Ensuring Quality Coverage for Mental Health and Substance Use Disorders

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About LAC and the CWH

- Legal Action Center
  - National law and policy organization that works to fight discrimination against people with histories of addiction, HIV/AIDS, or criminal records
  - Works for sound public policies in these areas, including policies to ensure access to the full range of needed substance use disorder services
- Coalition for Whole Health
  - A coalition of over 100 national, state, and local organizations in the mental health and substance use disorder fields and allied organizations working to ensure health reform is successfully implemented for individuals with mental health and substance use disorder needs

What I'll talk about today

- Essential Health Benefits (EHB) and the ACA's mental health (MH) and substance use disorder (SUD) benefit requirements
- States' role in defining EHB, including requirements and flexibility
- Covering the continuum of MH/SUD services
- Need for state-level advocacy and strategies for ensuring quality coverage

The ACA's MH and SUD Benefit Requirements

- MH and SUD services are required essential health benefits
  - Must be provided by all non-grandfathered small group and individual market plans, inside and outside the exchanges
  - Must be provided at parity with other benefits
- As a result of the framework HHS has designed to define EHB, there will likely be a fair amount of benefit variability across states, and even some variation across plans
- Ensuring access to the full range of MH/SUD services is a top priority for the Coalition for Whole Health

Defining Essential Health Benefits

- All states selected, or had selected for them, a "base-benchmark plan"
- States had ten options to choose from, including three small-group plans; default was the largest small-group plan in the state
  - Only about five states have large-group benchmarks
- All categories of EHB must be covered, and the regulations provide a framework for substituting missing categories
- The benchmark plan is the starting point; the ACA and regulations include some additional protections and allow states and plans some additional flexibility

Benefit Flexibility

- Plans are required to add in missing benefits under certain circumstances, particularly related to MH/SUD parity and other ACA protections
- Plans have some flexibility to reduce or even eliminate benchmark-covered benefits, if the state allows it
  - Coverage must be "substantially equal" to the benchmark
  - Regulations permit substitution within benefit categories, but give states ability to limit or prohibit substitutions
  - Any substitutions must be actuarially equivalent
- States and regulators should use the framework to ensure plans provide quality coverage in each of the EHB categories, including the MH/SUD category

Covering the Continuum of MH/SUD Services

- Adequate MH/SUD coverage addresses the full continuum of care for these illnesses, covers services to meet enrollees' multiple needs, and recognizes that no single treatment is effective for all individuals
- The CWH, SAMHSA, and others have developed MH/SUD benefit recommendations

Messages for State Policy Makers

- States have primary enforcement of the EHB
- Identify and meet with the appropriate officials in your state
- Regulators are reviewing plan proposals now, and they need to hear from advocates on the importance of these issues
  - Coverage should be adequately comprehensive to meet the full array of needs of all plan enrollees
  - Especially strong oversight needed for coverage of complex illnesses, including MH/SUD
- Regulators must refuse to certify plans that fall short of federal and state requirements

Reviewing Documents

- Plan documents will soon become available, and plans that are out of compliance with ACA and state requirements will need to be corrected
- Identify potential federal or state requirements that may be violated (such as parity or non-discrimination)
- Work with regulators to ensure compliance
- Advocates should document benefit shortcomings; HHS is relying on us for help informing their oversight responsibilities and EHB next steps

Ensuring Good Access to MH/SUD Care: Meeting the Parity and Other Consumer Protective Requirements of the ACA

Gabrielle de la Guéronnière,
Legal Action Center

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What I'll Discuss Today

- The MH/SUD (mental health and substance use disorder) parity requirements of the ACA
  - Background on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and major provisions of the parity law
- Non-discrimination and other consumer protections of the law
- Messages for state policy-makers

Pre-ACA background on the federal MH/SUD parity law

- Congress's attempt to eliminate certain forms of discrimination in insurance coverage of MH/SUD treatment benefits and to expand access to care
- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) became Public Law 110-343 in October 2008

Pre-ACA background on the federal MH/SUD parity law (cont'd)

- Prohibits large group health plans that offer MH and/or SUD benefits from providing those benefits in a more restrictive way than other medical and surgical procedures covered by the plan
  - Includes: fully insured and self-insured plans, and Medicaid managed care plans
  - Does not require MH/SUD coverage, doesn't apply to individual and small group plans
  - Existing parity rule includes a framework related to scope of services but more guidance is needed

Pre-ACA background on the federal MH/SUD parity law (cont'd)

- State laws providing greater consumer protections not preempted by MHPAEA
- Currently governed by MHPAEA statute, the Interim Final Rule on MHPAEA (issued January 2010)
  - Final MHPAEA rule is still due…expected out "soon"
- States share jurisdiction of the federal parity law with three federal agencies; States charged with primary jurisdiction

How does the ACA change the impact of the federal parity law?

