



Human Services Interim Committee

May 11, 2016

Representative Kathy Hogan, Chair

**Study of Behavioral Health
Mental Health Parity and Addiction Equity Act of 2008**

**Bob Stroup, Deputy General Counsel
Dr. Lisa Faust, Senior Medical Director**

Mental Health Parity at BCBSND

- The economic burden of mental illness and substance abuse in the U.S. (2002) was \$562.7 billion in direct care, mortality, crime and workplace costs.
- Depression is the leading cause of disability worldwide.
- Evidence is now clear about the relationship between physical illness and behavioral illness and consequences when one or both is unrecognized and/or untreated.

Mental Health Parity at BCBSND

- When we ignore behavioral health conditions, care for physical conditions becomes less effective and more costly.
- Assuring that our members' physical and behavioral health needs are recognized and met effectively and affordably is a core component of BCBSND's obligation to our members.

North Dakota Knew Parity When Parity Was Not Cool



- North Dakota was way ahead of the federal government and most other states in mandating coverage for behavioral health services in all group health insurance plans, requiring benefits for substance abuse coverage (§26.1-36-08, N.D.C.C.) and behavioral health coverage (§26.1-36-09, N.D.C.C.) since before 1985, and has permitted partial hospitalization benefits as an alternative treatment (§26.1-36-08.1, N.D.C.C.) since 2003.
- The enactment of federal mental health “parity” legislation may be confusing to some stakeholders because the generous mandates that existed in North Dakota required only minor changes in order to comply with these federal requirements. North Dakota did not experience a significant “sea change” following federal parity because North Dakota already required benefits “of the same type offered . . . for other illnesses for the diagnosis, evaluation, and treatment” of behavioral health services.
- Federal mental health “parity” legislation also may be confusing to stakeholders in North Dakota because of the seemingly ever-changing regulatory landscape.

Labyrinth of Legislative Initiatives Related to Federal Regulation of Behavioral Health Benefits.



- The Mental Health Parity Act of 1996, a part of the Kennedy-Kassebaum Act of 1996, better known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), enacted September 26, 1996. This law contained a “sundown” provision which required Congress to extend it every session from 1996 until 2008.
- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), enacted on October 3, 2008, supplemented the MHPA.
 - Interim Final Rule for MHPAEA is issued on February 2, 2010.
 - Subregulatory Guidance for MHPAEA - FAQs issued on June 30, 2010.
 - Subregulatory Guidance for MHPAEA - FAQs issued on December 22, 2010.
 - Interim Final Rule Amendment for MHPAEA - June 24, 2011.
 - Subregulatory Guidance for MHPAEA - FAQ issued on November 17, 2011.
 - MHPAEA Final Rules published on November 8, 2013.
 - Subregulatory Guidance for MHPAEA - FAQ issued on November 11, 2013.
 - Subregulatory Guidance for MHPAEA - FAQs issued on January 9, 2014.
 - Subregulatory Guidance for MHPAEA - FAQ issued on October 23, 2015.
 - Subregulatory Guidance for MHPAEA - FAQs issued on April 20, 2016.
- Patient Protection and Affordable Care Act of 2010, enacted March 23, 2010.
 - Essential Health Benefits Rule is issued on February 25, 2013 (MHPAEA extended to all small group and individual health plans).

Behavioral Health Benefits at BCBSND

- BCBSND has been complying with federal parity requirements since 1996.
- During this 20-year timeframe, BCBSND has never had a substantiated complaint regarding compliance with parity requirements.
- Over these years, BCBSND has gone through thousands of audits by regulators, group customers and federal & state government. There has never been a single objection or violation of parity requirements identified.

Behavioral Health Benefits at BCBSND

- BCBSND has been a leader in extending and reimbursing benefits for its members in the behavioral health arena.
- As general policy, BCBSND has always recognized the importance of behavioral health benefits and administered the same benefits mandated under state law through its self-funded health plans even though BCBSND was not required to do so.
- BCBSND has supported state mandates related to behavioral health services since before 1985, and extended these services to the self-funded health plans it administers in North Dakota.
- BCBSND provided coverage for partial hospitalization when not required to under state law.

Assessing Compliance with MHPAEA



- The MHPAEA does not require that all benefits and services offered through a health plan be equal, it seeks parity.
- The core issues for reviewing parity under the MHPAEA is assuring a fair comparison of the benefits being made available through completing an assessment of an analysis of financial requirements and quantitative treatment limitations across six classifications of benefits, as well as establishing standards for measuring nonquantitative treatment limitations (NQTL).
- This approach under the MHPAEA recognizes that there cannot ever be an “apples to apples” comparison of benefits under all classifications of benefits offered under a health plan but allows for recognition of differences based upon these permitted standards.
- Parity does not mean the same number of surgical procedures should be denied as requests for behavioral health benefits, it is about measuring access to these benefits using the same tools and criteria to level the playing field and allow for rational distinctions but not random or superficial differences.

