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Selection of the 2017 Essential Health Benefit Benchmark Plan
Comments to the Maryland Insurance Administration
May 14, 2015

The Drug Policy and Public Health Strategies Clinic of the University of Maryland Carey School of Law and the nine (9) undersigned organizations appreciate the opportunity to submit comments to the Maryland Insurance Administration on the selection of the 2017 Essential Health Benefit Benchmark Plan (EHB Benchmark Plan). The mission of the Drug Policy Clinic is to expand access to comprehensive treatment for persons with substance use and mental health disorders and to fight discrimination against individuals based on their history of substance use problems. The Drug Policy Clinic has advocated for robust enforcement of the Mental Health Parity and Addiction Equity Act (Parity Act) in both the public and private insurance markets so that Maryland's citizens may receive non-discriminatory coverage of and access to substance use and mental health treatment. The selection of the 2017 EHB Benchmark Plan provides an opportunity for the State to implement the right framework to achieve equitable coverage of substance use and mental health benefits in individual and small employer health plans, as required by the Affordable Care Act (ACA) and the Parity Act.

The Clinic is pleased that the three EHB benchmark options are non-grandfathered plans that have incorporated, to a significant degree, the mental health and substance use disorder benefit that was selected in 2012 for the State's EHB benchmark plan. The current benchmark plan adopted the mental health/substance use disorder benefit from the 2012 Federal Employee Health Benefit Program's Government Employees Health Association (GEHA) plan in order to comply with the Parity Act.[1] The GEHA plan provides a full continuum of outpatient and inpatient services and, with the exception of one feature that restricts the eligible providers of outpatient services, (see Section B below), satisfies the Parity Act's standard for the scope of benefits that must be offered in an EHB-based plan.

Although the current set of benefits is the correct starting point for the State's 2017 EHB Benchmark Plan, neither the CareFirst BlueChoice plans (HMO HSA/HRA 1500 and HMO Referral) nor the United Healthcare plan fully satisfies the Parity Act's standards. The BlueChoice benefit includes a limitation on the types of providers that are eligible for reimbursement for outpatient services, in violation of the Parity Act, and does not explicitly identify two preventive services related to behavioral health that must be included in that benefit. The United HealthCare plan, while addressing the provider restriction, excludes coverage of several substance use disorder services. The United HealthCare plan also delegates all coverage decisions to a Mental Health/Substance Use Disorder Designee, whose standards are not identified in the plan documents. We urge the MIA to adopt a parity compliant benchmark

[1] Under the ACA, the ten essential health benefits include mental health and substance use disorder services and, significantly, the definition of "providing essential health benefits" means that the mental health/substance use disorder benefit must comply with the Parity Act. 45 C.F.R. § 156.115(a)(3). To satisfy federal law, a health plan's financial requirements, quantitative treatment limitations and non-quantitative treatment limitations for mental health and substance use disorder benefits can be no more restrictive than the standards applied to medical and surgical benefits.

benefit by either addressing the restriction on outpatient providers, as set out in the BlueChoice plan benefits, or correcting the substance use disorder benefit exclusions in the United HealthCare plan.

A. Mental Health and Substance Use Disorder Benefits

1. Scope of Treatment Services

The current substance use and mental health benefit, adopted from the GEHA benefit and set out in MIA Bulletin 13-01, provides a full continuum of outpatient care; intermediate levels of care, such as partial hospitalization and residential treatment; and inpatient care; as well as diagnostic services, detoxification and medication management. The BlueChoice plans offer this set of benefits (HMO Referral and HMO HSA-HRA 1500 at B-30) and provide a level of specificity that helps consumers understand the full scope of covered services. For example, the explicit identification of methadone maintenance treatment in the schedule of benefits (HMO Referral at C-7 and HMO HSA-HRA 1500 at C-8) informs consumers of this important outpatient benefit.