- Huge potential to improve coverage for and access to MH/SUD care with the ACA

- The ACA builds on the parity law by:
  - Extending the requirements of the federal parity law to qualified health plans and non-grandfathered individual and small group plans outside the exchanges
  - Requiring coverage of MH and SUD benefits as Essential Health Benefits

How does the parity law work?

- The parity law prohibits:
  - Separate cost-sharing requirements or treatment limitations that are only imposed on SUD or MH benefits
  - Separate plans or benefit packages
- The central test to determine whether parity is met:
  - Health plans applying financial requirements or treatment limitations to SUD or MH benefits that are more restrictive than those applied to other covered medical/surgical benefits could violate parity
  - Specific framework discussed in the Interim Final Rule on MHPAEA

More restrictive financial requirements imposed on MH/SUD benefits could violate parity

- Financial requirements
  - Deductibles
  - Copayments
  - Coinsurance
  - Out-of-pocket maximums

More restrictive treatment limitations on MH/SUD benefits could violate parity

- Both quantitative treatment limitations and non-quantitative treatment limitations must be evaluated for parity purposes
- Quantitative treatment limitations
  - Day or visit limits
  - Frequency of treatment limits
- Non-quantitative treatment limitations
  - Medical management standards and criteria**
  - Prescription drug formulary design**
  - Fail-first policies/step therapy protocols
  - Standards for provider admission to participate in a network
  - Determination of usual, customary and reasonable amounts
  - Conditioning benefits on completion of a course of treatment

Messages to state policy-makers on the parity requirements of the ACA

- The product seeking certification must provide coverage for MH and SUD benefits, as required by the ACA
- The plan's MH/SUD coverage must comply with the ACA's parity requirements
  - No separate financial requirements or treatment limitations only applied to MH/SUD benefits
  - Financial requirements and treatment limitations imposed on the MH/SUD benefits shouldn't be more restrictive than those imposed on other covered medical/ surgical benefits

Messages to state policy-makers on the parity requirements of the ACA (cont'd)

- A plan with a more limited scope of MH/SUD benefits, compared with the plan's coverage of other medical/ surgical benefits, could indicate a problem with parity

- The ACA requires that coverage that doesn't meet the parity requirements must be brought into compliance with the law

ACA provisions related to non-discrimination and other consumer protections

- Language in the ACA offering protections for people with disabilities and people representing diverse segments of the population
- Additional protections for vulnerable individuals to raise in our outreach and advocacy

Messages to state policy-makers on the non-discrimination requirements of the law

- The plan's benefits must not be designed and/or managed in a way that discriminates against people with disabilities, including people with MH/SUD
- The benefits provided by the plan must address the health care needs of diverse segments of the population

Messages to state policy-makers on additional requirements of the law

- The plan's MH/SUD coverage must comply with the ACA's typical employer coverage requirement
- The plan's MH/SUD benefits category must not be significantly weaker than the other categories
- *If a plan's MH/SUD coverage fails to comply with any of the above-discussed provisions, the coverage should be adjusted to bring it into compliance with the law*

Additional thoughts

- Importance of working in coalition to strengthen our collective voice and support each other's work
- Additional resources on MH/SUD coverage and access for local advocates at: www.coalitionforwholehealth.org
- Thank you!!!

