and interact with a multi-state collaborative learning network of health insurance regulators and experts on Behavioral Health Parity;
b. Gain timely and expert knowledge and technical assistance on the implementation, enforcement and evaluation of Behavioral Health Parity; and

[3] The 2015-2017 OHIC Market Conduct Examination (MCE) of Parity Implementation is ongoing and, accordingly, the Examiners have yet to prepare a final report of their findings, conclusions and recommendations. Nothing in this RI Behavioral Health Parity Implementation Report of the General Assembly is, or should be interpreted to be, a statement of the examiners' or the commissioner's findings or conclusions regarding the MCE. However, some of the extensive work and focus that the Examiners undertook in the context of the examination have revealed areas of concern which are reflected in this report to the General Assembly.

c. Streamline and map the best parity implementation and evaluation processes for (1) OHIC Staff (2) Insurance Carriers and (3) Consumers.

Through RI's participation in the Policy Academy, OHIC has emerged as a national behavioral health parity enforcement leader among state health insurance regulators.

2. Review of Insurer Forms for Consumers, including Schedules of Benefits

In 2013, for policies to be sold in 2014, OHIC began the annual review of all forms used by insurers that govern the determination of what services will be covered and to what extent. All policies to be sold in Rhode Island must be filed for prior approval. The Office of the Health Insurance Commissioner reviews policies, certificates and schedules of benefits carefully to ensure there is no provision that violates mental health parity for either quantitative or non–quantitative measures.

OHIC has addressed issues discovered through this form review process on an ongoing basis. Many issues center around exclusions of coverage for certain behavioral health diagnoses and services that, in accordance with the Diagnostic and Statistical Manual of Mental Disorders, should be covered. These exclusions have been addressed and corrected as they have been uncovered. (For example, one insurer had 28 Behavioral Health-related coverage exclusions and now it has reduced their exclusions to 2.) OHIC is fortunate to have a federal grant, funded through the Affordable Care Act, to support the staff to conduct this activity through 2018.

This OHIC insurer form review process has become more sophisticated and is now looking beyond excluded diagnoses to medical management controls (such as prior authorization) that may be acting as obstacles to necessary care.

3. Enforcement & Consumer Protection (ECP) Grant

The most critical aspect of OHIC's mission is to enforce the laws of the state that are designed to protect consumers. To help fulfil this obligation, OHIC has utilized federal grant funding to pursue consumer and patient protection goals, to:

a. Maximize the effectiveness of the means and tools that OHIC uses to conduct behavioral health parity analysis, insurance form review, audits, and market conduct examinations;
b. Improve communication and education materials for consumers and providers; and
c. Establish insurer parity compliance as standard operating procedure.

A major question being addressed through the RI ECP grant is: How does managed care facilitate or hinder access to timely and appropriate behavioral health treatment? Additionally, during 2018, the focus of the OHIC parity implementation activity will be to review the application of behavioral health patient cost-sharing requirements (deductibles and co-payments) as they compare with other chronic disease treatment and pharmaceuticals. Taken together, these compliance checks will lead to the identification and correction of discriminatory insurance plan design features or practices.

4. Delivery System Improvements through Policy

Because of OHIC's statutory obligation to "view the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access[4]," ensuring affordability and quality of health care falls under the Office's purview. Consistent with the evidence and national standards, OHIC sees a robust primary care delivery system as an essential tool to ensuring high value quality delivery with regard to prevention, early detection, and timely treatment of behavioral health conditions at a cost that is significantly lower than for care delivered in more intensive settings. Since 2010, OHIC has developed policies that encourage a system-wide adoption of high quality, transformed primary care. There is growing recognition in the healthcare community that the systemic separation in the delivery of care for behavioral health from physical health has led to gaps in care and barriers to access. OHIC recognizes the need for the integration of behavioral health in the primary care setting, and has begun to promote this shift in the delivery system through various regulatory levers and grant funded programs.

Key policy accomplishments include:

a. OHIC's Quality Measure Alignment function enables OHIC, with the recommendations of a public working group, to develop and update annually a common set of quality measures that all payers must use in any contract that has financial quality incentive. The primary care measure set includes metrics that are meant to assist primary care providers to deliver basic behavioral health services such as depression screening.

b. Through its policy to encourage wider adoption of the Patient Centered Medical Home model of care delivery, OHIC has worked to establish a standard of high quality primary care. A key component of this model is having a care coordinator embedded within the practice that is responsible for managing referrals to behavioral health specialists, among other things.

c. OHIC has developed a primary care capitation model to facilitate adoption of non-fee-for-service payment models in a way that is somewhat standardized across payers. In early 2018, OHIC anticipates convening a working group to add a behavioral health component to the model, such that practices may be financially incentivized to consider patients in a more holistic manner, and integrate behavioral health into care delivery.

[4] http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-14.5/42-14.5-2.HTM

5. State Innovation Model (SIM) Test Grant

In addition to the above policies, OHIC is also heavily involved in the implementation of the State Innovation Model (SIM) Test Grant, awarded by CMS in 2015. The purpose of this grant is to advance multi-payer delivery and payment reform models, and behavioral health is a large component of Rhode Island's model. The Rhode Island SIM, working to enhance the efforts of OHIC, has funded several projects that are meant to advance integration of behavioral and physical health:

a. The Integrated Behavioral Healthcare Pilot has embedded behavioral health clinicians in 12 primary care practice sites and provided hands on coaching and support to improve the practices' ability to identify untreated mental health and substance use conditions, improve access to treatment, and enhance care coordination across primary care and behavioral health specialties.

b. The Child Psychiatric Access Project has implemented a telephonic psychiatric consultation system to interface with pediatric primary care providers such that a provider can call and receive consultation from psychiatric clinicians within 30 minutes to respond to diagnostic or therapeutic questions. As needed, face-to-face evaluation, brief treatment, and referral to ongoing services can be arranged through the program.

c. SIM funding is supporting an existing federal SAMHSA grant to ensure the success of the state's Screening, Brief Intervention, and Referral to Treatment (SBIRT) program. Funds will provide ongoing training to a 24-person workforce of Health Educators and Navigators to provide alcohol, drug and tobacco screening to 15,000 adults, and embed the program into existing primary care infrastructure.

d. The Provider Coaching project is designed to integrate physical healthcare into the behavioral healthcare settings. SIM funds will help Community Mental Health Centers improve their effectiveness in addressing consumers' health care needs by providing hands-on training on clinical practices, such as connecting more effectively with primary care providers, health information technology uses and benefits, collecting and measuring quality data, and strengthening quality improvement practices.

6. Fair Treatment of Providers

Embedded in the mission of OHIC is the unique role of encouraging commercial health insurers to treat health care providers fairly. This fair treatment has many facets. It includes prompt payment requirements for services provided. Often, it is less obvious, and relates to delays in processing contracts, requests, approvals and appeals. The use of prior authorization and utilization review are two major means for insurers to manage the use of services through the approval or denial of a medical provider's treatment recommendation. OHIC will be reviewing the insurer's use of these two care management tools more carefully in January 2018 when the insurers are expected to provide OHIC with further information on their use of prior authorization, and when OHIC takes on the responsibility to license and regulate utilization (benefit) review agencies.

7. Consumer Assistance, Complaint Resolution and Advocacy

Consumer and provider complaints that come to OHIC or its partner for consumer assistance, RIREACH (a program of the RI Parent Information Network-- RIPIN) serve as a very important first indicator of problems in the marketplace. OHIC and RIREACH staff are trained in insurance statutes and regulations and are vigilant in ensuring that the insurance companies comply with these requirements when reviewing consumer complaints. In investigating complaints, OHIC can quickly spot areas of concern and then work to resolve them.

