

# Ensuring Health Plans Meet ACA Standards for Access to Needed Mental Health and Substance Use Disorder Services

## A Toolkit for State-Level Advocates

The health insurance coverage expansion provisions of the Affordable Care Act (ACA) will begin to go into effect in January, with enrollment beginning in October. As private health insurance coverage is expanded, seventeen states will operate their own health insurance exchanges and will therefore be responsible for certifying the Qualified Health Plans (QHPs) that will operate in these exchanges. In addition, seven partnership exchanges will have ongoing plan management responsibilities, as will a handful of other federally run exchanges. Health plans seeking to become QHPs on the exchange must meet a number of consumer-protective requirements in federal and state law, and states have a considerable amount of flexibility to define criteria required for certification. Non-grandfathered plans sold to individuals and small businesses outside of exchanges also must comply with a number of new consumer protection standards. **Strong advocacy in the states is needed this summer and fall to ensure that enrollees in private plans will be able to appropriately access needed mental health (MH) and substance use disorder (SUD) services, as envisioned by the Affordable Care Act.**

To ensure that there is good access to MH and SUD care in the commercial market, between now and the end of 2013 it is important that affiliates and partners of national Coalition for Whole Health member organizations advocate with insurance commissioners, exchange board members, and other key policy-makers to ensure enrollees in exchange plans will be able to appropriately access needed MH and SUD services.

The purpose of this toolkit is to provide advocates with the materials they need to advocate with state officials responsible for health plan certifications, licensing, and oversight. The materials will focus on three main plan certification priorities of the Coalition:

1. Essential health benefits, including the use of any allowed flexibility to improve coverage for MH/SUD services rather than potentially undermine the continuum of care;
2. MH/SUD parity and meeting the other consumer protection requirements of federal law; and
3. Network adequacy requirements, including the requirement that provider networks be sufficient to allow access to MH/SUD services without unreasonable delay.

As states begin to certify plans as QHPs and oversee plans generally for ACA compliance, it is important for advocates representing individuals with MH/SUD to effectively work to ensure appropriate coverage for these illnesses. Although in most states detailed plan information is not yet publicly available, work this summer to educate insurance commissioners and other key state policy-makers about how best to ensure good access to MH and SUD care is extremely important.

This toolkit is intended to provide state advocates with the information they need to advocate for the three main priorities the Coalition has identified. This toolkit also includes

guides for MH/SUD stakeholders on working with insurance commissioners and state legislators. In addition, it is important for advocates to familiarize themselves with any state-specific benefit mandates, parity laws, network adequacy requirements, or other MH/SUD related requirements that QHPs operating in their state must meet.

Later this year, specific plan details will be made available in all states, including states with federally-facilitated exchanges. Over the coming months, the Coalition will develop additional materials to help state-level advocates to evaluate plans for MH/SUD coverage, identify instances and patterns of noncompliance with parity and other protections, and report potential violations.

Additional resources are available at [www.coalitionforwholehealth.org](http://www.coalitionforwholehealth.org). Please feel free to contact Dan Belnap ([dbelnap@lac.org](mailto:dbelnap@lac.org)) or Gabrielle de la Gueronniere ([gdelagueronniere@lac-dc.org](mailto:gdelagueronniere@lac-dc.org)) at Legal Action Center with any questions.

## Part I: MH and SUD Benefit Recommendations

Background: Before an insurance company can sell products on the exchange it must be certified as a Qualified Health Plan issuer, and to be certified it must meet a number of requirements under federal law. This includes the requirement that its proposed products for the exchange provide coverage for the ten categories of Essential Health Benefits (EHB) in the ACA, including mental health and substance use disorder benefits. These requirements also apply to non-grandfathered health plans sold to individuals and small businesses outside of exchanges. The EHB requirements vary by state and are based on a state-specific “benchmark plan.” However, the federal regulations governing the EHB requirements allow states and health plans some flexibility to deviate from the coverage offered by the benchmark plan, and states should use the available flexibility to ensure plans provide quality coverage of all medically necessary services across the continuum of care in each of the EHB categories, including the MH/SUD category.

Messages for state policy-makers: As regulators review health plan proposals, it is extremely important that they ensure adequate coverage of complex illnesses, including MH/SUD, and refuse to certify plans that fall short. To be certified, health plans must comply with federal and state laws and be adequately comprehensive to meet the full array of needs of all plan enrollees.