Medical Necessity Determination



- The evidence base for effectiveness of treatments for mental illness & substance use disorders is sizable. It is as good or better than the evidence for many standard treatments for cancers & heart disease.
- There is no standard system in place to ensure those with behavioral health disorders receive effective medical & psychosocial interventions.

Medical Necessity Determination



- There is considerable variability between behavioral health providers with respect to diagnoses, type and length of treatment, settings for care delivery, clinical efficacy, and adherence to empirically based standards of treatment.
- Studies show between 30-55% of patients with behavioral health disorders don't receive recommended evidence based care.

Medical Necessity Determination

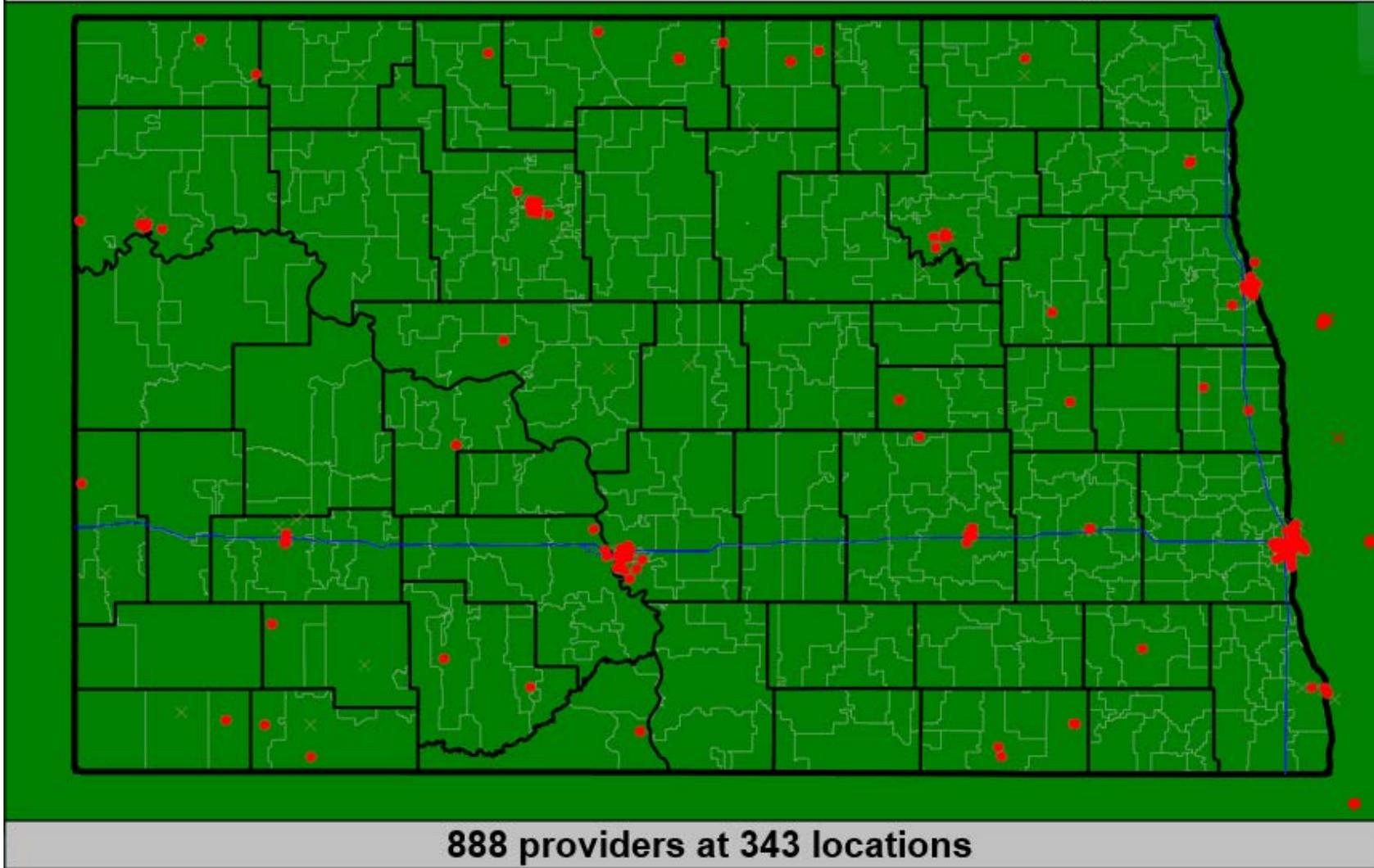
- The use of reasonable utilization management tools:
 - Is designed to protect members so they receive services that are medically necessary and appropriate.
 - Is designed to protect members from incurring unnecessary charges.
 - Serves the fiduciary responsibility BCBSND has to its members to steward their premium dollars.