OHIC's partner, Rhode Island Resource, Education, and Assistance Consumer Helpline (RIREACH), provides direct assistance to consumers and providers who need help understanding their insurance coverage, learning their rights and responsibilities, assisting with denials and appeals and/or navigating their benefit coverage with their insurer. RIREACH has a team of highly trained and experienced advocates that draw upon the same peer-to-peer support model that RIPIN has used successfully for over 21 years to address health, educational, and social determinants of health care for Rhode Islanders. RIREACH provides reporting and recommendations based on collected, qualitative and quantitative data, to assist OHIC with policy and regulatory responsibilities. OHIC utilizes RIREACH trends reporting to address administrative and operational issues to improve insurers operations and compliance to avert unnecessary investigations. RIREACH provides support and wrap around services for Rhode Island consumers.

OHIC and RIREACH staff share a strong commitment to the wellbeing of consumers. This partnership allows every Rhode Islander, regardless of income, location, or need, to obtain support in addressing health coverage issues.

8. Transition of Utilization Review Authority

The tracking of internal and external appeals beginning January 1, 2018 will be another OHIC tool to ensure insurance company adherence to the strict Utilization Review statute, §27-18.9 included in Budget Article 5 that passed in July 2017 and is effective January 1, 2018. Inherent in Article 5 is the transition of Utilization Review authority and operations from the RI Department of Health to the Office of the Health Insurance Commissioner.

Upon passage OHIC formed an Administrative Simplification Workgroup to begin to develop an updated regulatory approach to this new authority. The Administrative Simplification Workgroup is comprised of key stakeholders including representatives from major carriers and medical and behavioral health organizations and associations that have experience with the utilization review benefit denial appeals process.

The Workgroup members shared their knowledge and best practices to help re-tool RI's External Review process and procedures. Members assisted OHIC with the development of the following documents: External Review Regulations, External Review Request Form, Independent Review Organization (IRO) Application, OHIC/IRO Memorandum of Understanding, IRO Decision Notice, and the IRO Quarterly Report Form.

The Workgroup held its last in-person meeting on September 19, 2017; however, the members agreed to continue being of assistance to OHIC and provide input on the internal appeals process and procedures. Their continued assistance will help OHIC align RI's Utilization Review process with Federal review requirements by December 31, 2017.

9. State and National Behavioral Health Reform Efforts

OHIC intends to work cooperatively with state departments, the RI Office of the Mental Health Advocate, the Governor's Council on Mental Health, the Mental Health Association of RI, and the National Alliance on Mental Illness of RI, among others, to integrate behavioral health and parity reform efforts in the state. In addition, OHIC will take guidance from national initiatives and reports.

A November 2016 National Alliance for Mental Illness report outlines five strategies that insurers could adhere to in order to address disparities in accessing mental health care. They are listed below with a RI-specific response.

1. Maintain accurate up-to-date provider directories: Through the SIM grant, Rhode Island is in the process of building a statewide common provider directory that will contain contact information, licensure data, and relational information (such as insurance plans accepted, or membership in a larger system) so that patients and referring clinicians can make informed decisions about where specialty behavioral healthcare is received.

2. Provide easy to understand information about mental health benefits: OHIC reviews all health insurance forms such as Schedules of Benefits prior to sale in Rhode Island to ensure not only that plans offer benefits in full compliance with state and federal laws, but also that consumer-facing documentation is written at an eighth-grade reading level.

3. Promote integration of care: OHIC's Affordability Standards and the SIM test grant implement a number of strategies through policy and program development to encourage integration of behavioral health care into primary care, and vice versa. These strategies are discussed in more detail in this report.

4. Expand provider mental health networks: Rhode Island has a documented lack of some behavioral healthcare providers. Advancements in care delivery, such as the pediatric psychiatry access project or training of primary care providers to provide basic behavioral health screenings and services can help to mitigate the problem, but expanding the behavioral health workforce remains a long-term goal of the state.

5. Cover out-of-network care to fill provider gaps: There may be resources in neighboring states that could be considered "in-network" for specific needs that cannot be addressed in our state. OHIC intends to work with the insurers to determine means to fill gaps in the continuum of care.

10. Market Conduct Exam (MCE) on Mental Health and Substance Use Parity

Background

In January 2015, OHIC, under its market conduct examination (MCE) authority, issued a warrant (See Appendix #2) to Rhode Island's four major insurers[5] to begin the process of examining mental health and substance use parity implementation. The exam focuses on "non-quantitative treatment limitations" such as utilization management, provider networks, credentialing, and other restrictions that limit the scope or duration of covered behavioral health benefits that must be comparable to, and applied no more stringently than, similar limitations on medical surgical benefits. {Reference US statute 45 C.F.R. section 146.136(c) (4)[1], and R.I. General Laws section 27-18-38.1(d).}

OHIC began the exam process by reviewing, in detail, consumer coverage documents including Certificates of Insurance and Schedules of Benefits, for exclusionary language. These documents were obtained from each carrier through the MCE's first Request for Information (RFI) issued on September 24, 2015.

During this review, OHIC found it necessary to review carrier procedural and policy documents to determine obstacles to accessing covered benefits in a timely manner and parity with how medical and surgical services are obtained and paid (See Appendix #3). OHIC also determined that reimbursement parity, cost-share parity and parity of formulary as well as access to formulary drugs

[5] The four major health insurers are: Blue Cross & Blue Shield of RI, Neighborhood Health Plan of RI, Tufts Health Plan, and United Healthcare of New England.

needed to be assessed. Documents related to these items were obtained through additional Requests for Information from the insurers. To date, we have issued six formal requests for information, covering topics such as: 1) Utilization Review (UR) policies and procedures, 2) oversight of behavioral health UR (benefits approval) agents, 3) network adequacy, 4) reimbursement policies, 5) behavioral health and pharmacy prior authorization criteria, and 6) behavioral health and pharmacy case records.

The exam continued into 2016 until unexpected budget and staffing reductions caused OHIC to suspend its behavioral health market conduct exam on June 27, 2016. Because there was a significant community need for the continuation of this market conduct exam, OHIC restructured and resumed its review of parity in mental health and substance use disorder benefits and added additional quantitative and non-quantitative parity variables with the support of a federal Enforcement and Consumer Protection grant in 2017.

MCE Team and Statutory Authority

A core team of examiners including, Linda Johnson, OHIC's Operations Director, John Garrett, OHIC's Health Reform Specialist, and Herb Olson, Esq., an MCE contractor, is leading OHIC's Market Conduct Exam. In support of the exam, OHIC has also contracted with a team of seven psychiatrists from Massachusetts General Hospital (MGH) to provide their medical expertise with specific case reviews. Additional support is being provided by Charles DeWeese, Actuary, and OHIC's Legal Counsel, Emily Maranjian.

The primary laws used for the regulatory oversight of parity implementation include:

1. The **Federal Mental Health Parity and Addiction Equity Act (MHPAEA)** was first enacted in 2008, and subsequent regulations in 2010 and 2014. The federal regulations provide requirements for health insurers relating to:

a. Quantitative treatment limitations (QTLs) which are clear and more understandable for regulators to identify (e.g. co-pays, co-insurance).

b. Non-quantitative treatment limitations (NQTLs): The federal government's interim regulations issued February 2, 2010 provided little clarity in the area that generates the most consumer inquiries and confusion: non-quantitative treatment limits (included in the bullets below).

According to these federal policies, parity between mental health benefits and all other types of health benefits must be exhibited among the following categories:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether a treatment is experimental or investigative
- Formulary design for prescriptions drugs
- Standards for provider admission to participate in-network, including reimbursement rates for contracted providers

• Plan methods used to determine usual, customary, and reasonable fee charges (for out-of-network benefits)

• Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols)

• Exclusions based on failure to complete a course of treatment

The health insurance practices and programs listed above are not prohibited outright, but rather are prohibited when they are not established in a comparable manner for both behavioral health and medical surgical benefits, or are applied more stringently to behavioral health benefits than to medical surgical benefits.

2. The **State Mental Health Parity law RIGL §27-38.2-1: Coverage for the treatment of mental health and substance use disorders,** which requires the following:

(a) A group health plan and an individual or group health insurance plan shall provide coverage for the treatment of mental health and substance-use disorders under the same terms and conditions as that coverage is provided for other illnesses and diseases.