In contrast, the United HealthCare plan does not cover two important benefits that are clearly required under the State's benchmark benefit: ambulatory detoxification services and partial hospitalization that is provided in a substance use treatment facility. (Certificate of Coverage at 17). The United HealthCare plan covers "detoxification services in a Hospital or Related Institution." (Certificate of Coverage at 12). Hospital care requires an inpatient stay, as does care in a "related institution," which is defined as a facility that "admits or retains an individual for overnight care." (Certificate of Coverage at 68). This limitation conflicts with the substance use disorder benefit in MIA Bulletin13-01, § 5(a)(i)(E), which does not limit the setting in which detoxification services may be provided. This limitation on the setting of care would also constitute a violation of the final Parity Act regulations, which identify a restriction on "facility type" as a non-quantitative treatment limitation. 45 C.F.R. §146.136(c)(4)(ii)(H). A health plan cannot restrict the setting in which substance use detoxification services are provided unless the plan imposes a comparable restriction on the delivery of medical services. No such limitation is found in the United HealthCare benefit.

The United HealthCare plan's coverage for partial hospitalization is limited to services in a "Hospital, psychiatric day-care treatment center, or community mental health facility." (Certificate of Coverage at 66). This restriction conflicts with the partial hospitalization benefit in MIA Bulletin 13-01, which imposes no restriction on the setting in which such service can be provided (*see* § 5(c) "services such as partial hospitalization or intensive day treatment"). Like the detoxification benefit, this restriction would violate the Parity Act. **These limitations should have been identified in the MIA's plan certification process and must be corrected immediately so that consumers receive the benefits they are entitled to receive.**

Finally, the scope of benefits under the United HealthCare plan appears to be fluid because the plan delegates all coverage decisions to its Mental Health/Substance Use Disorder Designee. (Certificate of Coverage at 17). Although the plan sets out the covered benefits, the Certificate of Coverage states that "[t]he Mental Health/Substance Use Disorder Designee determines coverage decisions for all levels of care." (Certificate of Coverage at 17). While this provision could be

interpreted to reference the Designee's authority to determine whether a listed service is medically necessary for a specific patient, it also suggests that other limitations may exist on the covered services which have not been identified in the plan documents. The Designee's standards are critical to a determination of whether the United HealthCare plans comply with the Parity Act, and should be included in the plan documents and reviewed by the MIA prior to plan certification.

2. Preventive Services

Both the BlueChoice and the United HealthCare plans state that preventive services designated as A or B services by the United States Preventive Services Task Force are covered under the Benchmark Plan. This benefit complies with the ACA, however, the Blue Choice plan fails to identify two critical behavioral health services – screening for depression in adolescents and alcohol misuse screening and counseling – despite the fact that the plan lists, with great specificity, a range of preventive services that it does cover. These two evidence-based preventive services should be identified in the benefit to the extent the BlueChoice Plan documents set out any other preventive service.

Based on a review of the scope of services in the three benchmark options, the Blue Choice plans are better aligned with the existing benchmark benefit and are more consistent with the Parity Act standards.

B. Providers of Outpatient and Intensive Outpatient Treatment Services

The State's current EHB Benchmark Plan provides for the delivery of outpatient and intensive outpatient services by ***licensed practitioners***, and, by its terms, excludes the delivery of outpatient services by state-certified/licensed substance use disorder treatment programs and certified substance use disorder practitioners acting within the scope of their practice. *See* MIA Bulletin 13-01.[2] This restriction, incorporated from the GEHA benefit, effectively excludes from carrier networks the core set of substance use disorder treatment providers that deliver outpatient and intensive outpatient services in the State. This benefit limitation fails to reflect Maryland's "program-based" substance use disorder treatment system[3] and the delivery of care through both

[2] The benefit explicitly covers outpatient and intensive outpatient services provided "by ***licensed*** professional mental health and substance use practitioners when acting within the ***scope of their license***, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists." MIA Bulletin 13-01, § 5(a) at 3. This licensed practitioner limitation does not apply to partial hospitalization or residential treatment services as those services are covered when provided by the "residential treatment center" or the "partial hospitalization or intensive day treatment program." MIA Bulletin 13-01, § 5(b) and (c) at 4.