Medical Necessity Determination



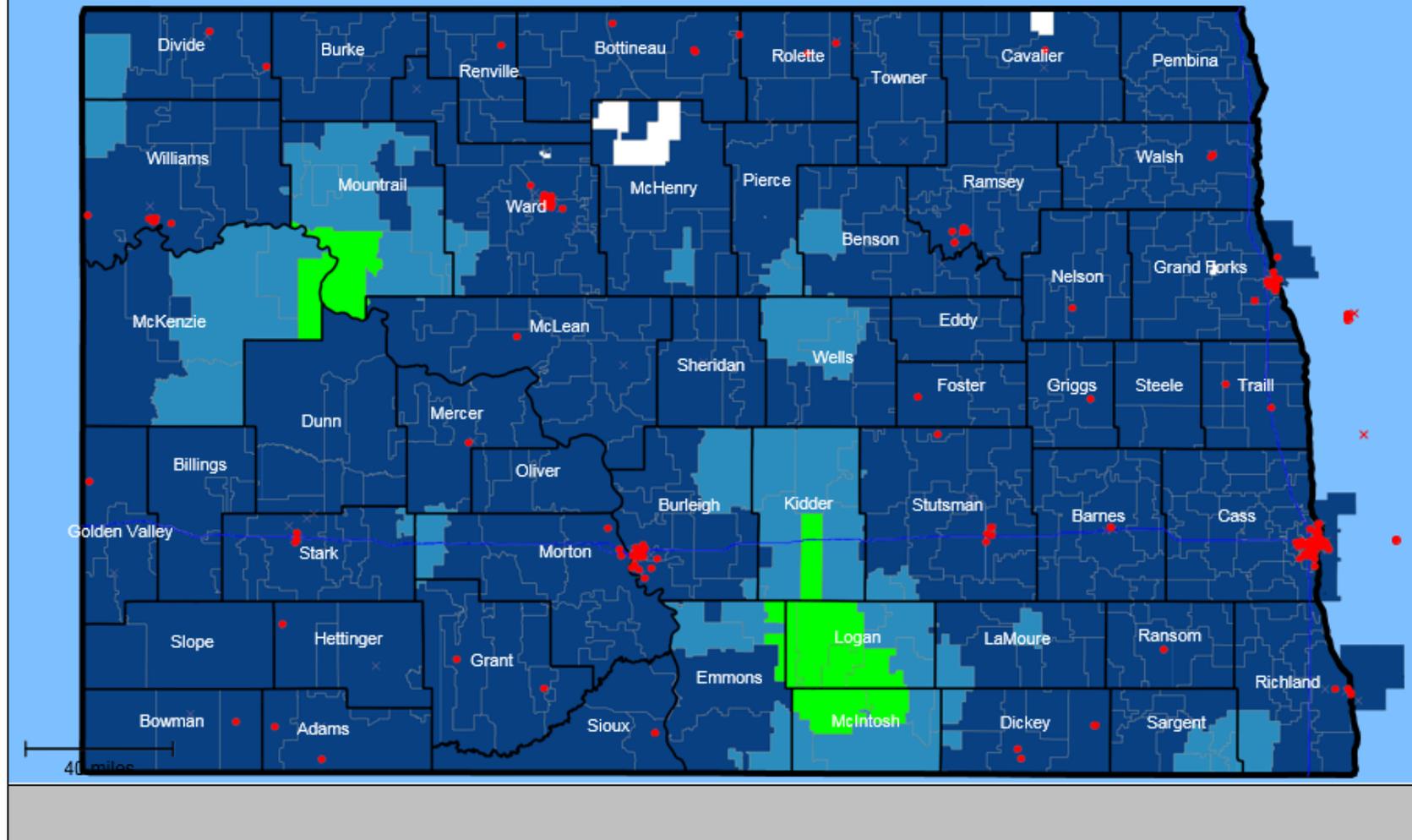
- BCBSND uses evidence based medical necessity standards founded on scientific evidence, professional standards of care and expert opinion.
- Guidelines of the American Society of Addiction Medicine (ASAM), the American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry, SAMHSA, and others are foundational.

