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Federal Parity Law (MHPAEA): NQTL of In-Network Reimbursement Rates:
Non-Comparable Use of Factors of
Provider Leverage a/k/a Bargaining Power and Workforce Shortages

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I. Introduction

This Issue Brief is intended to inform readers of the authors' analysis of how some plans are defining and using "provider leverage", also known as ("a/k/a") "bargaining power", as a key factor to support disparately lower in-network reimbursement rates for MH/SUD providers as compared to M/S providers. Most plans use multiple factors in developing and applying provider network admission standards, including reimbursement rates. This Issue Brief is directed at the use of the specific factor of "provider leverage" a/k/a "bargaining power" and associated workforce shortages, as part of plans' development and application of provider network admission standards, particularly reimbursement rates, between MH/SUD and M/S benefits. The focus on provider leverage as a factor is not intended to minimize the importance of other factors. *It is important to note that any factor, evidentiary standard or methodology used to develop and apply in-network reimbursement rates must also be analyzed by examining the impact of such rates on MH/SUD network adequacy.*

Under the Mental Health Parity and Addiction Equity Act ("MHPAEA" or "federal parity law"), provider network admission standards, including reimbursement rates, are a "nonquantitative treatment limitation" ("**NQTL**") that must be applied *comparably and no more stringently, both in writing and in operation, for mental health and substance use disorder ("MH/SUD") benefits as compared to medical and surgical ("M/S") benefits*. This "comparability and no more stringency test" for NQTLs under the federal parity law applies to "factors" used by health plans and health insurance issuers (hereinafter "plans"), and how such factors are defined when plans develop and apply NQTLs to plan benefits.

In performing the required NQTL comparative analyses, "factors" relied on to develop and apply NQTLs *must be defined **in the same manner** for MH/SUD and M/S benefits*. The MHPAEA requirement of *comparability and no more stringency* is intended to ensure that any plan activity constituting an NQTL is performed in a non-discriminatory manner as between MH/SUD and M/S benefits.

This Issue Brief analyzes how some plans define and use the factor of "provider leverage" a/k/a "bargaining power" in ***different and inconsistent*** manners in setting network reimbursement rates for M/S providers as compared to MH/SUD providers – and how and why the non-comparable use of this factor is noncompliant with MHPAEA.

II. Plans' Opposite Approaches to Provider Leverage

Plans frequently state that M/S providers, who often operate in large groups, have a ***great deal*** of provider leverage, and that this is a key factor that drives the need to offer reimbursement rates high enough to incentivize an adequate number of such groups to join their M/S provider networks. Meanwhile, many of such plans also state that MH/SUD providers, who often practice alone or in small groups, have ***little*** provider leverage, which justifies ***not*** offering higher reimbursement rates to such providers. ***In contradiction***, however, when responding to concerns regarding the adequacy of their MH/SUD provider networks, many plans also state that they are unable to recruit MH/SUD providers into networks due to MH/SUD providers' unwillingness to join (frequently due to low reimbursement rates). An unwillingness to join networks is, of course, a clear demonstration of the significant provider leverage of many MH/SUD providers, whether part of a larger or smaller group practice. ***The ability to refuse low reimbursements exemplifies provider leverage (bargaining power).***

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In fact, some plans have stated that it is not possible to incentivize sufficient numbers of MH/SUD providers to join networks. For example, when plans have much higher out-of-network (OON) utilization for MH/SUD providers than for M/S providers, some plans have relied on the following points to **disclaim control** over behavioral health provider network adequacy:

- **Behavioral health workforce shortages**
- Behavioral health providers' **unwillingness to join networks**
- Market forces (such as **strong demand for MH/SUD services**)

All of these items underscore the strength of behavioral health provider leverage. When plans are faced with the same type of leverage for M/S providers, they typically **do not disclaim control** and instead recognize and respond to this factor by increasing reimbursement rates, as well as accelerating enrollment, to create and maintain adequate M/S networks. Some plans, though, have not acknowledged that the items above comprise the same type of provide leverage for behavioral providers as for M/S providers, thereby defining this factor differently. Further, these plans have **not** used the same "measures", such as increasing reimbursement rates and accelerating enrollment, to improve network adequacy for MH/SUD consumers. In this way, these plans are defining and using the factor of provider leverage a/k/a bargaining power in a non-comparable and more stringent manner for MH/SUD providers than for M/S providers in setting reimbursement rates - which is noncompliant with the federal parity law.

III. Provider Leverage (Bargaining Power) Explained

Provider leverage, or bargaining power, is best understood under circumstances in which one party has more leverage than another:

> "Inequality of bargaining power in law, economics and social sciences refers to a situation where one party to a bargain, contract or agreement, has more and better alternatives than the other party. This results in one party having greater power than the other to choose not to take the deal and makes it

more likely that this party will gain more favorable terms…"[1]

Provider leverage, or bargaining power, is primarily a result of "**supply and demand**" (sometimes referred to as "**competitive market forces**"). If there is high demand for a good or service and a relatively low supply, suppliers can "hold out" for a higher price. If there is modest demand and a large supply, buyers can negotiate a low price. In the healthcare context, a core function of health plans is to negotiate with providers (whether they have little or great leverage) to develop and maintain adequate networks. Network adequacy is, in fact, required and regulated by both state and federal laws, including MHPAEA.