Adequate MH and SUD coverage addresses the full continuum of care for these illnesses, covers services to meet plan enrollees’ multiple needs, and recognizes that no single treatment for mental illness and substance use disorders is effective for all individuals. As states move forward to certify health plans for participation on the exchanges and to assess general compliance with ACA requirements, each product’s coverage of mental health and substance use disorder services should include, at a minimum, the following Coalition for Whole Health recommended benefits<sup>1</sup> to adequately address MH/SUD:

- Outpatient treatment, such as assessment, treatment planning, laboratory services, individual, group, and family evidence-based psychotherapy services, and appropriate medication prescribing and monitoring. Outpatient treatment should also cover screenings, referral, and ambulatory detoxification.
- Inpatient hospital services, including detoxification and psychiatric stabilization services.
- Intensive outpatient services, including partial hospitalization services.

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<sup>1</sup> The Coalition for Whole Health list of recommended mental health and substance use disorder services follows the benefits outlined in the Coalition’s [“EHB Consensus Principles and Service Recommendations,”](#) a set of benefit recommendations released by the Coalition and endorsed by over 150 national, state, and local organizations in the MH/SUD fields. These recommendations are similar to other MH/SUD benefit recommendations that have been developed, including those outlined in the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) [“Description of a Good and Modern Addictions and Mental Health Service System.”](#) They are based on a review of which MH/SUD services have typically been offered through employer plans and on evidence-based practices that are effective and necessary to help people get well and stay healthy.

- Intensive home-based treatment, including services for children and adults with serious mental illness and/or substance use disorders such as counseling, behavior management, and medication management.
- Crisis services, including emergency room crisis intervention, stabilization, and mobile crisis services.
- Residential substance use disorder treatment, including all services related to sub-acute residential substance use disorder treatment that corresponds to the American Society of Addiction Medicine's care level III.
- Prescription drug coverage of all appropriate medications for mental health and substance use disorders.
- Psychiatric rehabilitation skills training and related services to address functional impairments, and rehabilitative services designed to avoid institutional placement for children and adults with severe mental illness.
- Recovery support services, including peer support and coaching.
- Prevention, early identification, and treatment services, including age appropriate outpatient, inpatient, and home-based pediatric mental health and substance use disorder prevention services, screenings, treatment, recovery, and rehabilitative services.
- Additional preventive and wellness services that include home visiting programs, consumer and family education services related to healthy lifestyles and substance use prevention, other prevention services required by the ACA, and education and skills training.
- Comprehensive care management, including intensive case management for persons with severe mental illness and substance use disorders.
- Care coordination and health promotion, including care coordination services for children, adults, and elderly persons with mental illness and substance use disorders, and appropriate referral to community and social support services.

In addition, as regulators work to certify plans and confirm plan compliance generally with EHB requirements, it is important to pay special attention to additional protections related to MH/SUD that were included in the [final EHB regulations](#). Specifically:

- The final rule made clear that states must supplement the EHB as needed to meet the requirements of parity and clarifies that states will not have to defray the cost associated with bringing the EHB into compliance with parity, since parity is a requirement of individual and small group health plans under the Affordable Care Act.
- The rule also provides special rules for prescription drugs, requiring a plan to cover at least the greater of 1) one drug in every category and class, or 2) the same number of drugs in each category and class as the EHB-benchmark plan, and requires a plan offering the EHB to have procedures in place to ensure that enrollees have access to clinically appropriate drugs that are prescribed by a provider but not included on the plan's drug list. The regulations also state that plans are permitted to go beyond the number of drugs offered by the benchmark without exceeding the EHB.

Regulators should carefully review proposals to ensure that the plans meet these prescription drug requirements for MH/SUD and the requirements related to the EHB, parity, and other protections discussed in Part II of this toolkit.

## **Part II: Ensuring Compliance with Parity and the other Consumer-Protective Requirements of the ACA**

**Background:** The ACA requires that each Qualified Health Plan's coverage, along with coverage in individual and small group plans sold outside of exchanges, complies with a number of consumer-protective parity and non-discrimination provisions. Under the ACA, the Essential Health Benefits package—the minimum benefits that must be provided by all QHPs—must meet these protections. In addition, a QHP's policies and practices beyond the EHB, such as benefit management and treatment limitations, must meet the consumer protection requirements in the law. As regulators review health plans for certification to participate on the exchange and for ACA compliance generally, they must pay detailed attention to the proposals to ensure that all protections in the law are being met.