(b) Coverage for the treatment of mental health and substance-use disorders shall not impose any annual or lifetime dollar limitation.

(c) Financial requirements and quantitative treatment limitations on coverage for the treatment of mental health and substance-use disorders shall be no more restrictive than the predominant financial requirements applied to substantially all coverage for medical conditions in each treatment classification.

(d) Coverage shall not impose non-quantitative treatment limitations for the treatment of mental health and substance-use disorders unless the processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

(e) The following classifications shall be used to apply the coverage requirements of this chapter: (1) Inpatient, in-network; (2) Inpatient, out-of-network; (3) Outpatient, in-network; (4) Outpatient, out-of-network; (5) Emergency care; and (6) Prescription drugs.

(f) Medication-assisted treatment or medication-assisted maintenance services of substance-use disorders, opioid overdoses, and chronic addiction, including methadone, buprenorphine, naltrexone, or other clinically appropriate medications, is included within the appropriate classification based on the site of the service.

(g) Payers shall rely upon the criteria of the American Society of Addiction Medicine (ASAM) when developing coverage for levels of care for substance-use disorder treatment.

Methodologies and Processes for the MCE

Insurance regulators do not have the medical expertise in-house to conduct clinical reviews. For this reason, OHIC contracted with the afore-mentioned team of seven psychiatrists at Massachusetts General Hospital (MGH) to provide the clinical expertise to ensure health insurers are handling these medical management and other non-quantitative treatment limitation (NQTL) requirements properly, consistently and in accordance with the parity law and regulations.

Once all the case records requested were sent confidentially and securely, OHIC's core examiners reviewed hundreds of patients' cases extensively, and then selected the records for the MGH medical team to review. The case selection is not a random process. Cases are stratified by categories such as various drugs, age groups, conditions, etc. Once identified, the selected cases were sent to MGH for an independent and thorough clinical review looking at the criteria used by the insurance company to determine approval for payment for care-- assessing it and determining if it was applied properly. The lead doctor reviewing the case records reports to OHIC on observations and conclusions, from which OHIC determines findings and offer recommendations.

In addition to the extensive and intensive case review, OHIC sent a Request for Information (RFI) from the insurers on August 4, 2017 to further assess compliance with state and federal mental health parity requirements. The objective was to ensure that each insurer's provider reimbursement models demonstrate parity (equitable and consistent) policies, methodologies, and operational implementation.

Initial MCE Identified Areas of Concern

1. **Overall Process Areas of Concern**

OHIC intends to work cooperatively with the insurers through the medium of the MCE to develop the best responses to following areas of concern that will result in the maximum level of compliance with behavioral health parity for patients in Rhode Island.

- Is utilization review for behavioral health services more pervasive and restrictive than utilization review of medical surgical services? For example, are there more frequent concurrent reviews, and shorter duration approvals for behavioral health services when compared to medical surgical services?
- Should health insurers use national evidence-based utilization review criteria, rather than proprietary criteria developed by UR companies, to approve or deny prior authorization requests?
- Should utilization review criteria be reformed to be more objective and measurable, rather than conferring significant discretionary power to UR agents/insurers?
- Should utilization review programs be used to manage undesirable provider treatment practices, or are patients best served by addressing quality of care issues through quality assurance programs?

- Should the utilization review process give more weight (than is currently bestowed) to the clinical judgment of the treating provider?
- Should health insurers fully document the treating provider's rationale for the behavioral health service or prescription drug requested for his or her patient?
- Do health insurer utilization review practices improperly impeded or delay care, or fail to adequately consider care transition and continuity of care?

Pursuant to Rhode Island's Insurance Examination Statute, RIGL 27-13.1-1 et seq., at the end of the examination process, if the examination report adopted by the Commissioner reveals that a carrier is operating in violation of any law, regulation, or prior order of OHIC, the Commissioner may order the carrier to take any action considered necessary and appropriate by OHIC to cure the violation.

2. More Specific Areas of Concern

Within the hundreds of patient cases reviewed, some patterns and practices were observed. OHIC intends to work with the state's insurers to achieve behavioral health parity in the commercial insurance market by addressing certain specific areas of concern. These areas did not either individually or collectively appear with regards to every insurer, however at least one insurer's practices raised one of more of these areas of concern:

- Are insufficient or inappropriate criteria being used to deny payment for health provider-recommended care?
- Are insurers inappropriately applying review criteria and/or misinterpreting that criteria?
- Is the use and increased frequency of Utilization Review (UR) to approve care for Behavioral Health more pervasive when compared to the scope of UR for Medical/Surgical services (whereby the need for continuation and payment for behavioral health care is questioned more often than for other services)?
- Are UR processes impeding care, impacting transitions and continuity of care during the decision process?
- Is there a problem with inconsistent organization and clarity of insurer documentation, including missing documentation to substantiate compliance with state and federal rules?

These findings and concerns are being discussed with the insurers who have the opportunity to clarify the data and refute their case-specific findings prior to their individual exam report being made public.

3. Other Key Observations

<u>Provider Reimbursement</u>
Through OHIC's Form and Rate Review process, insurers have indicated the standards and criteria for payment models applied to mental health and substance use disorder providers that are comparable and applied no more stringently relative to medical and surgical providers. Additionally, OHIC found the same criteria for parity are considered in establishing fee schedules for all providers. However, insurers did confirm their ability to adjust payment criteria based on a provider's specific licensure, discipline, and level of education.

Network Adequacy

Insurers were asked to summarize their process for recruiting mental health, behavioral health, and substance use disorder practitioners into their networks. Delivery system inadequacy, particularly the lack of a treatment continuum from inpatient through community care has been an issue of community concern. Particular needs for services for children and individuals with eating disorders, as well as an overall lack of resources in the state for residential treatment for mental health and substance use have been noted.

In accordance with the State's Fiscal Year 2018 Budget Article 5, responsibility for the RI Health Plan Act shall transfer from the RI Department of Health to OHIC, effective January 1, 2018. Consistent with that role, OHIC anticipates gathering additional network adequacy data from the issuers.

Patient Deductibles

OHIC's issuer request for information mentioned above did require respondents to identify the composite cost share[6] by percent for each of the following categories:

- Outpatient office visits (medical/surgical)
- Outpatient office visits (behavioral health/mental health)
- Outpatient treatments (medical/surgical)
- Outpatient treatments (behavioral health/mental health)

Deductibles were excluded from this analysis. OHIC anticipates leveraging a future Market Conduct Examination request to gather additional consumer cost sharing information.

4. Change to Prior Authorization Resulting from the MCE

Even though the Market Conduct Exam is not finished, it produced preliminary findings that OHIC felt were serious enough to act on quickly. Findings showed that 95% of prior authorizations for medication-assisted treatments of substance use disorders were approved during the test period. Since this percentage was so high, OHIC reached out to insurers and requested that-- to the extent they had such prior authorization requirements in place for certain medication-assisted treatments-- they eliminate the prior-authorization requirement in order to expedite a treatment that is often an immediate need.

In May 2017, OHIC's leadership began discussions with RI's four major insurance carriers and proposed an agreement for terminating prior-authorization for medication assisted treatments. After weeks of discussion, a partnership came to fruition and an MCE preliminary finding became an agreed policy change, (See Appendix #4).

5. Next Steps

1. By February 2018, OHIC anticipates completing reports of findings for each carrier and setting up discussion meetings to address clarity on criteria, deficiencies, and patient case handling.
2. By March 2018, the Commissioner anticipates adopting, possibly with modifications or

[6] Composite cost share includes copayments, coinsurance at time of service

corrections, a report on the Market Conduct Exam on Behavioral Health Parity Implementation in RI, and issuing any orders deemed necessary and appropriate resulting therefrom.

3. By March 2018, OHIC will develop and/or update instructions, checklists and tools for the 2019 Form Review informed by MCE Examiner findings.
4. In July of 2018, begin follow-up to the MCE on specific behavioral health parity implementation topics needing more investigation, including provider reimbursement, application of patient cost-sharing (co-payments and deductibles), and provider network adequacy.

