UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

The Director

Thursday, July 13, 2000
MSG 2000-058

MEMORANDUM FOR: Human Resources Directors

FROM: JANICE R. LACHANCE (signed 7-13-00) DIRECTOR

Subject: Mental Health and Substance Abuse Parity Implementation in the Federal Employees Health Benefits (FEHB) Program

In 2001, we will introduce an important enhancement to the FEHB Program - parity benefits for mental health and substance abuse treatment. We want to ensure that this contributes to healthy outcomes for Federal employees and their families. Federal agency personnel, particularly Employee Assistance Program (EAP) staff, represent an important front line in our effort to do this. In this memo, we want to offer information and assistance to you and your EAPs, enlist your support, and encourage your suggestions. We need your help.

At the White House Conference on Mental Health held on June 7, 1999, President Clinton directed the Office of Personnel Management (OPM) to achieve mental health and substance abuse parity in the (FEHB) Program for contract year 2001. Subsequent to the President's directive, OPM issued its annual policy guidance letter for the year 2001 to all FEHB health plans on April 11, 2000 (relevant section attached). Our letter directed health plans to provide network parity coverage for all diagnostic categories of mental health and substance abuse conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV).* We encouraged health plans to manage mental health and substance abuse care in order to expand coverage cost effectively. We required that coverage be made available for services to treat all DSM IV diagnoses to the extent that the services:

- are included in authorized treatment plans;
- delivered in accordance with standard protocols; and
- meet medical necessity determination criteria

Parity in the FEHB Program means that coverage for mental health, substance abuse, medical, surgical, and hospital services will be identical with regard to traditional medical care deductibles, coinsurance, copays, and day and visit limitations. Historically, health plans have applied higher patient cost sharing and shorter day and visit limitations to mental health and substance abuse services than they did to services for physical illness or injury. Beginning January 1, 2001, this practice will stop when patients use network providers and comply with authorized treatment plans.

We anticipate that FEHB health plans will implement these benefit enhancements in a variety of ways. Some health plans will use the services of managed behavioral health care organizations (MBHO) and their networks of providers, while others will manage their own provider networks.

Since your front line EAP personnel are involved in the initial assessment of conditions and treatment referrals, they play a vital role in achieving healthy outcomes for Federal employees and their families. Your EAP personnel, who already have relationships with FEHB health plans and their MBHOs, need to work closely with those organizations so that they can effectively coordinate the changes that will occur at the beginning of the 2001 contract year. They need to be certain that they are up to date on their local health plans' benefits, network entry procedures, authorization processes, care transition procedures, and telephone systems to facilitate appropriate referrals.

OPM's Office of Insurance Programs will work with FEHB health plans to educate Federal enrollees and their families on this parity initiative through a multi-faceted approach using enrollment guides, brochures, and web sites. Your EAP personnel will be able to access health plan brochures that contain plan benefits, procedures and phone numbers on the FEHB web site at www.opm.gov/insure by mid-November. The web site also will have other information on parity including a set of questions and answers that will explain our approach.

Smooth coordination between your EAPs and FEHB health plans will enable Federal enrollees and their families to get the care they need when they need it. This will benefit our workforce by improving health outcomes, providing financial protection, and reducing employee absences and disabilities.

Please share this memorandum with your EAP personnel and encourage them to participate fully in our upcoming communication and education efforts. Their participation is vital to our success. They may contact Mike Kaszynski, Policy Analyst, Insurance Policy and Information Division, through email at mwkaszyn@opm.gov with any suggestions on implementation or any problems they become aware of when implementing this initiative. The point of contact for EAP matters is Frank Cavanaugh, EAP Program Manager, Office of Workforce Relations, at ftcavana@opm.gov.

We would like to thank you for your help in implementing this important initiative.

Attachment

Attachment

Mental Health and Substance Abuse Parity

Introduction. At the White House Conference on Mental Health held on June 7, 1999, President Clinton directed OPM to achieve mental health and substance abuse parity in the FEHB Program by contract year 2001. Achieving parity means that your Plan's coverage for mental health and substance abuse must be identical with regard to traditional medical care deductibles, coinsurance, copays, and day and visit limitations. We recognize that there are a variety of benefit design approaches that can meet this standard. This letter sets out the elements that we anticipate will be present in your proposal for introduction of parity in the 2001 contract year. We look forward to working cooperatively with you to implement this initiative.

Background. For the past several years, we have negotiated changes to improve mental health and substance abuse benefits in the FEHB Program. At our 1998 and 1999 carrier conferences, we featured presentations by panels of experts who discussed the desirability and feasibility of achieving mental health and substance abuse treatment parity at an affordable cost. We stated then and in subsequent discussions that we expect your proposals for 2001 to eliminate differences in benefit levels and limitations between coverage for mental health and substance abuse services and medical, surgical, and hospital services. We also provided you with extensive information about this initiative at our carrier conference in October 1999.