**Messages for state policy-makers:** Under the ACA, individual and small group plans must comply with a number of specific consumer protective requirements for benefits, parity, non-discrimination, typicality of coverage, and EHB categorical balance. Following the subheadings are short summaries of what the law requires and a discussion of what would constitute a violation.

### **The product seeking certification must provide coverage for MH and SUD benefits, as required by the ACA**

The ACA requires that all qualified health plans and non-grandfathered individual and small group plans sold outside of exchanges provide ten categories of essential health benefits, including benefits for mental health and substance use disorder services. The Department of Health and Human Services has allowed states the flexibility to influence their own EHB by benchmarking to existing health coverage available in the state, and provided a framework for adding in benefits for EHB categories that may be missing in the benchmark.

The state's EHB benchmark is a starting point for defining the benefits that a qualified health plan will offer. Within the regulatory framework and as allowed by the state, plans have the flexibility to provide benefits that are "substantially equal" to the EHB-benchmark but may not always be identical. In addition, the regulations give plans the flexibility to substitute benefits or sets of benefits within an EHB category, unless a state limits or forbids substitution, as long as the substituted benefits are identical in value to the benefits being replaced.

If a plan is proposing to offer coverage that does not include MH and/or SUD coverage, or if that coverage is less than "substantially equal" to the coverage in the benchmark, then the plan should be required to improve its MH/SUD coverage before it can be certified in compliance with the ACA. Similarly, if a plan proposes to weaken the value of the MH/SUD category of coverage by substituting a benefit or set of benefits of lower actuarial value for a benefit or set of benefits of higher actuarial value, its request for certification should not be granted.

## **The plan's MH/SUD coverage must comply with the ACA's parity requirements**

The plan's MH and SUD coverage must be consistent with generally recognized independent standards of current practice

The regulations that implement the federal parity law (MHPAEA) require a plan's MH/SUD coverage to meet standards of clinical practice, such as those established in the DSM-V, the ICD-10, and state guidelines. If the plan's proposed coverage of MH and SUD benefits omits certain levels of care and is inconsistent with generally recognized standards of MH and SUD care, the coverage could violate the MHPAEA requirements of the ACA and may need to be supplemented.

The plan's MH/SUD coverage must be consistent with the parity law's requirement that financial requirements and treatment limitations on MH/SUD benefits not be more restrictive than those imposed on other medical/surgical benefits covered by the plan

The MHPAEA regulations are clear that both quantitative treatment limitations (including day or visit limits or frequency of treatment limits) and non-quantitative treatment limitations on MH/SUD benefits must comply with the parity requirements of the law.

Non-quantitative treatment limitations are medical management tools including:

- Medical management standards
- 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

To determine whether a plan meets these parity requirements, regulators should carefully examine the criteria a plan proposes to use to determine whether certain MH/SUD services are covered and whether medications used to assist in the treatment of mental illness or substance use disorders are included on the plan's proposed prescription drug formulary. Regulators should look carefully at a plan's financial requirements (co-pays, deductibles, co-insurance, and other out-of-pocket costs) to ensure that they are no more restrictive than the financial requirements for other benefits. If a plan proposes to impose treatment limitations or financial requirements on MH/SUD benefits that are more restrictive than those imposed on other medical/surgical benefits covered by the plan, then that plan's proposal potentially violates the parity requirements of the ACA.

The plan cannot impose separate financial requirements and treatment limitations on MH/SUD benefits

The law prohibits plans from imposing separate financial requirements and treatment limitations on MH/SUD benefits that are not applied to other medical/surgical benefits. A

plan applying separate financial requirements or treatment limitations on MH/SUD benefits would be in violation of the parity requirements of the law.