Ensuring Behavioral Health Parity Implementation—

Key Areas of Concern and Action Plans

Based upon the ten categories of activities discussed above, OHIC has identified the following general issues of concern and action plans. These items focus primarily on non-quantitative insurer practices and requirements that may pose barriers to achieving behavioral health parity:

- Issue: More detailed examinations are needed to measure the level of compliance with many non-quantitative parity requirements, such as provider reimbursement, network adequacy, and patient cost-sharing necessities.

  Action Plan: OHIC will continue to carry out market conduct examination-related activities.

- Issue: OHIC has worked with the insurers to measure the value of certain "medical management tools," such as prior authorization.

  Action Plan: OHIC will continue to work cooperatively with the insurers on opportunities to remove prior authorization requirements that are not productive or are contrary to achieving parity.

- Issue: Utilization Review processes --obtaining specific approvals for certain services to be paid for—may impede medically necessary care, impact care transitions, and interrupt continuity of care during the decision/approval process.

  Action Plan: As of January 1, 2018, OHIC will become the state authority for "Utilization Review Agent" oversight. New regulations must be drafted, a revised patient/provider appeals process

must be implemented, and monitoring of compliance must be integrated into the OHIC consumer protection and insurer regulatory processes.

In addition to the parity-driven recommendations above, the following are recommended approaches for OHIC to improve access to and quality of behavioral healthcare service delivery:

1. Build upon opportunities for inter-agency coordination: This work and a common interest in improving behavioral health parity and outcomes allows opportunities for interagency coordination. This includes more robust alignment with the state Medicaid program, and collaboration with the RI Departments of Children, Youth and Families (on access to appropriate levels of care) and Behavioral Health, Developmental Disabilities and Hospitals (on system development and consumer engagement), and Health (on access and population health).

2. Community Stakeholder Engagement: OHIC understands that alignment also needs to occur across sectors. It is critical to bring stakeholders from the community together to identify investments needed to develop a continuum of care to meet the identified needs in Rhode Island.

3. Continue efforts to integrate Behavioral Health into Primary Care: OHIC will continue to implement their Affordability Standards to shape the development of payment and care delivery models that incentivize high quality, integrated behavioral health.

4. Continue State Innovation Model (SIM) Grant investments: SIM projects related to the behavioral health workforce, screening, access, and care transformation continue to be implemented. Further, SIM is in the process of strategizing the long-term sustainability of investments in behavioral health so that progress made thus far is continued beyond the life of the SIM grant.

OHIC is uniquely situated-- through legislative authority, federal grant opportunities, and health system reform priorities—to encourage and ensure parity implementation in Rhode Island. OHIC will continue to integrate behavioral health parity into its regulatory and policy efforts, employing multiple strategies to improve access, quality, and coverage of behavioral health services.

Appendix #1-- RI HEALTH INSURANCE ADVISORY COUNCIL

Gregory Allen, DO
Physician

Stephen Boyle (Co-Chair)
President, Greater Cranston Chamber of Commerce

Herbert Brennan, DO
Physician

Karl Brother
Small Business Advocate

Al Charbonneau
Executive Director, Rhode Island Business Group on Health

Howard Dulude, MBA, FHFMA
Vice President Human Resources Operations and Lifespan Health, Lifespan

Ruth Feder, Esq., MSW
Executive Director, Mental Health Association of Rhode Island

David Feeney, RPh
Pharmacy Consultant

Marie Ganim, PhD (Co-Chair), Rhode Island Health Insurance Commissioner

David Katseff
President & CEO, MasterCast Ltd.

Teresa Paiva Weed, President
Hospital Association of RI

Sam Salganik, JD
Health Policy Analyst, Rhode Island Parent Information Network

Bill Schmiedeknecht
Vice President Human Resource Partnerships and Labor Relations, Lifespan

Lisa Tomasso
Community Relations Manager, The Providence Center

Vivian Weisman
Consumer Advocate

Appendix #2

TEXT OF NOTICE OF MARKET CONDUCT EXAMINATION

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
1511 PONTIAC AVENUE, BLDG 69-1
CRANSTON, RI 02920

In Re: Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations OHIC-2014-3

NOTICE OF EXAMINATION, WARRANT, AND APPOINTMENT

Whereas, Blue Cross Blue Shield of Rhode Island ("Blue Cross") is engaging in business of health insurance in the State of Rhode Island ("State");
Whereas, Neighborhood Health Plan of RI ("Neighborhood") is engaging in the business of health insurance in the State;
Whereas, Tufts Insurance Company and Tufts Associated Health Maintenance Organization (collectively "Tufts") is engaging in the business of health insurance in the State;
Whereas, UnitedHealthcare Insurance Company, and UnitedHealthcare of New England, Inc. (collectively "United") is engaging in the business of health insurance in the State;
Whereas, Blue Cross, Neighborhood, Tufts, and United (collectively "the Carriers"), are subject to the jurisdiction of the Office of the Health insurance Commissioner ("the Office") by virtue of Title 27, and by virtue of Title 42 Chapters 14 and 14.5 of the General Laws of Rhode Island;
Whereas, pursuant to Chapter 13.1 of Title 27 of the General Laws of Rhode Island, the Health Insurance Commissioner ("Commissioner") or her designee, in her sole discretion, may upon proper notice order an examination of any Rhode Island health insurance carrier to ascertain carriers' compliance with their legal obligations;
Whereas, the Rhode Island Legislature has requested the Office to conduct a review of the Carriers' compliance with their legal obligations under mental health and substance abuse ("behavioral health") laws and regulations. R.I. Gen. Laws § 42-14.5-3(j) and (m); and
Whereas, this notice shall be considered the examination warrant pursuant to Section 27-13.1-4(a).
Now therefore be it ORDERED:

A. The Office of the Health Insurance Commissioner ("the Office") shall conduct a market conduct examination of the Carriers.

B. Linda Johnson, Herbert Olson, Charles DeWeese, and Jack Broccoli ("the Examiners") are appointed pursuant to R.I. Gen. Laws § 27-13.1-4 to represent the Commissioner in this examination. The Examiners are authorized to retain, utilize and rely on the services and work

of consultants, experts, actuaries or other persons as they deem necessary to assist in the conduct of this examination.

C. The examination will be a targeted examination to determine:

1. Whether the Carriers are complying with their legal obligations relating to emergency behavioral health services, including the prohibition on the use of prior authorization as a condition of coverage of emergency behavioral health services, in accordance with state and federal laws and regulations.
2. Whether the Carriers are complying with their legal obligations to provided coverage of behavioral health services, in accordance with state and federal laws and regulations.
3. Whether the Carriers are complying with their legal obligations to provided coverage of behavioral health services at parity with other health care coverage, in accordance with state and federal laws and regulations.

D. In accordance with R.I. Gen. Laws §§ 27-13.1-4(b) and 27-13.1-4(c), the Carriers must provide timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business, and affairs of the company and provide timely and complete access to all persons under the company's control from whom the Office seeks to take testimony under oath.

E. In accordance with R.l. Gen. Laws §§ 27-13.1-7 and 27-13.1-4(d), the total cost of such examinations, including the costs of any attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists used as examiners, but excluding the costs of employees of the Office and of the Department of Business Regulation, must be borne by the Carriers.

Dated at Cranston, RI this 8th day of January, 2015.