To help us develop more specific guidance for implementing parity in the FEHB Program, we contracted with the Washington Business Group on Health (WBGH) for a report on the practices of other large employers. WBGH assembled a group of eight employers who provide parity or near parity benefits in their health plans and collected information from them on best practices and potential pitfalls. They analyzed and synthesized the approaches of the participants and provided recommendations to OPM in a report published March 10, 2000. We sent you a copy by email. The text also is available on both the OPM and WBGH web sites. The OPM web site is www.opm.gov/insure. The WBGH web site is wbgh.com/html/new_at_wbgh.html. The report helped us immeasurably to clarify issues and refine our approach.

Delivery Systems. The overriding goal of parity is to expand the range of benefits offered while managing costs effectively. Based on studies by the National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, and others, we believe that you can deliver parity coverage cost effectively in a fully coordinated managed behavioral health environment. We anticipate that your parity benefit proposals will likely encompass an appropriate care-management structure. For Plans that currently provide unmanaged fee-for-service or point of service mental health and substance abuse benefits levels that are below those for medical benefits, you may continue to offer these benefits, but you must also provide in-network benefits that meet the parity standards. However you choose to provide parity benefits, access to providers of care should be consistent with the intent of the "Access to Network Providers" discussion below.

Managed behavioral healthcare organizations (MBHO) can provide a range of services to fully implement or supplement your program. They can establish networks of providers for you and manage network services using treatment plans and care coordinators. Alternatively, they can manage the care delivered by your existing network providers. If you decide to contract with a MBHO, please include in your selection criteria such factors as accreditation by an independent organization.

If you do not choose to use an MBHO, we still encourage you to consider approaches such as gatekeeper referrals to network providers, authorized treatment plans, pre-certification of inpatient services, concurrent review, discharge planning, case management, retrospective review, and disease management programs. We will be looking for proposed strategies that will expand access to services and mitigate the cost impact of doing so.

We also expect you to develop benefit packages that will make effective use of available treatment methods. Since much successful treatment for mental health and substance abuse conditions is now being delivered through alternative modalities such as partial hospitalization and intensive outpatient care, we encourage a flexible approach to covering a continuum of care from a comprehensive group of facilities and providers.

The experience of other purchasers has shown that in order to manage care effectively, access should be available 24 hours a day 7 days a week to facilitate immediate referral to appropriate treatment. While the prudent layperson standard will continue to apply to mental health and substance abuse as well as medical emergencies, this level of access can ensure that care is rendered in settings that are most appropriate and cost effective.

Full coordination of care between primary care physicians and behavioral health providers and networks can also improve both outcomes and cost effectiveness. Discharge planning should assure that inpatient treatment is followed by appropriate outpatient care. Coordination of care is especially important for patients with multiple diagnoses.

Covered Services. You must provide coverage for clinically proven treatment for mental illness and substance abuse. We expect that will include all categories of mental health and substance abuse conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV)* to the extent that the services for these conditions are included in authorized treatment plans. Treatment plans should be in accordance with standard protocols, and meet medical necessity determination criteria. You may limit parity benefits when patients do not substantially follow their treatment plans. However, you must continue to provide medically necessary services to stabilize the patient during acute episodes. As before, you are not required to cover services that are currently covered and paid for by public entities, such as state or local government or schools.

Network Cost-Sharing and Day/Visit Limitations. You must provide network or similar medical, hospital, pharmaceutical, outpatient facility, and professional services for the treatment of mental and substance abuse conditions at the same benefit levels as for any other illness or disease. Cost-sharing, including deductibles, coinsurance, copays and catastrophic maximums must be the same. Day and visit limits must also be the same.

Mental health and substance abuse benefit levels should be based on the benefit category for comparable medical treatment, such as, inpatient hospital, professional office visits for specialists, diagnostic tests, and pharmacy benefits. The copayment, coinsurance, or deductible that applies to a specialist office visit for a physical illness will apply to an office visit for therapy from a mental health provider. The same cost sharing that applies to a test to diagnose a physical illness, such as diabetes, must be applied to a test to diagnose depression. The same inpatient deductible, copayment, or coinsurance that applies to an acute inpatient hospital admission for a physical illness or disease should apply to an inpatient hospital admission for a substance abuse or mental health condition.

Where there are no coverage limits for other diagnoses, there should be none for DSM-IV diagnoses. If there are coverage limits or other conditions under your medical benefits for certain services, you may apply the same limits for analogous services under your mental health and substance abuse benefits. For example, the allowable number of visits for speech, occupational, or physical therapy may be no fewer for an autistic child who requires those services than for a person recovering from a stroke who needs the same services.

Out-of-Network Cost-Sharing and Day/Visit Limitations. HMOs may continue to limit services to network providers only, unless your Plan has a point-of-service option. All other delivery systems must give members the option to use non-network providers. However, we do not expect parity for out-of-network coverage so long as you meet reasonable standards for access to network providers and facilities. You may keep cost sharing, day/visit limits, and catastrophic maximums for out-of-network services for mental health and substance abuse at or near year 2000 levels.

