Access to Mental Health Services for All Ohioans

HB 443 - Mental Health Parity

Primary Sponsors: Representatives Phil Plummer (R) District 40 and Allison Russo (D) District 24
Co-Sponsors: Representatives Gil Blair, Kristin Boggs, Janine R. Boyd, Juanita Brent, Randi Clites, Jeffrey Crossman, David Leland, Michele Lepore-Hagan, Mary Lightbody, Beth Liston, Don Manning, Adam C. Miller, Jessica Miranda, Phil Robinson, Gary Scherer, William Seitz, Michael Skindell, Kent Smith, Lisa Sobecki, Fred Strahorn, Bride Rose Sweeney, Terrence Upchurch, Casey Weinstein, Thomas West

According to the 2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Health Insurance companies are not allowed to have any restrictions on mental health coverage that they do not impose on physical health coverage.

The lack of access to mental health services is a contributing factor in several trends in the country in Ohio.

- The lack of access has contributed to a 55% increase in emergency room admission from 2006 to 2013.
- 25% of those discharged from Mental Hospitals are re-hospitalized for the same reason, due to a lack of follow up in the community.
- From 2017 to 2018, Ohio experienced a 25% increase in suicides.

Historically, the healthcare industry has viewed mental health and substance use issues as less critical. This is the case despite the fact that mental health issues underlie many chronic physical health problems, such Chronic Pain, Diabetes and Coronary care.

Right now, our ability to respond to the opiate crisis is restrained by limitations the health insurance industry imposed on substance abuse treatment.

> *The federal court finding against United Health Care in California was based on this latter problem. Patients were being released from their substance use treatment too soon, thereby setting them up for relapse, because the insurance company determined more extended treatment was not "medically necessary."*

QUANTITATIVE LIMITATION

Limit's on the length of care, copays, and deductible are example of the kind of limitations the MHPAEA Act sought to eliminate. Even though they are the clearest and most easily identified, these types of differential limits are still being imposed.

- Limits set on number on outpatient mental health or substance treatment visits per year.
- Overly strict limits set on inpatient or intensive outpatient treatment (patients being released from treatment too soon, setting them up for relapse).

INSURANCE PROCEDURES THAT CAN LIMIT COVERAGE (NON-QUANTITATIVE LIMITS)

Although on their face, a policy may look fair and balanced, however in practice the ways companies make coverage decision can lead significant limitations of their mental health coverage.

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Prior authorization: Insurance companies require prior authorization for certain crucial services, such as

- Hospital Detox (checking)
- Length of Stay in Inpatient/Residential treatment or
- Extended therapy session (1 hour) or more frequent sessions,
  - For example with suicidal patient, PTSD or one experience panic attacks
- Psychological Testing
  - Insurance companies seldom restrict physician's or other health care providers from ordering routine lab tests to rule-out various disorders. However, in mental health these restrictions are commonplace.

The Example of prior authorization in psychological testing
On paper, and per their policy, Health Insurance companies may state "We cover psychological testing. It just needs to be preauthorized." In practice, the barriers imposed create requirements and hoops which drain providers or the time, to limit their use.

Medical Necessity: All insurance companies state that the treatment they cover must be "medically necessary". Care is limited by how they define medically necessity. In the hands of a profession, medical necessity is a health care standard. However, in the hands of the insurance industry, this can be used as a mean of limiting needed care in order to maximize profits.

To the degree that accountants and financial experts are allowed to define medical necessary, the art of health care, concern for patient welfare, and the public good of having insurance are lost.

- If those standards are too strict, an individual may quite validly need certain treatment (as determined by the professional in question) but be deemed not "medically necessary" (as determined by the insurance company).
  - Examples of this would be
    - length of inpatient stay (described above) or
    - frequency of outpatient visits.

Provider Networks: The procedures for limiting the number of providers on their panel are another non-quantitative way the Insurance Companies limits access. When Mental Health provider networks are smaller and more restrictive than physical health networks, this limits access. By not having available providers in-network, Insurance companies push consumer's to pay more for out-of-network care.