[3] A significant portion of substance use treatment is provided by community-based substance use programs that are certified or, under new standards, licensed by the State. MD. CODE ANN. HEALTH-GEN. §§ 8-403 and 8-404. Methadone treatment services, for example, can only be provided by a program, pursuant to 42 C.F.R. Part 8 and COMAR § 10.47.02.11. Although the State is beginning to implement a new program licensure process, it will not alter the State's program-based treatment system or the mix of practitioners who deliver substance use treatment services.

licensed and certified providers. This restriction limits access to substance use treatment services, and it violates the Parity Act, as clarified in the final regulations.[4] In April 2013, the Drug Policy Clinic raised this significant issue with the MIA and asked that it clarify that state-certified substance use treatment programs would be eligible for reimbursement for outpatient services. Although the MIA declined to amend the standard, it issued Bulletin 13-19 to clarify that carriers may contract "with State-certified outpatient and intensive outpatient treatment programs to assist the carrier in delivering a full continuum of medically necessary and appropriate substance use disorder services." (MIA Bulletin 13-19).

The Parity Act compels a different result now. The final Parity Act regulations make clear that the existing limitation on the professionals who may provide outpatient and intensive outpatient services constitutes a restriction based on "provider specialty" that is a non-quantitative treatment limitation. 45 C.F.R. § 146.136(c)(4)(ii)(H). The EHB Benchmark Plan may not restrict the delivery of outpatient substance use disorder services by excluding eligible providers that meet state qualifications to deliver outpatient treatment unless it imposes the same restrictions on outpatient medical/surgical services.

The BlueChoice plans retain this limitation (HMO HSA-HRA 1500 and Referral at B-30). That benchmark benefit may not be adopted unless the restrictive standard is removed. On the other hand, the United HealthCare plan appropriately adjusts for the State's program-based delivery system, consistent with the Parity Act regulations. (Certificate of Coverage at 17). The United HealthCare plan provides that outpatient mental health and substance use disorder services "include those received on outpatient basis [sic] in a provider's office or an Alternate Facility." The plan defines "alternate facility" as a non-hospital "health care facility that provides…services on an outpatient basis, as permitted by law [including] Mental Health Services or Substance Use Disorder Services." (Certificate of Coverage at 60). Accordingly, as long as a substance use treatment program is authorized by law to provide services, it is eligible under the United HealthCare plan to deliver and be reimbursed for outpatient substance use services.

We recommend that MIA revise the BlueChoice outpatient mental health and substance use disorder benefit by inserting the "alternate facility" standard provided in the United HealthCare plan. Failure to do so will allow for a Parity Act violation to be baked into the benchmark benefit.

C. Conclusion

The adoption of the 2017 EHB Benchmark Plan is only the first step in ensuring that EHB-based health plans comply with the Parity Act. A wide range of plan design features – defined as non-quantitative treatment limitations – are implicated in the provision of essential health benefits for mental health and substance use disorders. Yet very few of those standards are identified in the consumer's insurance contract or plan documents, providing no basis on which to evaluate

[4] The final Parity Act regulations, which were promulgated in November 2013 after the selection of the 2012 EHB Benchmark Plan, offer additional guidance on the standards that constitute a non-quantitative treatment limitation. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240 (Nov. 13, 2013).

whether a plan offers essential health benefits or to file a complaint when mental health or substance use disorder services are denied.

The Clinic reiterates the serious concern it has raised with both the MIA and Health Benefit Exchange since 2014: carriers do not submit sufficient information in their rate and form filings or other submissions to allow for a complete review of plan compliance with the Parity Act prior to plan certification. In addition, a review of the benchmark plan options reveals that the MIA has not identified violations of the Parity Act, even when the non-compliant provisions are set out in the plan documents. More individuals than ever have private insurance coverage as a result of the ACA's individual mandate and expanded insurance market. They should not be denied life-saving care by carriers that continue to implement discriminatory insurance standards. The Clinic urges the State to require carriers to submit additional information relevant to a parity compliance review and to pursue a far more robust review of plans to ensure that consumers receive the mental health and substance use disorder benefits that they are paying for and are entitled to receive.

Thank you for considering our views.

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