Catastrophic Maximums, Deductibles and other Plan Provisions. We will leave to your judgment how you decide to handle deductibles and catastrophic limits, and we will entertain all reasonable proposals. In keeping with the goal of parity, you may propose either to combine or separate deductibles and catastrophic limits for medical services and mental health and substance abuse services. You may also propose other changes to your basic Plan structure such as copayment, coinsurance or deductible levels. We will consider your proposals in the context of your entire benefits package. Proposals from HMOs must be consistent with their community practices.

Access to Network Providers. We have encouraged you to contract with a broad range of providers and facilities to ensure adequate access to care. In addition, we learned from the WBGH report that patients often get better results with providers with whom they feel comfortable because they share common characteristics such as race, sex, or ethnicity. This finding parallels experience in other areas of our increasingly diverse world. You should consider the advantages associated with providing access to a diverse group of practitioners.

We understand that enabling access to providers can be more difficult in some geographic areas. Nevertheless, we expect you to explore every possible option, including contracting with existing community mental health and substance abuse providers and facilities, and incorporating into your networks providers who are already treating some of your members. It is important to provide significant levels of in-network services in 2001 and beyond. We expect you to work continually toward increasing access to network providers, particularly in areas where there may be initial shortages.

Coverage provided outside the United States for mental health and substance abuse services must be handled in the same manner as you provide benefits for treatment of a physical illness for members residing or traveling outside the United States.

Minimum Access Standards. As you know, there are no universally accepted standards for access to network providers. As with preferred provider standards in general, access is typically measured by waiting times for various categories of appointments, such as emergency/critical, or routine, and by distance or travel time to the nearest available provider or facility. We will apply a reasonableness test to your proposals, with the clear understanding that an improvement effort will be ongoing.

Transitional Care. Your current members undergoing services for mental health and substance abuse conditions at the beginning of the new contract year will be eligible for transitional care coverage under specified conditions. Transitional care must be provided if a patient can no longer receive any benefits for services from a specialty provider with whom the patient is already in treatment in January 2001, or if the reimbursement for that provider will be less than it was in contract year 2000. Under either of these circumstances, you must allow members reasonable time to transfer care to a network specialty provider. Note that the transition period may begin with notice given before January 1, 2001. We believe that 90 days will be sufficient except under extraordinary circumstances.

Claims and Coverage Disputes. As you know, all FEHB members have the right to a fair and efficient process for resolving disputes with their Plans. This dispute resolution process will continue under parity. You must continue to review all disputed claims before they are referred to OPM, including those involving your MBHO, if you use one. We expect that you will review all disputed claims involving mental health or substance abuse treatment. We will not accept a dispute for review that has been considered only by your MBHO.

Employee Education and Communication. Where there are significant changes, we must ensure that all FEHB members are thoroughly informed about benefits, network restrictions, network entry procedures, telephone numbers, authorization processes, and referral procedures before January 2001. We will use enrollment guides, communication with Federal agencies, and the OPM website to provide general information to the Federal population. We will not specify a particular strategy, but will ask you to provide a description of how you intend to educate your members. Plan brochures, Plan websites, fact sheets, newsletters, frequently asked question and answer sheets, provider directories, explanation of benefits documents (EOBs) over the remainder of this year, or other patient mailings, telephone calls, and health fairs are all acceptable means of communication. Acceptable strategies will require multi-faceted efforts.

Plan personnel who will have contact with members and potential members should be knowledgeable about your network entry procedures, point of entry telephone numbers, authorization processes, transfer of care procedures, and referral procedures. It is especially important that your nurse advice telephone staff or customer service staff and your representatives at health fairs be prepared to discuss all aspects of your mental health and substance abuse parity program. If you decide to use a vendor, you may want to bring their representative to health fairs with you.

Provider Network Education. All of your medical providers and facilities should be thoroughly informed about mental health and substance abuse network entry procedures, telephone numbers, authorization process, care transition procedures, and referral processes. If you are introducing a vendor into the process for the first time, it is critical to define lines of communication and acceptable methods for sharing information while preserving patient privacy. You also will need to establish and communicate a clear line of responsibility between you and your vendor.

The American Psychiatric Association can provide guidelines to help primary care providers to identify mental health problems early so that appropriate treatment can be initiated or referrals made.

Interface with EAP Programs. We will provide information to Federal Employee Assistance Programs (EAP) about our new mental health and substance abuse parity benefits. To ensure continuity of care, you should use existing EAP contacts or develop contacts where they do not already exist to facilitate appropriate member referrals. EAP personnel will need to understand your network entry procedures, authorization processes, care transition procedures, and telephone systems. We will facilitate the exchange of information between health Plans and EAP Programs.

Program Evaluation. We are working with the Department of Health and Human Services (HHS) to evaluate the implementation and operation of our mental health and substance abuse parity initiative. We look forward to your cooperation as we undertake this effort to understand more systematically the implications of parity for employers, health plans and participants.

Quality Assessment and Performance Management. This year our focus is on meeting the requirements for implementing mental health and substance abuse parity in 2001, but we look forward to the time when we work with you to institute performance measurement and quality assessment activities. We will continue to work with accrediting organizations and others toward the goal of identifying a set of standards and measures that are generally accepted by the industry and by both public and private purchasers. We will keep you informed and seek your collaboration and cooperation in this process.