IV. MHPAEA Requirements and Plans' Use of Provider Leverage as a Factor

As expressly stated in DOL's 2020 MHPAEA Self-Compliance Tool, to be compliant with MHPAEA, health plans "must take measures that are comparable to and no more stringent than those applied to medical/surgical providers to help ensure an adequate network of MH/SUD providers" (including increasing reimbursement rates). The Self-Compliance Tool provides:

> "***NOTE*** – Plans and issuers may attempt to address shortages in medical/surgical specialist providers and *ensure reasonable patient wait times* for appointments by adjusting provider admission standards, through *increasing reimbursement rates*, and by developing a process for accelerating enrollment in their networks to *improve network adequacy*. *To comply with MHPAEA*, plans and issuers *must take measures that are comparable to and no more stringent than those applied to medical/surgical providers to help ensure an adequate network of MH/SUD providers,* even if ultimately there are disparate numbers of MH/SUD and medical/surgical providers in the plan's network…"[2] (Emphasis added).

To comply with MHPAEA, "plans and issuers must take measures that are comparable to and no more stringent than those applied to medical/surgical providers to help ensure an adequate network of MH/SUD providers." 2020 Self-Compliance Tool.

V. Out-of-Network Use Disparities Highlight MH/SUD Network Inadequacy

Multiple surveys and insurance claims analyses have shown the high levels of out-of-network ("OON") use of MH/SUD providers as compared to M/S providers, which is a significant indicator of lack of network adequacy. These significant disparities in consumers' access to in-network MH/SUD providers is additional confirmation of the bargaining power that MH/SUD providers do, in fact, have. Milliman, Inc., a nationally recognized actuarial firm, analyzed all health care claims for 37,000,000 members enrolled in commercial PPO plans[3]. This claims analysis demonstrated that:

(1) Nationally, the average in-network reimbursement for primary care professional office visits from commercial insurers was approximately *20% above* Medicare reimbursement, and OON use of such visits was approximately 3% (i.e., 3% of all claims were paid to OON providers). ***So, even though there is an overall shortage of primary care providers in our country, within insurer networks there was no evidence of a shortage.***

[1] Wikipedia: https://en.wikipedia.org/wiki/Inequality_of_bargaining_power
[2] Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) (dol.gov)
[3] Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement (milliman.com)

(2) Nationally, the average in-network reimbursement for ***MH/SUD*** professional office visits from commercial insurers was approximately ***2.5% below Medicare*** reimbursement, and ***OON use*** of such visits was approximately 17%, i.e., ***5.4 times higher than for primary care providers***. In several states, this disparity was 10 times higher. For adolescents nationally, OON use of adolescent MH/SUD providers was 10 times higher than for pediatric providers.

Nationally, the average in-network reimbursement for MH/SUD professional office visits from commercial insurers was approximately 2.5% below Medicare reimbursement, and OON use of such visits was approximately 17%, i.e., 5.4 times higher than for primary care providers.

Nationally, the average in-network reimbursement for primary care professional office visits from commercial insurers was approximately 20% above Medicare reimbursement, and OON use of such visits was approximately 3%.

VI. Workforce Shortages Data for both M/S and MH/SUD

The degree to which a specific M/S or MH/SUD provider has provider leverage (bargaining power), can be understood in part by assessing, in any given market, the overall supply of M/S and MH/SUD providers in comparison to the demand for M/S and MH/SUD services, respectively. The federal government Health Resources and Services Administration (HRSA) analyzes: (a) supply and demand for both MH/SUD and M/S providers; and (b) inadequate access to healthcare throughout the country. HRSA identifies "Health Provider Shortage Area" (HPSA) designations, which indicate that demand far exceeds supply. As reported by Kaiser Family Foundation, **this national data as of Sept. 30, 2021 shows more shortages for PCPs than for mental health providers (7447 vs. 5930 shortage areas).** [4]

As reported by Kaiser Family Foundation, national data as of Sept. 30, 2021 shows more shortages for PCPs than for mental health providers (7447 vs. 5930 shortage areas).

The Association of American Medical Colleges (AAMC) has projected a deficit of up to 124,000 physicians in the U.S. by 2034. While this projection includes a deficit of up to 48,000 primary care physicians, the AAMC projects an even larger deficit of 76,000 specialist physicians.[5]

A study by Bishop et al.,[6] indicated that approximately **90% of primary care** physicians were in commercial insurer networks. The same study estimated that **only 55% of psychiatrists** were in commercial networks. Thus, while there is **overall** shortage of both MH/SUD providers and PCPs, there is **no** shortage of **PCPs within** insurer networks, while there is a **significant shortage** of **MH/SUD** providers **within** insurer networks. It is clear that plans have not responded to MH/SUD provider leverage as they do for M/S providers – i.e., by increasing rates offered to OON MH/SUD providers in order to incent them to join networks.

