Promoting Mental Health & Addiction Parity In Multiemployer Defined Benefit Plans

Equitable coverage of mental health and addiction care services is critical both for union members and their dependents, just as it for others. However, the unique structure of most multiemployer defined benefit plans makes it particularly important that unions help ensure that the rights of their members to such equitable coverage is protected. These insurance arrangements are often referred to as "Taft-Hartley" plans" or "Union" plans.

Most multiemployer defined benefit plans are governed by a joint board of trustees (Trustees) with equal representation from labor and management that is responsible for the operation and administration of the plan. The Trustees often hire a third party administrator (TPA) to carry out the functions of the plan. As a result, both the Trustees and the TPA share fiduciary responsibility under the Employee Retirement Income Security Act of 1974 (ERISA) and the Mental Health Parity and Addiction Equity Act of 2008 (Federal Parity Law).

Background

Multiemployer defined benefit plans are created by collective bargaining agreements between at least one labor union and two or more employers, typically in the same industry. There are about 1,400 multiemployer defined benefit pension plans, covering about 10 million participants. Many of these participants are employed by small companies in the building and construction industries.[1]

IMPAQ in a detailed study published in 2017 notes:

> Participants in the multiemployer system span many industries, but almost 40 percent work in the construction industry; construction plans generally rely on a large number of small contributing employers. About 15 percent of multiemployer plan participants are in the transportation industry and are covered by Teamster plans, which tend to be among the largest plans. Other industries in which multiemployer plans operate include manufacturing, retail trade, health care, entertainment, communication workers, print news media, printing, and mining. The number of active participants in multiemployer plans has declined in all industries since the turn of the century, with manufacturing and transportation experiencing the largest decline.[2]

Some industries, such as the sports industry, have multiemployer defined benefit plans that are not Taft-Hartley plans. These insurance arrangements are formed through contributions from several employers

[1] Source: The Pension Benefit Guarantee Corporation (A U.S. Government Agency). See https://www.pbgc.gov/prac/multiemployer/introduction-to-multiemployer-plans

[2] See U.S. DOL Labor Website at https://www.dol.gov/sites/default/files/ebsa/researchers/analysis/retirement/multiemployer-plans-their-current-circumstances-in-historical-context.pdf

and one or more collective bargaining agreements, but these plans do not have trust funds governed by a joint board of labor and management trustees.

Another type of insurance arrangement is a multiple employer welfare arrangement (MEWAs), which is not a union plan per se. MEWAs are insurance arrangements that help market health and welfare benefits to employers for their employees. MEWAs are a way for smaller companies to offer employee benefits outside of traditional commercial insurance options or government-run health insurance exchanges by sharing risk.

Multiemployer defined benefit plans and MEWAs are both subject to ERISA, but differ regarding state regulatory oversight. Whereas multiemployer plans are exempt from state regulations, MEWAs may be subject to state oversight depending on how the insurance risk is allocated.

Clearly, these multiemployer defined benefit plans, MEWAs and similar arrangements support millions of hardworking Americans that need proper access to both mental health/addiction services, as well as medical/surgical care. However, the applicability of federal and state parity laws to these types of plans is complex and sometimes confusing.

Promoting Parity

Unfortunately, despite The Kennedy Forum and other advocates' tireless efforts – and numerous regulatory actions and court decisions – compliance with the Federal Parity Law (and any applicable state laws) is still a concern. In many cases, employees and union members in all types of health plans, including multiemployer defined benefit plans, Taft-Hartley plans and MEWAs, continue to be denied care when they need it the most.

The most recent example of insurer noncompliance is a recent landmark federal court ruling against United Behavioral Health (*Wit v. United Behavioral Health)*. In *Wit*, Chief Magistrate Judge Joseph C. Spero of the U.S. District Court in the Northern District of California found that United Behavioral Health (UBH), the largest managed behavioral health care company in the United States, failed to properly cover mental health and substance use treatment for enrollees across the country. The court ruled that UBH breached its fiduciary duty under ERISA. While the court did not examine violations of the Federal Parity Law directly, Judge Spero findings infer a number of implied or potential parity violations by UBH and United Healthcare relating to Non-Quantitative Treatment Limitations (NQTLs) between mental health/substance use coverage and medical/surgical coverage. (For a more detailed summary of the *Wit* decision, see Appendix A.)

While significant on its own, *Wit* is just one of many similar court decisions showing a disregard for regulatory and legislative compliance. Sadly, United Healthcare is not alone in its actions. Other health plans such as Aetna, Kaiser, Cigna, and Anthem Blue Cross Blue Shield have been subject to recent court decisions and regulatory fines.

Given these recent findings and the critical need for union members to be able to access mental health and addiction care services, it is essential that federal regulators aggressively a plan's compliance with ERISA, the Federal Parity Law, and any applicable state laws. It also is important to note the plan fiduciaries, such as Trustees and TPAs, also will be held accountability to these laws.

Plan administrators need to proactively build, maintain and update a parity compliance program. A number of resources are available to assist in that effort. Examples include:

- The Kennedy Forum's Parity Registry Resource Page
- The U.S. DOL Self-Compliance Tool

- The CMS Medicaid Parity Compliance Toolkit
- The Six Step Compliance Guide
- The ClearHealth Quality Institute Online Parity Compliance Tool

We urge unions to ask the following questions to ensure that your members are getting the mental health and substance use disorder coverage they need:

- How is the plan administrator ensuring that your members have equal access to treatment for mental health and substance use disorders?
- What is your plan administrator doing to ensure compliance with ERISA and the Federal Parity Law (and any applicable state laws)?
- How is the plan administrator protecting your health insurance coverage, including Taft-Hartley plans, from potential lawsuits or regulatory fines?