The scope of MH/SUD coverage must be consistent with additional MHPAEA requirements

The federal parity law seeks to ensure that access to MH/SUD care is not more restrictive than for care for other illnesses. The MHPAEA regulations specify that if a plan provides coverage for Outpatient, Inpatient, Emergency Care, and Prescription Drug benefits for the treatment of other illnesses, the plan must also cover MH/SUD services in those benefit categories. Not providing coverage in these benefit categories for MH/SUD, where comparable medical/surgical benefits are covered, could violate parity.

If a plan were to cover medical/surgical benefits that help prevent chronic disease, aid in chronic disease management or provide supports to help people stay healthy, but not cover analogous MH/SUD benefits, that coverage could also be inconsistent with parity and would need to be brought into compliance. A final MHPAEA rule is needed for greater clarity on scope of service.

**The plan's MH/SUD coverage must comply with the ACA's non-discrimination requirements**

The plan's benefits must not be designed and/or managed in a way that discriminates against people with disabilities

The ACA precludes plans from designing and managing the essential health benefits in a way that limits coverage for people with disabilities. The law specifies that the essential health benefits cannot be designed in ways that discriminate against individuals because of their age, disability, or expected length of life. The ACA also prohibits the denial of essential benefits services based on age, life expectancy, disability, degree of medical dependency or quality of life. If a plan is designed or managed in a way that limits coverage for people with disabilities, including individuals with mental illness and SUD, and provides inadequate care, the plan would be in violation of the non-discrimination requirements of the ACA and would need to be brought into compliance with the federal law.

The benefits provided by the plan must address the health care needs of diverse segments of the population

The ACA requires that the essential health benefits address the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups. If the benefits offered by the plan exclude certain services or medications that are effective, consistent with recognized standards of clinical care, or are beneficial to diverse groups of people, including individuals with MH and SUD service needs, the benefits may be inconsistent with the ACA and might need to be supplemented to be brought into compliance.



**The plan's MH/SUD coverage must comply with the ACA's typical employer coverage requirement**

The ACA requires that the scope of coverage in the essential health benefit package be equal to the scope of benefits provided under a typical employer plan. If the plan provides significantly more limited MH/SUD coverage than the MH/SUD coverage generally offered by other employer plans, the ACA's typical employer coverage requirement would not be met.

**The plan's MH/SUD benefits category must not be significantly weaker than the other categories**

The ACA requires that the essential health benefits reflect an appropriate balance among the ten EHB categories, so that benefits are not unduly weighted toward any category. If the benefits provided in the MH/SUD category are significantly weaker than the other categories, then the plan's MH/SUD benefits would need to be adjusted to bring it into compliance with the requirement that there be balance among the categories.

### **Part III: Ensuring Qualified Health Plans have Adequate Networks of MH/SUD Providers to Ensure Access to Services without Unreasonable Delay**

Background: Health plans requesting or maintaining certification as a qualified health plan for the exchange must maintain a sufficient network of mental health and substance use disorder providers to guarantee enrollees' timely access to the full continuum of MH and SUD services.<sup>2</sup> The [regulations governing exchanges](#) require that "a QHP's provider network must maintain a network of a sufficient number and type of providers, *including providers that specialize in mental health and substance abuse*, to assure that all services will be available without unreasonable delay." Below are the Coalition for Whole Health's recommendations for minimum network adequacy requirements for QHP certification and ongoing operations as they relate to access to MH/SUD services. Because network adequacy must be maintained even as plans' provider capacities and enrolled populations change, regulators must review network adequacy at the time a plan requests certification and regularly thereafter as part of ongoing plan management responsibilities. Therefore, this section of the toolkit provides recommendations for both developing standards for certification and conducting ongoing reviews of QHPs.

Messages to state policy-makers: Networks should be sufficient in number, mix, and geographic distribution of providers to ensure access to all covered MH and SUD services in a timely manner that is not detrimental to the health or wellbeing of the enrollee. At a minimum, a qualified health plan should be required to meet network adequacy standards related to:

- Enrollee to provider and staff ratios, including ensuring a sufficient number of MH and SUD providers licensed or certified by the state is available to enrollees to ensure adequate choice, a sufficient number of specialty providers to enrollees, as well as the ratio of enrollees to staff, including health professionals and administrative and other support staff;
- Network sufficiency to ensure enrollees are able to access providers to address their MH and SUD needs within 24 hours for urgent care and ten to fourteen calendar days for routine care, and to ensure that enrollees in need of more comprehensive, coordinated care are able to access providers that offer a full range of services;
- Travel time and distance to providers, which should take into consideration geographical barriers and other barriers, such as a lack of accessibility by public transportation, that are not accounted for by simple mileage and travel time criteria;
- Availability standards, including appointment waiting times, hours of operation, 24 hour service availability when medically necessary, and provider acceptance of new patients. Appointment standards should be followed for transitional care, preventive care, non-urgent care, and emergency care.