For an insured to receive full benefits, they must obtain care from a "in-network provider. Otherwise they must use "out of network benefits", at significantly higher cost. Two factors are highly relevant to this circumstance:

1. Due to below market rates reimbursement, panels are frequently too small to meet the consumer needs
2. Insurance companies strictly limit the number of mental health professionals allowed on these panels. (Are these saying the same thing)
   - Most insurance company's mental health panels are considered woefully inadequate,
   - These panels may contain providers, who are no longer in the area or practicing, or are inadequate to meet the amount of demand for services in your area.

Access to Mental Health Services for All Ohioans

HB 679
Establish/Modify Requirements for Telehealth Services

Primary Sponsors: Representative Mark Fraizer (R) District 71 and Representative Adam Holmes (R) District 97
Co-Sponsors: Representatives Cindy Abrams, Jim Butler, Rick Carfagna, Sara Carruthers, Jeffrey Crossman, Al Cutrona, Jay Edwards, Tavia Galonski, Haraz N. Ghanbari, Diane V. Grendell, Jeff LaRe, Laura Lanese, Beth Liston, Joe Miller, Michael J. O'Brien, John Patterson, Thomas F. Patton, Rick Perales, Phil Plummer, Phil Robinson, John M. Rogers, Allison Russo, Gary Scherer, William Seitz, Jason Stephens and D. J. Swearingen

RATIONALE:

- During the current COVID 19 crisis, Telebehavioral health services have been essential for many Ohioans.
- For many Teletherapy has become the only means of treatment for those affected by the crisis and those with pre-existing mental health issues.
- Telebehavioral health has opened up services to those who previously could not get to their therapists office due to disability and transportation problems.
- Access to Telebehavioral health has decreased lost productivity for those in rural Ohio, eliminating the need to drive 1-2 hours to get competent and qualified mental health treatment.
- This has also opened up Ohioans access to specialist throughout the state, eliminating the barrier created by distance.
- For the majority of Ohioans the only way they can access competent, affordable telebehavioral health is if their insurance covers this service.
- Most insurance companies have been very responsive to the COVID-19 crisis. However, there is no requirement that they continue to cover these teletherapy service.
- Many Ohioans receive services through self-funded insurance plans, some of which do not cover telebehavioral health services.
- Currently, Telebehavioral Health Services could be discontinued at anytime leaving Ohioan's without access to treatment.

H.B. 679 would address these issues/concerns, creating more certainty for Ohioans, insuring they can receive safe and effective care, while providing certainty and stability in market.

PSYCHOLOGY INTERJURISDICTIONAL COMPACT

PSYPACT

The demand for telepsychological services has grown dramatically during the current COVID-19 crisis. It has provided a means to assist those dealing with the stress of isolation, loss for loved ones and employment, and provided continuity of care for those with ongoing behavioral health needs. PSYPACT will expand teletherapy access for Ohioans to the highest trained providers.

WHAT ARE THE BENEFITS OF PSYPACT TO OHIOANS?

Currently, state laws provide little, if any, protection for consumers when psychological services are provided electronically across state lines. PSYPACT is a cooperative agreement enacted into law by participating states that:

- Increases patient access to care
- Assists with continuity of care when a patient relocates or travels
- Provides a mechanism for psychologists to practice electronically across state lines
- Certifies psychologists meet acceptable standards of practice
- Promotes cooperation and communication between PSYPACT states in the areas of licensure and consumer complaints
- Offers consumers protection when psychological services are provided electronically across state lines

HOW WOULD PSYPACT WORK IN OHIO?

Eligible psychologists apply for and are issued an E.Passport by the Association of State and Provincial Psychology Boards (ASPPB). The E.Passport assures that psychologists in participating states meet licensing standards and are knowledgeable of providing services electronically.

Psychologists with an E.Passport may provide psychological services electronically from Ohio to citizens located in other PSYPACT states. Similarly, psychologists from other PSYPACT states may provide services electronically from their home states to citizens in Ohio.

In the event a consumer complaint is filed against an Ohio psychologist from another PSYPACT states, the Ohio State Board of Psychology will consider the complaint and, if necessary, take appropriate action, including revoking the psychologist's permission to provide telepsychology services in Ohio.

CAN PSYCHOLOGISTS PRACTICE IN-PERSON IN OTHER PSYPACT STATES?

The PSYPACT has a component that would allow eligible psychologists to temporarily practice in-person for up to 30 days per calendar year in other PSYPACT states.

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