Appendix #3

MARKET CONDUCT EXAM INITIAL REQUEST FOR INFORMATION

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
1511 PONTIAC AVENUE, BLDG 69-1
CRANSTON, RI 02920

In Re: Examination of Health Insurance Carrier Compliance)
with Mental Health and Substance Abuse) OHIC-2014-3
Laws and Regulations)

Amended Request for Information No. 1
Section 1. Scope and Purpose.
Pursuant to the Warrant and Notice of Examination issued by the Commissioner of the Office of the Health Insurance Commissioner (Office) in the above-captioned matter, and in accordance with R.I. Gen. Laws Chapters 13, 13.1, 18, 19, 20, 38.2, and 41, the Examiners hereby make the following Amended Request for Information No 1 to Neighborhood Health Plan of RI "the Carrier"). The Examiners in this matter are Linda Johnson, Herb Olson, Jack Broccoli, and Charlie DeWeese.
Nothing in this Request for Information constitutes a limitation on the authority of the Commissioner and the Office to conduct further inquiries, examinations, or requests for information from the Carrier, or to conduct enforcement proceedings with respect to violations of laws and regulations during the pendency of the Examination and the responses to the Request for Information No. 1, and any subsequent requests.
Section 2. Procedure for Responding to the Request for Information.
1. The Carrier shall make available to the Examiners the information requested as soon as the information is collected or prepared by the Carrier in accordance with the Carrier's Examination Process Grid, but in no event later than October 13, 2015, except that the information requested in Section 6(7) shall be made available no later than September 23, 2015.
2. Unless otherwise specified, the Examination Period is January 1, 2014 to December 31, 2015.
3. The Carrier shall transmit the information requested by electronic means to:
linda.johnson@ohic.ri.gov
herb.olson123@gmail.com
4. A Certificate of Authenticity, in the form prescribed by Exhibit A, attached, shall be completed by the Carrier, and shall accompany each electronic transmission, or each referenced group of transmissions.

5. All non-excel documents shall be submitted in searchable PDF format, unless otherwise specified.
6. Where specified, the information requested shall be transmitted on an excel document in the format and manner identified in the request.

7. At any time before the required response date, a Carrier may request the Examiners for additional time to respond to the request. The Carrier request must include a brief written statement of the reasons for the request.

8. In the event that a carrier fails to provide any of the information requested by the Examiners in a timely manner, the Examiners will notify the Commissioner and the carrier of said failure, and the Commissioner may subject the carrier to such fines, penalties or any other remedy provided for by law.

Section 3. Definitions.

1. Administrative denial" means any non-payment (in whole or part) by a carrier for a treatment, or service other than a medical necessity denial, including denials as a non-covered benefit.
2. "Adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in a plan or to receive coverage under a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. The term also includes a rescission of coverage determination.
3. "Behavioral health claim" means a claim that is a mental health claim or a substance abuse claim.
4. "Behavioral health disorder" means a disorder that is a mental health disorder or a substance abuse disorder.
5. "Denied claim" means a submitted claim for an enrollee that is not paid in whole or part by the carrier, including administrative denials and medical necessity denials.
6. "Emergency admission" means an admission to an inpatient facility where sudden onset of a medical, mental health, or substance abuse or other health care condition manifesting itself by acute symptoms of a severity (e.g. severe pain) where the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any body organ or part.
7. "Health plan" means an individual, small group or large group health insurance plan approved by the Office.
8. "Medical necessity denial" means an adverse benefit determination based on lack of the necessity and/or the appropriateness of a service/treatment ordered by a provider.

9. “Medical/surgical services” means all health care benefits with respect to items or services for medical conditions or surgical procedures, consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD).
10. “Member” means an individual enrolled in a health plan.
11. “Mental health claim” means any claim for coverage of treatment of, or services in connection with a mental health disorder.
12. “Mental health disorder” means any mental disorder that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICO) published by the World Health Organization.
13. “Related benefits, coverage, and claims” means benefits, coverage and claims in connection with a member with a behavioral health disorder, such for prescription drugs.
14. “Related functions” means Carrier or Vendor functions related to behavioral health benefits, coverage and claims administration, such as benefits, coverage and claims administration related to prescription drugs.
15. “Substance abuse claim” means a claim for coverage of treatment of, or services in connection with a substance abuse disorder.
16. “Substance abuse disorder” means any substance abuse disorders that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICO) published by the World Health Organization; provided, that tobacco and caffeine are excluded from the definition of "substance" for the purposes of this Request for Information.
17. “Third party vendor” or “Vendor” means an entity under contract with a Carrier for claims administration, utilization management, or case management, or other similar or related functions for behavioral health services (including the administration of prescription drug claims), including any entity that sub-contracts with a Vendor in connection with such functions.
18. “Utilization management” means the process used by Carriers and Vendors to review and assess the necessity and/or appropriateness of the allocation of health care services of a provider, given or proposed to be given to a patient.
19. “Zero-paid claim” means a claim submitted for the treatment or service that is covered, but the claim is not paid due to co-insurance applying or deductible not being met.

Section 4. Carrier operations and management.

1. For calendar years 2014, and 2015 a corporate structure and business relationship description, including

a. An organizational chart showing:

i. The Carrier.

ii. The Carrier’s parent.

iii. Those affiliates of the parent with a business relationship with the Carrier for behavioral health benefits, coverage and claims administration, and for behavioral health related functions.

iv. The internal functional units of the Carrier for behavioral health benefits, coverage and claims administration, and for behavioral health related functions.

b. An organizational chart showing the business relationships between the Carrier and its Third Party Vendors.

2. For calendar years 2014, and 2015 a summary description, and a functional organizational chart that describes how the Carrier (internally), and any Third-Party Vendor, performs the following functions in connection with behavioral health and related benefits, coverage and claims administration:

a. Establishing the behavioral health and medical/surgical terms and conditions for health plans issued by the Carrier, including the following elements of the health plan:

i. Benefit coverages, limitations and exclusions.

ii. Benefit design.

b. Establishing financial and quantitative treatment limitations relating to behavioral health and related benefits and coverage.

c. Establishing and administering standards and procedures for behavioral health and medical/surgical provider admission to participate in a network.

d. Establishing and administering claims administration functions for behavior health and related claims, including:

i. Utilization management/review.

ii. Prospective, concurrent and retrospective review programs.

iii. Medical necessity policies, procedures and criteria.

iv. Case management.

e. Establishing and administering fee schedules and other payment methodologies: (i) for behavioral health services, and (ii) for medical/surgical services.

f. Establishing and administering any other financial limitations, quantitative treatment limitations, or non-quantitative treatment limitations in connection with behavioral health and related benefits, coverage and claims.

3. For calendar years 2014, and 2015 (red-lined showing changes from the prior year, if available, otherwise accompanied by a summary description of material changes from the prior year), the contracts, agreements, protocols, delegations, or any other written material that govern or guide or are used by the Carrier and any Third Party Vendors for behavioral health and related benefits, coverage and claims administration.

Section 5. Subscriber policies and certificates of coverage.

1. For calendar years 2014, 2015, and 2016 a list of all unique plan provisions (in the plan's policy form and certificate of coverage) relating to emergency services for mental health conditions, including an attached plan or plans (if provisions differ from plan to plan), and identifying each emergency services provision by page, and by section or paragraph. Plan provisions for 2015 and 2016 must be red-lined to show changes from the prior calendar year.

2. For calendar years 2014, 2015, and 2016 a list of all unique plan provisions (in the plan's policy form and certificate of coverage) relating to emergency services for substance abuse conditions, including an attached plan or plans (if provisions differ from plan to plan), and identifying each emergency service provisions by page, and by section or paragraph. Plan provisions for 2015 and 2016 must be red-lined to show changes from the prior calendar year.

Section 6. Health Plan Certification and Utilization Review Policies and Procedures.

1. For calendar years 2014 and 2015 (red-lined showing changes from the prior year, if available, otherwise accompanied by a summary description of material changes from the prior year) the following materials of the Carrier and the Vendor submitted to the Department of Health, in the form and manner required by the Department of Health. The response shall be updated to include any responsive information approved by the Department of Health during 2015:

a. Oversight and responsibility. Health Plan Certification Application ("HP") Tab C.
b. Availability and accessibility of services. HP Tab D.
c. Continuity of care. HP Tab E.
d. Complaints. HP Tab G.
e. Professional provider application and credentialing. HP Tab I
f. Scope of services. Utilization Review Application ("UR") Tab C.
g. Supporting documentation. UR Tab F.
h. Complaint resolution. UR Tab H.
i. Patient interviews. UR Tab K.
j. Medical necessity standards and screening procedures. UR. Tab I.