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<sup>2</sup> Unlike many of the other protections discussed in this toolkit, the network adequacy requirements of the ACA only apply to QHPs. However, state laws may provide important network adequacy requirements for plans operating outside the exchange.

The health plan should be required to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. Distance standards should require reasonable proximity of network providers to enrollees of at least two network MH providers and at least two network SUD providers, for each point along the continuum for these illnesses, within specified urban, suburban, and rural distances for at least 90 percent of plan enrollees. If there are no network providers that meet availability standards, plans should arrange and pay for services provided by a non-network provider at no additional cost to the enrollee.

To ensure that plans meet the minimum standards for network adequacy on a consistent basis, each plan must have in place a system for monitoring its network and develop procedures to react to impending and ongoing changes in its network that may impair adequacy. Plans must demonstrate on an initial and ongoing basis to regulators that they have sufficient capacity to meet the full continuum of MH and SUD needs for the expected enrollment in the service area.

In any case where the health carrier has an insufficient number or type of participating providers to deliver a covered benefit, the health plan should be required to ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers.

Network adequacy standards should require all plans to undergo a detailed network adequacy review at the time a plan requests certification or expansion, at least annually thereafter, and whenever there are general changes in the plan's provider network. A review should include:

- Anticipated enrollment
- Expected utilization of services
- The numbers and types of providers required to furnish the services
- The total, unduplicated number of MH and SUD service providers in the network
- The numbers of network providers who are not accepting new patients
- The geographic location of providers and plan enrollees, considering distance, travel time, the means of transportation used by enrollees, and physical access for enrollees with disabilities
- The plan's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the MH and SUD needs of its enrolled population
- Identification of any direct or indirect barriers to access

A health plan should also be required to demonstrate that it monitors, on an ongoing basis, the ability, clinical capacity, financial capacity and legal authority of its providers to furnish all contracted benefits to covered persons. The goal of the review is to ensure that the network provides sufficient access to the participating providers in order to deliver the services promised under the benefit contract and consistent with federal and state regulations. If access is not available, then the plan should be required to make

arrangements acceptable to the state insurance commissioner, the state exchange board, federal regulators, or other regulating entities that the services are provided at no greater out-of-pocket cost to the enrollee.

Health plans should also be required to assess and report enrollee satisfaction with their network of MH and SUD providers. These requirements should be applied uniformly to all health carriers offering QHPs on the exchange. This information should be made available to consumers before they enroll in coverage to ensure they make an informed choice.

Plans should be required to submit the provider and intermediary contracts used to create and maintain their MH and SUD networks to the appropriate regulatory authorities for review. Plans should be required to demonstrate to regulators that their contracts with providers:

- Prohibit the plans from using standards to select providers that would allow the plan to avoid providers serving potentially high-risk populations,
- Require plans to make their provider selection standards available for review, and
- Prohibit the plan from penalizing a provider for reporting in good faith to state or federal authorities any act or practice by the plan that jeopardizes patient welfare.

Provider selection standards should be reviewed to ensure that plans are not able to avoid high-risk populations because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses, or health services utilization. Standards should also be reviewed to ensure that a plan cannot exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health services utilization. Plans could be required to demonstrate a minimum proportion of overlap between their QHP network and Medicaid managed care networks or providers serving a high number of Medicaid patients in their practices.

There should be a formal enforcement policy in place for plans that do not maintain an adequate network of MH/SUD providers. Depending on the violation, enforcement could include financial penalties, giving a notice and opportunity to correct, restricting the plan's service area if the concern is with a plan's network in a particular area, requiring plans to base an enrollee's responsibility for any coinsurance, deductibles, or copayments related to MH and SUD care on in-network benefits regardless of the provider, precluding a plan from selling new policies, and other formal administrative penalties that may include revocation or suspension of the plan's QHP certification or license.