BCBSND Mental Health Par Providers Coverage



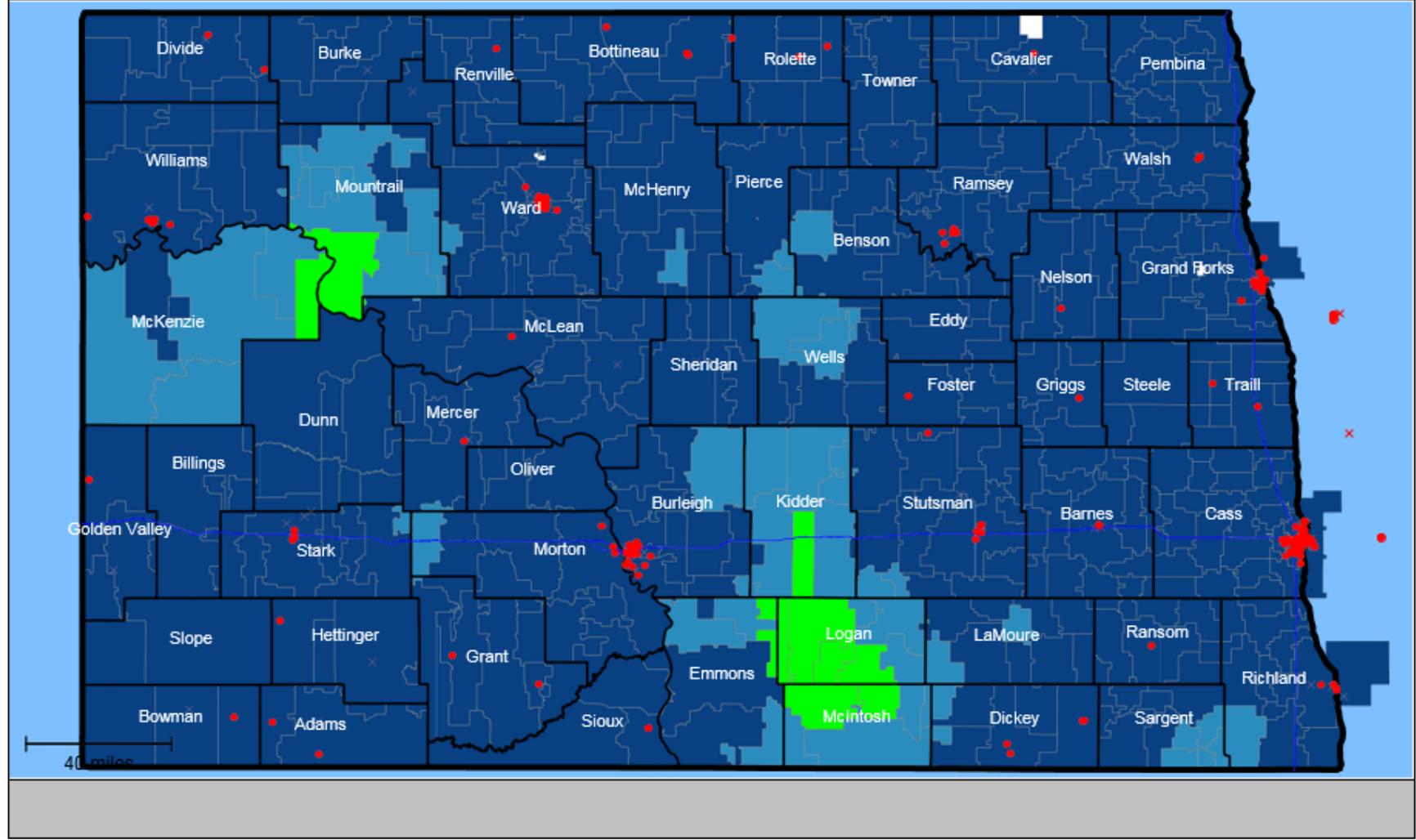
- Single provider locations (198)
- ✕ Multiple provider locations (145)
- 60 mile radius

0 to 17 Years Old (Commercial)



- 0 to 30 miles to 1 provider
- 30 to 45 miles to 1 provider
- 45 to 60 miles to 1 provider
- 60 to 100 miles to 1 provider More
- than 100 miles to 1 provider
- No Members
- Single Provider locations (198)
- × Multiple Provider locations (145)

18 and Older (Commercial)