2. If not submitted in response to Para. 1, above, the Carrier's and any Vendor's claims administration manual or manuals, and any other policies, standards, procedures or other written material (effective during 2014 and 2015) governing, guiding or describing: (i) the administration of mental health claims, and (ii) the administration of substance abuse claims, including but not limited to written material relating to:

a. Medical necessity standards, procedures, and denials.
b. Adverse determinations and internal appeals process.
c. Adverse determination notification.
d. Prior, concurrent and retrospective authorization determinations.
e. Case management.
f. Any financial or quantitative treatment limitation for behavioral health services.
g. Any non-quantitative treatment limitation for behavioral health services.
h. Administrative denials.

3. For calendar years 2014 and 2015 the Carrier's, updated to include any quarterly reports submitted in connection with 3rd and 4th Quarter 2015 reports:

a. The Carrier's Quarterly Health Plan Data Reports submitted to the Department of Health.
b. The Carrier's Quarterly Utilization Review Reports submitted to the Department of Health.

c. Third Party Vendors Quarterly Utilization Review Reports submitted to the Department of Health.

4. In connection with the Carrier's Quarterly Health Plan Data Reports identified in Para. 3(a), above:

a. Describe how the Carrier and its Third Party Vendors define "provider complaints" and "consumer complaints" so as to distinguish those complaints from an "inquiry" or other category in connection with mental health complaints, and substance abuse complaints.

b. Describe how the Carrier and its Third Party Vendor categorize complaints related to an emergency room visit where the member has one or more behavioral health disorders.

c. Describe how the Carrier and its Third Party Vendor categorize a complaint related to pharmaceutical benefits or coverage where the member has one or more behavioral health disorders.

d. When a member has at least one mental health service, and one substance abuse service in connection with a claim, describe how the Carrier and its Third Party Vendor categorize a complaint related to those services and the claim.

5. In connection with the Carrier's Quarterly Utilization Review Health Plan Data Reports identified in Para. 3(b), above (including determinations on prospective, concurrent and retrospective review):

a. Describe under what category the Carrier places emergency room data related to substance abuse claims, and mental health claims.

b. Describe under what category the Carrier places prescription drug data related to substance abuse claims, and to mental health claims.

c. Describe under what category the Carrier places data related to the following behavioral health services:

i. Residential treatment.

ii. Intensive Outpatient Program.

iii. Partial hospitalization.

iv. Rehabilitation facility.

v. In-Patient treatment.

vi. Out-patient treatment.

vii. Detoxification.

viii. Any other mental health and substance abuse services or treatment not listed in (i) through (viii) above.

6. In connection with the Vendor's Quarterly Utilization Review Health Plan Data Reports identified in Para. 3(c), above (including determinations on prospective, concurrent and retrospective review):

a. Describe under what category the Vendor places emergency room data related to substance abuse claims, and mental health claims.

b. Describe under what category the Vendor places prescription drug data related to substance abuse claims, and to mental health claims.

c. Describe under what category the Vendor places data related to the following behavioral health services:

i. Residential treatment.
ii. Intensive Outpatient Program.
iii. Partial hospitalization.
iv. Rehabilitation facility.
v. In-Patient treatment.
vi. Out-patient treatment.
vii. Detoxification.
viii. Any other mental health and substance abuse services or treatment not listed in (i) through (viii) above.

7. A summary description of the Carrier and Third Party Vendor's behavioral health contractual provisions, policies, procedures, standards, guidance, or other written material (effective during calendar years 2014 and 2015) relating to the following, with references to the applicable written material by name, date, page, and section or paragraph number:

a. Blanket denials; i.e. a denial of a behavioral health claim without reference to specific claim-related clinical criteria or facts. e.g. "The services requested are not medically necessary."

b. Diagnosis denials; i.e. the denial of behavioral health admission or readmissions, or the activation of a peer review process based upon the patient's diagnosis, or the patient's dual diagnosis, or without reference to specific claim-related clinical criteria or facts.

c. Length of stay denials; i.e. the denial of a length of stay for behavioral health admissions and readmissions, or the activation of the peer review process based upon a pre-determined admission or readmission timeline, or without reference to specific claim-related clinical criteria or facts.

d. Level of care denials; i.e. a denial based on the level of care sought to be covered, including step down services, appropriateness of site of service, intermediate level of care, residential care, and rehabilitation care.

e. Visit limit denials; i.e. the denial of visits in excess of a carrier or vendor pre-determined limit during a calendar year or other period of time for:

i. Mental health provider visits.
ii. Psychotherapy provider visits.
iii. Substance abuse provider visits.

f. Discharge prescription prior authorization; i.e. the process for approving prescriptions upon discharge for behavioral health patients for suboxone or other necessary medications upon discharge from in-patient treatment.

g. Geriatric admissions and discharges; i.e. material relating to admissions and discharges of geriatric patients from a nursing home or other care environments with a behavioral health diagnosis such as dementia or other cognitive dysfunction.

h. Emergency admission length of stay limitations; i.e. approving behavioral health coverage of a limited number of in-patient days post-emergency admission, based upon a diagnostic category, or without reference to specific claim-related clinical criteria or facts.

i. Failed treatment denials; i.e. a denial of behavioral health coverage of treatment based in part on the patient's failure to improve during past episodes of treatment.

j. Requiring prior authorization or certification for emergency in-patient admissions: (i) for behavior health treatment, and (ii) for medical/surgical treatment.
k. Recommending or encouraging or entertaining prior authorization for emergency in-patient admissions: (i) for behavior health treatment, and (ii) for medical/surgical treatment.
l. Conducting concurrent or retrospective review of emergency in-patient admissions and subsequent hospital stay: (i) for behavior health treatment, and (ii) for medical/surgical treatment.
m. Secondary diagnosis denials to include dually diagnosed patients defined as those patients with both a mental health and substance abuse disorder or a denial of treatment for any level of care based upon the existence of a secondary diagnosis.
n. Self-management and patient education programs offered in connection with (i) behavioral health treatment, and (ii) medical/surgical treatment.
o. Court ordered treatment denials; i.e. the denial of behavioral health treatment based upon the existence of a court order for the patient to undergo such treatment.
8. The clinical criteria or other written standards used by the carrier or the third party vendor during the examination period to approve, disapprove, authorize (prior, concurrent and retrospective authorization), or partially approve, disapprove or authorize, or apply a non-quantitative treatment limitations on claims for:
a. Emergency mental health services.
b. Emergency substance abuse services.
9. Written materials describing whether a representative of the carrier or third party vendor is available in emergency or emergent circumstance after normal business hours, and on weekends, for:
c. Mental health services.
d. Substance abuse services.
e. Medical/surgical services.
10. Identify by name, phone number and email address the Carrier representatives responsible for the material and data requested in Section 6, Paras. 1-9, and who can speak with knowledge to the material and data requested in Section 6, Paras. 1-9.
11. Identify by name, phone number and email address the Vendor representatives responsible for the material and data requested in Section 6, Paras. 1-9 and who can speak with knowledge to the material in Section 6, Paras. 1-9.

Dated this 24th day of September, 2015.

Appendix #4

THE FOUR (4) INSURER-OHIC AGREEMENTS TO DISCONTINUE PRIOR AUTHORIZATION REQUIREMENTS FOR SPECIFIC MEDICATION ASSISTED TREATMENT FOR SUBSTANCE USE DISORDERS

Blue Cross & Blue Shield of RI

Neighborhood Health Plan of RI

Tufts Health Plan

United Healthcare of New England

OFFICE OF THE HEALTH INSURANCE COMMISSIONER
1511 PONTIAC AVENUE, BLDG 69-1
CRANSTON, RI 02920

In Re: Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations OHIC-2014-3

AGREEMENT

It is hereby agreed between the Rhode Island Office of the Health Insurance Commissioner (OHIC) and Blue Cross & Blue Shield of Rhode Island (Blue Cross) as follows:

1. Blue Cross is a health insurance carrier subject to the jurisdiction of the Commissioner. RIGL § 42-14-5(c) and (d).

2. The Health Insurance Commissioner for the State of Rhode Island (Commissioner) is authorized to examine the business affairs of health insurance carriers for compliance with applicable federal and state laws and regulations. RIGL § 27-13.1-1 et seq.