By asking these simple questions, you can help to safeguard your members' mental and physical well-being, and send a clear message that equal access to care must be prioritized.

APPENDIX A

***Wit v. United Behavioral Health* Key Findings**

In *Wit*, Judge Spero found that the company's Clinical Guidelines (aka review criteria) represented an "unreasonable and an abuse of discretion" and were "infected" by financial incentives meant to restrict access to care. At the heart of the case was UBH's reliance and manipulation of its own review Guidelines (i.e., Level of Care Guidelines – LOCGs and Coverage Determination Guidelines – CDGs) and its failure to use guidelines consistent with generally accepted standards of care. Judge Spero found that UBH developed, implemented and maintained restrictive medical necessity criteria over the years that systematically denied or limited residential, outpatient and intensive outpatient services. He also found that UBH's Guidelines focused more on "acute" care and failed to address chronic and co-occurring disorders requiring greater treatment intensity and/or duration. In addition, the Judge was particularly troubled by UBH's lack of coverage criteria specific to children and adolescents.

Judge Spero highlights how UBH was circumventing the Federal Parity Law when he noted in Section 182 (page 93) that "the record is replete with evidence that UBH's Guidelines were viewed as an important tool for meeting utilization management targets, mitigating the impact of the 2008 Parity Act, and keeping 'benex' [benefit expense] down."

Violations of States' Insurance Laws

Judge Spero ruled that UBH misled state regulators about its substance use disorder guidelines being consistent with the American Society of Addiction Medicine (ASAM) criteria, which insurers must use or follow in principle in certain states such as Connecticut, Illinois, and Rhode Island. The court also found that UBH failed to apply Texas-mandated substance use criteria for at least a portion of the class period.

Deviations from Generally Accepted Standards of Care

Judge Spero found the following to be the generally accepted standards for behavioral healthcare from which UBH's Guidelines deviated:

- *More than Symptom-Based* (Section 71*)*. It is a generally accepted standard of care that effective treatment requires treatment of the individual's underlying condition and is not limited to alleviation of the individual's current symptoms.
- *Co-Occurring Conditions* (Section 72*)*. It is a generally accepted standard of care that effective treatment requires treatment of co-occurring behavioral health disorders and/or medical conditions in a coordinated manner that considers the interactions of the disorders and conditions and their implications for determining the appropriate level of care.
- *Safe and Effective Threshold Requirements* (Section 73*)*. It is a generally accepted standard of care that patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective – the fact that a lower level of care is less restrictive or intensive does not justify selecting that level if it is also expected to be less effective. Placement in a less restrictive environment is appropriate only if it is likely to be safe and *just as* effective as treatment at a higher level of care in addressing a patient's overall condition, including underlying and co-occurring conditions.
- *Higher Level of Care Default Requirement* (Section 74*)*. It is a generally accepted standard of care that when there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care.

- *Supporting Status Quo or Preventing Deterioration* (Section 75*)*. It is a generally accepted standard of care that effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration.
- *No Default Limits* (Section 76*)*. It is a generally accepted standard of care that the appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment.
- *Factoring the Needs of Young Patients* (Sections 77-78*)*. It is a generally accepted standard of care that the unique needs of children and adolescents must be considered when making level of care decisions involving their treatment for mental health or substance use disorders.
- *The Need for a Multidimensional Assessment* (Sections 79-81*)*. It is a generally accepted standard of care that the determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made based on a multidimensional assessment that considers a wide variety of information about the patient.

Findings of Financial Bias

The court noted that UBH "Guidelines were riddled with requirements that provide for narrower coverage than is consistent with generally accepted standards of care (which) gives rise to a strong interference that UBH's financial interest interfered with the Guideline development process." This was highlighted in several ways:

- *Committee Bias* (Section 180). Judge Spero found that certain financial incentives "infected" the Guideline development process. He notes "instead of insulating its Guideline developers from (UBH's) financial pressures," the organization "placed representatives of its Finance and Affordability Departments in key roles in the Guidelines development process…"
- *Applied Behavioral Analysis* (Section 185). "Although the Utilization Management Committee had approved a Guideline broadening coverage (for Applied Behavioral Analysis), UBH's CEO overruled the recommendations, cautioning UBH staff, "[w]e need to be more mindful of the business implications of guideline change recommendations."
- *TMS Coverage* (Section 186). UBH's in-house counsel offered legal advice to stop UBH's Clinical Policy Committee from only recommending that Transcranial Magnetic Stimulation (TMS) be reimbursed only for members of self-funded plans and not for members of fully insurance plans. This legal advice was ignored because a senior UBH official indicated that they needed to manage TMS benefits "very tightly".
- *Avoiding ASAM Criteria* (Sections 161, 189). UBH clearly violated Illinois law beginning on August 18, 2011 by using its own Guidelines rather than using the ASAM criteria which were mandated by state law. And "(d)espite the clear consensus among UBH's addiction specialists that the ASAM Criteria were preferable to UBH's own Guidelines from a clinical standpoint, UBH consistently refused to replace its standard Guideline with ASAM Criteria without first obtaining approval from the Finance Department."