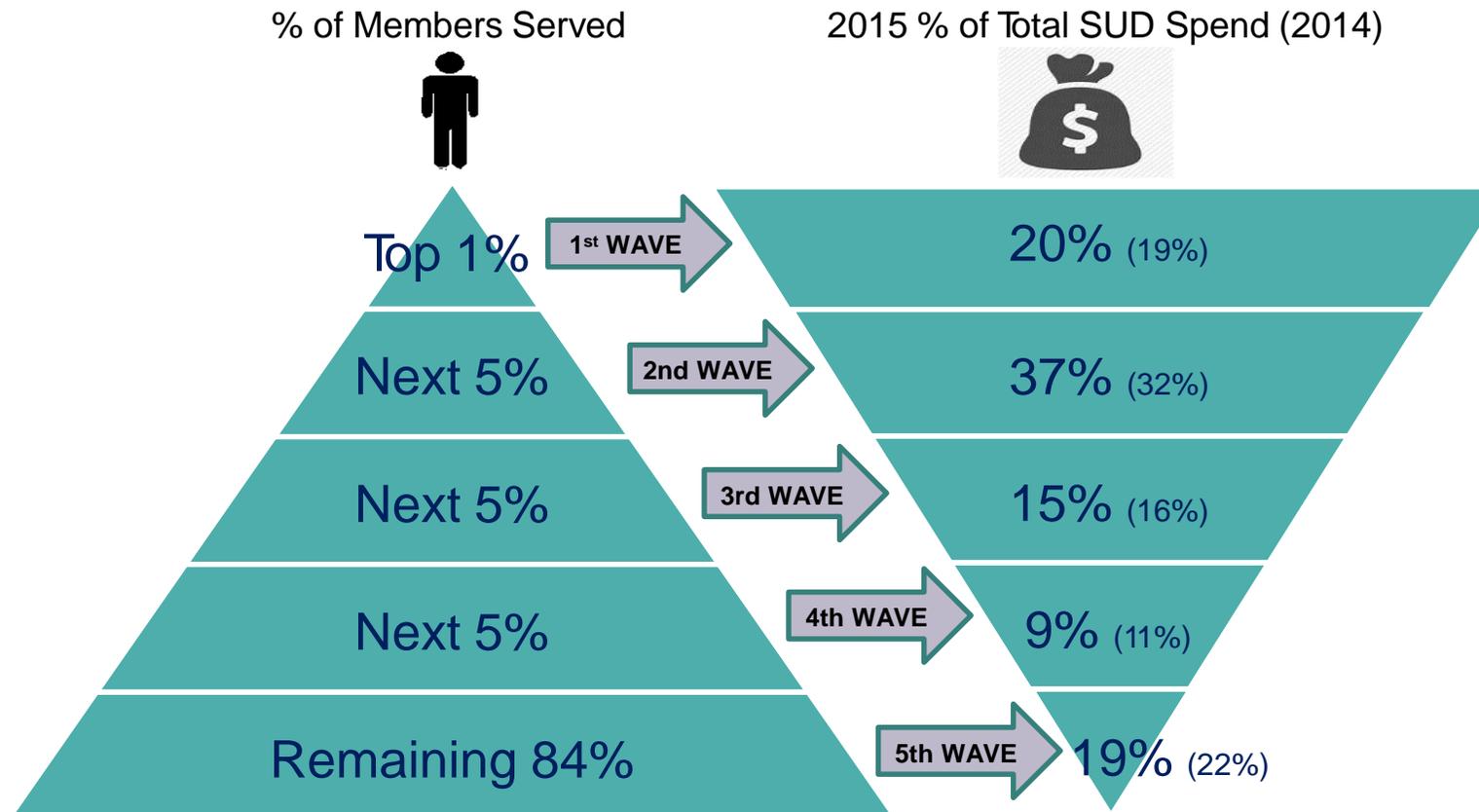


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What portion of BCBSND spend is used by the most expensive members?



The top six percentiles of members use over 57% of the total SUD spend for 2015.



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Meaningful Review of Behavioral Health Decisions



- Communication and collaboration between stakeholders.
- Health care provider reviews.
 - Process is included in every health care provider participating contract.
 - Process includes an initial review and a right to appeal.
 - Providers also have a statutory right to an independent review (§26.1-36-44, N.D.C.C.).
- Member reviews.
 - There is a claim for benefits review and right to appeal provision contained in every health insurance benefit plan offered by BCBSND to its members.
 - This process is mandated under state and federal law, and includes an initial review and a right to appeal (§26.1-36-47, N.D.C.C. and 42 U.S.C. 300gg-19).
 - The process also requires the right to an independent external appeal. For insurance plans this right is secured by requesting an appeal to the North Dakota Department of Insurance and for self-funded plans, requested through BCBSND (§26.1-36-46, N.D.C.C. and 42 U.S.C. 300gg-19).

Q & A