Discussion and Questions

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www.coalitionforwholehealth.org

Network Adequacy for Mental Health And Substance Use Disorder Providers

Claire McAndrew

September 3, 2013

Network Adequacy Goal

A health plan should have:

-The right kinds of providers

-In the right places

-Available at the right times

-In sufficient quantity to meet enrollee needs in a timely manner

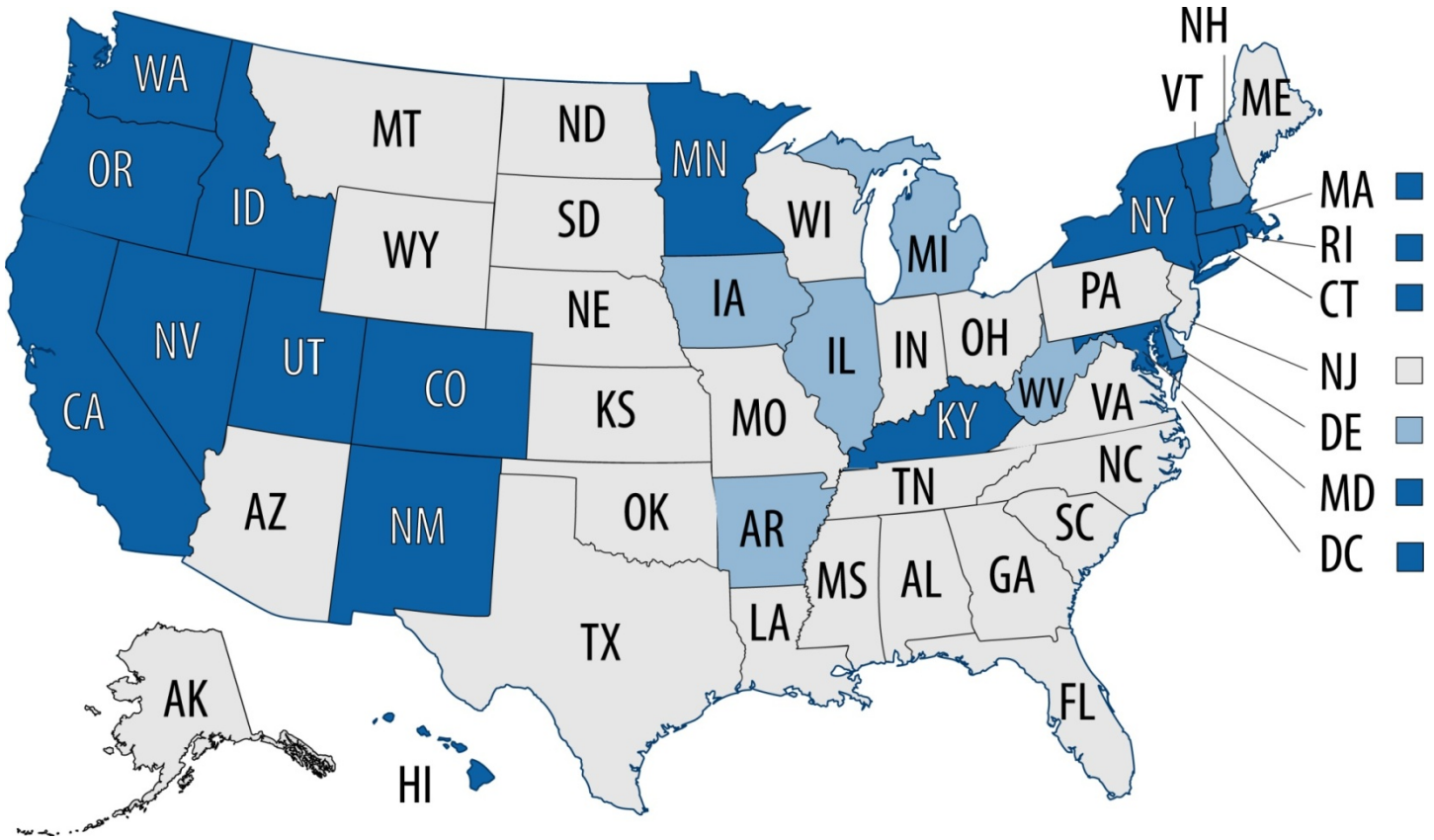
ACA: Network Adequacy

All qualified health plans (QHPs) must have a network that is sufficient in the number and types of providers, **including providers that specialize in mental health and substance abuse services,** to assure that all services will be accessible without unreasonable delay.