It is important to note that despite relative shortages of MH/SUD providers in certain geographic areas, the Milliman OON use claims analysis demonstrates that there are thousands of OON MH/SUD providers

[4] https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[5] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034 (aamc.org); AAMC Report Reinforces Mounting Physician Shortage | AAMC

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3967759/

delivering services to insured members. Therefore, if a larger percentage of MH/SUD providers were incented to join networks, the MH/SUD "in-network shortage" would be materially mitigated.

As stated by HHS' Office of Assistant Secretary for Planning and Evaluations ("ASPE") in its 2021 report entitled *Network Adequacy for Behavioral Health: Existing Standards and Considerations for Designing Standards*: **"Low reimbursement rates and burdensome credentialing and documentation requirements may discourage behavioral health providers from contracting with health plans."**[7]

VII. State Parity Regulator Rejected use of Bargaining Power to Justify Low Reimbursement for MH/SUD Providers

The authors point out that the New Hampshire Insurance Department (NHID) rejected Anthem's reliance on bargaining power as a factor to justify higher reimbursement rates for M/S providers compared to MH/SUD providers. In its Market Conduct Targeted Examination of MHPAEA compliance as of Jan. 2020, NHID determined that:

> "To the extent that the Company [Anthem] attributed the vast differences in commercial-to-Medicare payment ratios between Med/Surg services and MH/SUD services to differences in bargaining power between MH/SUD providers on the whole and Med/Surg providers on the whole, this explanation of its practices does not support a finding that it applied a consistent, non-arbitrary, and non-discriminatory methodology…"
>
> "While reimbursement rates need not be identical, a consistent pattern of reimbursing MH/SUD providers at a lower level as compared to a standard resource-based payment methodology is evidence that a more stringent treatment limitation is being applied to MH/SUD services. The Company's position is that MH/SUD providers are less likely to be affiliated with a large practice group and thus have less bargaining leverage, leading these providers to accept lower rates. This position implies that market forces require the carrier to contract with large group practices, but that demand for MH/SUD providers and their services is comparatively weak. The Company did not provide evidence supporting this position."[8]

"[D]ifferences in bargaining power between MH/SUD providers on the whole and Med/Surg providers on the whole does not support a finding that it applied a consistent, non-arbitrary, and non-discriminatory methodology…" NHID.

VIII. Conclusion

There are multiple strategies that plans can use to recruit MH/SUD providers to join networks, including "increasing reimbursement rates", and "accelerating enrollment in their networks"[9], fast tracking the credentialing process, prompt payment on claims, reducing burdensome UR requirements, etc. The fact that some plans define and utilize the factor of provider leverage a/k/a bargaining power differently for M/S as compared to MH/SUD providers, leading to opposite approaches to in-network reimbursement rates, results in a non-comparable and more stringent reimbursement methodology and rates for MH/SUD providers. This also contributes to significant inadequate network access, and higher financial burden for

[7] Network Adequacy for Behavioral Health: Existing Standards and Considerations for Designing Standards | ASPE (hhs.gov)
[8] anthem-parity-exam-final-report.pdf (nh.gov)
[9] Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) (dol.gov)

MH/SUD consumers, which is highlighted by higher OON provider use by such consumers. This is clearly noncompliant with the federal parity law.

The fact that some plans define and utilize the factor of provider leverage (bargaining power) differently for M/S as compared to MH/SUD providers, leading to opposite approaches to in-network reimbursement rates, results in a non-comparable and more stringent reimbursement methodology and rates for MH/SUD providers.

About the Authors: Dr. Henry T. Harbin and Beth Ann Middlebrook, J.D. have extensive experience and expertise in the area of MHPAEA compliance, particularly, NQTLs. Select parity-related experience includes:

Dr. Henry T. Harbin and Beth Ann Middlebrook, J.D. have been providing input on MPHAEA regulations and enforcement to DOL/HHS/IRS beginning 2009 to the present. They have Informed federal agencies on regulatory and sub-regulatory processes with numerous submissions of exemplar FAQs, best practice analyses, consumer parity disclosure templates, and presentations on scope of services and non-quantitative treatment limitation (NQTL) implementation and enforcement. They are co-authors of the "Six Step" Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements, published by the American Psychiatric Association, The Kennedy Forum and Parity Implementation Coalition (Sept. 2017). They are advisors to The Bowman Family Foundation and have assisted in developing the Milliman research reports on disparities in key NQTL operational measures. They are currently advising several state insurance regulators on best practices for NQTL examinations, including reviews of carrier NQTL submissions.

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This Issue Brief is the opinion of the authors and does not purport to represent the views of state or federal regulators, issuers of insurance or administrators of insurance plans.

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