3. Health insurance carrier claims administration is subject to the requirements of RIGL § 27-9.1, the Unfair Claims Settlement Practices Act: RIGL § 27-38.2-1, Insurance Coverage for Mental Illness and Substance Abuse; RIGL § 23-17.12, and other applicable state and federal laws and regulations.

4. A market conduct examination of health insurance carrier compliance with mental health and substance abuse laws and regulations (Examination) was ordered by the Commissioner on January 8, 2015. Blue Cross is one of the carriers subject to the Commissioner's examination warrant.

5. The examination warrant appointed Linda Johnson and Herbert Olson, among others, as Examiners to represent the Commissioner. The Examiners utilized personnel within the Office and experts outside the Office to assist in the conduct of the examination, including John Garrett, Health Reform Specialist, and including certain behavioral health clinicians associated with Massachusetts General Hospital.

6. The Commissioner has concluded that there is a public health crisis facing Rhode Island regarding opioid dependence and related deaths necessitates immediate action to reduce unnecessarily delays in access to medically necessary treatment for patients with opioid dependence disorders. To address the crisis, the Commissioner requested that the Examiners consult with clinical experts to inform the development of policies designed to reduce delays in access to certain prescription drugs used to treat patients with opioid dependence disorders (commonly referred to as Medication Assisted Treatment or MAT).

THEREFORE, Blue Cross and OHIC hereby agree as follows:

1. Blue Cross' pharmaceutical formularies must include, at a minimum,

a. One buprenorphine combination Medication Assisted Treatment product approved for use by the FDA in the treatment of opioid use disorder (commonly known as buprenorphine/naloxone), in tablet or film form; and

b. One buprenorphine (mono-formulation) Medication Assisted Treatment product approved for use by the FDA in the treatment of opioid use disorder (commonly known as buprenorphine), in tablet or film form.

2. Blue Cross shall discontinue any prior authorization requirements or programs for the formulary medications identified in Para. 1, above, no later than May 15, 2017, with the limited exceptions that:

a. Blue Cross may propose the adoption of dose limit and supply limit criteria consistent with federal guidelines; however, any such dose or supply limit criteria must allow for the

dispensing of formulary Medication Assisted Treatment within FDA recommended dose guidelines without any prior authorization requirements while the prescribing clinician is provided the opportunity to clinically justify a dose outside the guidelines.

b. Blue Cross may establish prior authorization requirements for a mono formulation MAT provided that health care providers are able to prescribe the mono formulation MAT for pregnant women without prior authorization.

3. In connection with: (i) a patient that is already taking a MAT medication not identified in Para. 1, above, and (ii) a patient that is already taking an MAT medication at a prescribed dose level outside the FDA recommended dose guidelines, Blue Cross shall continue to permit such treatment while the prescribing clinician is provided the opportunity to clinically justify continued treatment through the formulary exception process.

4. This Agreement shall apply until the Commissioner issues a final examination order in the above-captioned matter, unless earlier amended with the agreement of the parties.

5. Nothing in this Agreement shall limit the authority of the Commissioner pursuant to RIGL § 27-13.1-1 et seq.

6. Nothing in this Agreement shall be construed to allege or admit to any violation of law.

OFFICE OF THE HEALTH INSURANCE COMMISSIONER
1511 PONTIAC AVENUE, BLDG 69-1
CRANSTON, RI 02920

In Re: Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations OHIC-2014-3

AGREEMENT

It is hereby agreed between the Rhode Island Office of the Health Insurance Commissioner (OHIO) and Neighborhood Health Plan of Rhode island as follows:

1. Neighborhood Health Plan of Rhode Island (Neighborhood) is a health insurance carrier subject to the jurisdiction of the Commissioner. R1GL § 42-14-5(c) and (d).

2, The Health Insurance Commissioner for the State of Rhode Island (Commissioner) and examiners appointed by the Commissioner are authorized to examine the business affairs of health insurance carriers for compliance with applicable federal and state laws and regulations. RIGL § 27-13.1-1 et seq.

3. Health insurance carrier claims administration is subject to the requirements of RIGL § 27¬9.1, the Unfair Claims Settlement Practices Act: RIGL § 27-38.2-1, Insurance Coverage for Mental Illness and Substance Abuse; RIGL § 23-17,12„ and other applicable state and federal laws and regulations.

4. A market conduct examination of health insurance carrier compliance with mental health and substance abuse laws and regulations (Examination) was ordered by the Commissioner on January 8, 2015. Neighborhood is one of the carriers subject to the Commissioner's examination warrant.

5. The examination warrant appointed Linda Johnson and Herbert Olson, among others,

5. Examiners to represent the Commissioner. The Examiners utilized personnel within the Office and experts outside the Office to assist in the conduct of the examination, including John Garrett, Health Reform Specialist, and including certain behavioral health clinicians associated with Massachusetts General Hospital.

6. The Examiners have reviewed and evaluated carrier policies related to prior authorization for certain prescription drugs used to treat patients with opioid dependence disorders (commonly referred to as Medication Assisted Treatment or MAT).

7. The Examiners acknowledge that Neighborhood's prior authorization policies for Medication Assisted Treatment have been revised since the time frame being examined by the Examination. Notwithstanding the foregoing, the Examiners have concluded that the public health crisis facing Rhode Island regarding opioid dependence and related deaths necessitates immediate action to reduce unnecessarily delays in access to medically necessary treatment for patients with opioid dependence disorders,

THEREFORE, Neighborhood and OHIC hereby agree as follows:

1. Neighborhood's pharmaceutical formularies must include, at a minimum,

a. One buprenorphine combination Medication Assisted Treatment product approved for use by the FDA in the treatment of opioid use disorder (commonly known as buprenorphineinaloxone), in tablet or film form; and

b. One buprenorphine (mono-formulation) Medication Assisted Treatment product approved for use by the FDA in the treatment of opioid use disorder (commonly known as buprenorphine), in tablet or film form.

2. Neighborhood shall discontinue any prior authorization requirements or programs for the formulary medications identified in Para. 1, above, no later than May 15, 2017, with the limited exceptions that:

a. A carrier may propose the adoption of dose limit and supply limit criteria consistent with federal guidelines; however, any such dose or supply limit criteria must allow for coverage of formulary Medication Assisted Treatment within FDA recommended dose guidelines without any prior authorization requirements while the prescribing clinician is provided the opportunity to clinically justify a dose outside the guidelines.

b. A carrier may establish prior authorization requirements for a mono formulation MAT provided that coverage will be provided for the mono formulation MAT for pregnant women without prior authorization.

3. In connection with: (I) a patient that is already taking a MAT medication not identified In Para. 1, above, and (ii) a patient that is already taking an MAT medication at a prescribed dose level outside the FDA recommended dose guidelines, Neighborhood shall continue to provide coverage of such treatment while the prescribing clinician is provided the opportunity to clinically justify continued treatment through the formulary exception process.

4. This Agreement shall apply until the Commissioner issues a final examination order in the above-captioned matter, unless earlier amended. with the agreement of the parties. Nothing in this Agreement shall be construed to allege or admit to any violation of law. Nothing in this Agreement shall limit the authority of the Commissioner and the Examiners pursuant to RIGL § 27-13.1-1 et seq. to issue findings, recommendations and orders with respect to the subject matter of this Consent Agreement.

OFFICE OF THE HEALTH INSURANCE COMMISSIONER
1511 PONTIAC AVENUE, BLDG 69-1
CRANSTON, RI 02920

In Re: Examination of Health Insurance Carrier Compliance
with Mental Health and Substance Abuse OHIC-2014-3
Laws and Regulations

AGREEMENT

It is hereby agreed between the Rhode Island Office of the Health Insurance Commissioner (OHIC) and Tufts Insurance Company and Tufts Associated Health Maintenance Organization, Inc. (collectively "Tufts Health Plan") as follows:

I. Tufts Health Plan is a health insurance carrier subject to the jurisdiction of the Commissioner. RIGL § 42-14-5(c) and (d).