Implementing Network Adequacy Standards

- ACA outlines broad requirements
- State-based and partnership exchanges: State implements
- FFE: Federal government implements

Marketplace Decisions



Dark Blue: State Exchange

Gray: FFE

Light Blue: Partnership Exchange

Credit: Dave Chandra, Center on Budget and Policy Priorities

Implementing Network Adequacy

- **Could just ask QHPs to attest, or show accreditation**
  - Is that sufficient?
- **CWH recommendation**:
  - Detailed network adequacy review at the time of plan certification, at least annually thereafter, and whenever there are general changes in a plan's network
  - Demonstration of compliance with specific standards

Network Adequacy Standards

Consider:

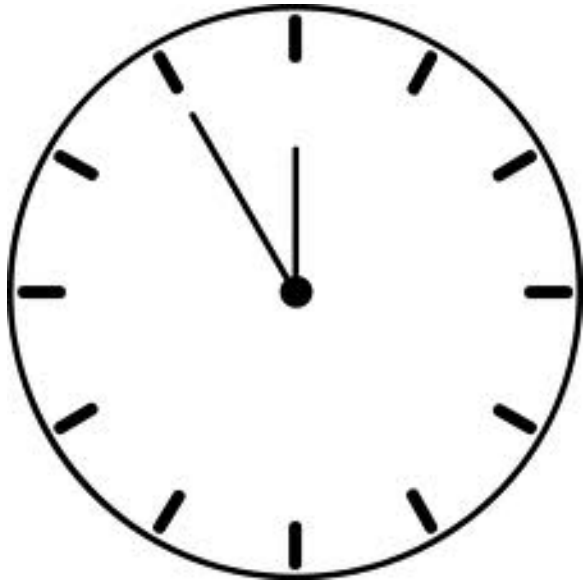
- Travel time/distance standards
- Provider: Enrollee ratios
- Appointment wait-time standards
- Hours of operation standards
- Access to out-of-network services at in-network rates when in-network care is unavailable

Travel Time/ Distance Standards

- **CWH Recommendation**
  - Should have at least two MH and two SUD providers, for each point along the continuum for these illnesses, within specified urban, suburban, and rural distances for at least 90 percent of enrollees.
  - Standards should also incorporate factors such as accessibility by public transportation and for people with disabilities.
- **Vermont**
  - Access to a PCP and **office-based mental health and substance abuse services** within 30-minute drive.
- **Delaware**
  - Provider: Patient Ratio**-** QHPs must have at least one primary care provider for every 2,000 enrollees

Appointment Wait-Time

- **CWH Recommendation**
  - Enrollees able to access providers within 24 hours for urgent MH and SUD needs; within 10-14 days for routine care.
- **Vermont**
  - Non-emergency, non-urgent care within two weeks.



Hours of Operation

- **CWH Recommendation**
  - Network should have 24-hour service availability when medically necessary
- **California**
  - Networks must offer access to care at least 40 hours/ week AND until 10 PM on at least one weekday or at least 4 hours on a weekend day (applies to PPOs)

Network Adequacy in the FFE (2014)

- State analyses when possible
- In states without review, rely on accreditation.
  - Unaccredited issuers must submit access plans.
- HHS will monitor network adequacy
  - Complaint tracking
  - QHP data

Provider Directories

- **ACA requires:**
  - QHP provider directories available for online publication by exchange and in hard copy on request
  - Identification of providers that are not taking new patients
- **Ideal: Integrated Directory: Search by provider, integrated updates**
  - California
- **Real-time Updates: Good faith effort**
  - Require regular updates (example: every two weeks)
  - Develop system to allow reporting of inaccuracies

Contact and Key Resource

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Consumer-Friendly Standards for Qualified Health Plans

http://familiesusa2.org/assets/pdfs/health-reform/Consumer-Friendly-Standards-in-Exchange-Plans.pdf

FamiliesUSA
The Voice for Health Care Consumers

Monitoring and Enforcement

- **CWH Monitoring Recommendation**
  - Each plan must have a system to monitor its network and develop procedures to react to impending and ongoing changes in its network
- **Secret Shopper:** Directories, wait-times, etc.

- **Enforcement- Consider:**
  - Tier 1: Notice to plan; opportunity to correct
  - Tier 2: Financial penalties, restricting service area, hold on sale of new policies
  - Tier 3: Suspension or revocation or QHP certification or even license