

## TESTIMONY

**Presented by:** Rebecca Ternes  
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**Before:** Human Services Committee  
Representative Kathy Hogan, Chairman

**Date:** May 11, 2016

Good morning Chairman Hogan and members of the Committee. My name is Rebecca Ternes and I am the Deputy Insurance Commissioner at the North Dakota Insurance Department.

I was asked to provide you with some background information on the Mental Health Parity and Addiction Equity Act also known as MHPAEA, some information on how MHPAEA has been applied through health insurance plans in North Dakota and any other implications for the state.

Here is a basic timeline of the federal actions related to mental health parity:

### **1996 – Mental Health Parity Act Passed**

For plan year 1998 and beyond, it restricted large group health insurance plans (more than 50 employees) from having aggregate annual or lifetime limits on mental health that did not exist in major medical coverage. It did not cover treatment limits or limits on facilities. It also was silent on differences in cost sharing for mental health benefits as they compared to major medical cost sharing.

### **2008 – Mental Health Parity and Addiction Equity Act Passed**

For plan years on or after October 3, 2009, it applied to large group (more than 50 employees) fully and self-insured health insurance plans. It prohibited differences in treatment limits (frequency, number of visits, days of coverage); financial requirements

(deductibles, copayments, coinsurance, other out-of-pocket expenses); and in and out of network coverage between mental health and major medical benefits. It also made the law clearly cover substance abuse.

### **2013 – Affordable Care Act (ACA) Rule**

For plan year 2015 and beyond, MHPAEA was extended to non-grandfathered small group and individual health insurance plans, through the Essential Health Benefits (EHB) only. MHPAEA was also extended to individual grandfathered plans, while allowing for an exemption for grandfathered small group. In reality, for simplicity, many health insurance carriers in our state began applying MHPAEA to all products if they had not previously.

The rule further defined how mental health benefits could be substantially similar to major medical benefits under specific classifications of benefits. It further defined how an insurer can aggregate the out-of-pocket costs and it provided guidance on what types of limits—quantitative and non-quantitative—are allowed. For example, non-quantitative limits such as medical management techniques or therapy protocols are not generally allowed to be different than in applying major medical benefits, but quantitative limits such as visit limits or day limits are acceptable.

### **2016 – MHPAEA and Medicaid Managed Care Organizations and CHIP Rule**

Recently, a final rule was released on the application of mental health parity requirements to coverage offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP) and Medicaid alternative benefit plans (APB). The rule requires access to mental health and substance abuse benefits, specific disclosures on benefits and disclosures explaining any denials of benefits. I would defer any questions on this rule to representatives from the Department of Human Services.

Regardless of any federal law or rule, there are still state mandates requiring coverage of mental health and substance abuse and certain allowances that can restrict

coverage. North Dakota had existing mental health and substance abuse mandates and those mandates were required to be included in the EHB benchmark plan. However, just because a health insurance plan has the benefits, just like major medical benefits, medical necessity must exist for coverage to be applied. Finally, each insurer implements these benefits differently, so comparing coverage among insurers is not always easy.

In August 2014, Commissioner Hamm testified to this Committee explaining the application of the ACA rule with regards to the North Dakota statutes on substance abuse benefits. The confusion had to do with the federal effective date of the rule (July 1, 2014) and the real implementation date available to insurers (January 1, 2015).

All plans renewing on or after January 1, 2015, where the rule applied complied with the changes. Our complaint files show no complaints related to parity since this date.

The 2017 ACA health insurance plans must be filed with the Department by May 20, 2016. Final approval and release of the plans and rates will be later this fall.

I would be happy to answer any questions you may have. Thank you.