2. The Health Insurance Commissioner for the State of Rhode Island (Commissioner) is authorized to examine the business affairs of health insurance carriers for compliance with applicable federal and state laws and regulations. RIGL § 27-13.1-1 et seq.

3. Health insurance carrier claims administration is subject to the requirements of RIGL § 27¬9.1, the Unfair Claims Settlement Practices Act: RIGL § 27-38.2-1, Insurance Coverage for Mental Illness and Substance Abuse; RIGL § 23-17.12, and other applicable state and federal laws and regulations.

4. A market conduct examination of health insurance carrier compliance with mental health and substance abuse laws and regulations (Examination) was ordered by the Commissioner on January 8, 2015. Tufts Health Plan is one of the carriers subject to the Commissioner's examination warrant.

5. The examination warrant appointed Linda Johnson and Herbert Olson, among others, as Examiners to represent the Commissioner. The Examiners utilized personnel within the Office and experts outside the Office to assist in the conduct of the examination, including John Garrett, Health Reform Specialist, and including certain behavioral health clinicians associated with Massachusetts General Hospital.

6. The Commissioner has concluded that the public health crisis facing Rhode Island regarding opioid dependence and related deaths necessitates immediate action to reduce unnecessarily delays in access to medically necessary treatment for patients with opioid dependence disorders. To address this crisis, the Commissioner requested that the Examiners consult with clinical experts to inform the development of policies designed to reduce delays in access to certain prescription drugs used to treat patients with opioid dependence disorders (commonly referred to as Medication Assisted Treatment or MAT). Tufts Health Plan wishes to collaborate with the Commissioner and the Examiners in their efforts to address the opioid crisis.

THEREFORE, Tufts Health Plan and OHIC hereby agree as follows:

1. Tufts Health Plan's Rhode Island pharmaceutical formularies will continue to include, at a minimum,

a. One buprenorphine combination Medication Assisted Treatment product approved for use by the FDA in the treatment of opioid use disorder (commonly known as buprenorphine/naloxone), in tablet or film form; and

b. One buprenorphine (mono-formulation) Medication Assisted Treatment product approved for use by the FDA in the treatment of opioid use disorder (commonly known as buprenorphine), in tablet or film form.

2. To the extent they exist, Tufts Health Plan shall discontinue any prior authorization requirements or programs for the formulary medications identified in Para. 1, above, no later than May 15, 2017, with the limited exceptions that:

a. Tufts Health Plan may propose the adoption of dose limit and supply limit criteria consistent with federal guidelines; however, any such dose or supply limit criteria must allow for the coverage of formulary Medication Assisted Treatment dispensed within FDA recommended dose guidelines without any prior authorization requirements while the prescribing clinician is provided the opportunity to clinically justify a dose outside the guidelines.

b. Tufts Health Plan may establish prior authorization requirements for a mono formulation MAT provided that coverage is provided for the mono formulation MAT for pregnant women without prior authorization.

3. In connection with: (i) a member that is already taking a MAT medication not identified in Para. 1, above, and (ii) a member that is already taking an MAT medication at a prescribed dose level outside the FDA recommended dose guidelines, Tufts Health Plan shall continue to permit such coverage while the prescribing clinician is provided the opportunity to clinically justify continued coverage through the formulary exception process.

4. This Agreement shall apply until the Commissioner issues a final examination order in the above-captioned matter, unless earlier amended with the agreement of the parties.

5. Nothing in this Agreement shall limit the authority of the Commissioner and the Examiners pursuant to RIGL § 27-13.1-1 et seq.

6. Nothing in this Agreement shall be construed to allege or admit to any violation of law or regulation by Tufts Health Plan.

OFFICE OF THE HEALTH INSURANCE COMMISSIONER
1511 PONTIAC AVENUE, BLDG 69-1
CRANSTON, RI 02920

In Re: Examination of Health Insurance Carrier Compliance
with Mental Health and Substance Abuse
OHIC-2014-3
Laws and Regulations
AGREEMENT

It is hereby agreed between the Rhode Island Office of the Health Insurance Commissioner (OHIC) and UnitedHealthcare Insurance Company, and UnitedHealthcare of New England, Inc. (collectively "United") as follows:

3. United is a health insurance carrier subject to the jurisdiction of the Commissioner. RIGL § 42-14-S(c) and (d).

2. The Health Insurance Commissioner for the State of Rhode Island (Commissioner) and examiners appointed by the Commissioner are authorized to examine the business affairs of health insurance carriers for compliance with applicable federal and state laws and regulations. RIGL §27-13.1-1 et seq.

3. Health insurance carrier claims administration is subject to the requirements of RIGL §27-9.1, the Unfair Claims Settlement Practices Act: RIGL §27-38.2-1, Insurance Coverage for Mental Illness and Substance Abuse; RIGL §23-17.12, and other applicable state and federal laws and regulations.

4. A market conduct examination of health insurance carrier compliance with mental health and substance abuse laws and regulations (Examination) was ordered by the Commissioner on January 8, 2015. United is one of the carriers subject to the Commissioner's examination warrant.

5. The examination warrant appointed Linda Johnson and Herbert Olson, among others, as Examiners to represent the Commissioner. The Examiners utilized personnel within the Office and experts outside the Office to assist in the conduct of the examination, including John Garrett, Health Reform Specialist, and including certain behavioral health clinicians associated with Massachusetts General Hospital.

6. The Examiners have reviewed and evaluated carrier policies related to prior authorization for certain prescription drugs used to treat patients with opioid dependence disorders (commonly referred to as Medication Assisted Treatment or MAT).

7. The Examiners acknowledge that United's prior authorization policies for Medication Assisted Treatment have been revised since the time frame being examined by the Examination. Notwithstanding the foregoing, the Examiners have concluded that the public health crisis facing Rhode Island regarding opioid dependence and related deaths necessitates

immediate action to reduce unnecessarily delays in access to medically necessary treatment for patients with opioid dependence disorders.

THEREFORE, United and OHIC hereby agree as follows:

1. United's pharmaceutical formularies must include, at a minimum,

a. One buprenorphine combination Medication Assisted Treatment product approved for use by the FDA in the treatment of opioid use disorder (commonly known as buprenorphine/naloxone), in tablet or film form: and

b. One buprenorphine (mono-formulation) Medication Assisted Treatment product approved for use by the FDA in the treatment of opioid use disorder (commonly known as buprenorphine), in tablet or film form.

2. United shall discontinue any prior authorization requirements or programs for the formulary medications identified in Para. 1, above, no later than May 15, 2017, with the limited exceptions that:

a. United may propose the adoption of dose limit and supply limit criteria consistent with federal guidelines; however, any such dose or supply limit criteria must allow for coverage of formulary Medication Assisted Treatment within FDA recommended dose guidelines without any prior authorization requirements while the prescribing clinician is provided the opportunity to clinically justify a dose outside the guidelines.

b. United may establish prior authorization requirements for a mono formulation MAT provided that coverage will be provided for the mono formulation MAT for pregnant women without prior authorization.

3. In connection with: (i) a patient that is already taking a MAT medication not identified in Para. 1, above, and (ii) a patient that is already taking an MAT medication at a prescribed dose level outside the FDA recommended dose guidelines, United shall continue to provide coverage for such treatment while the prescribing clinician is provided the opportunity to clinically justify continued treatment through the formulary exception process.

4. This Agreement shall apply until the Commissioner issues a final examination order in the above-captioned matter, unless earlier amended with the agreement of the parties. Nothing in this Agreement shall be construed to allege or admit to any violation of law. Nothing in this Agreement shall limit the authority of the Commissioner and the Examiners pursuant to RIGL § 27-13.1-1 et seq. to issue findings, recommendations and orders with respect to the subject matter of this Agreement.