Federal Mental Health Parity

Bruce R. Croffy MD, PhD
Medical Director
Blue Cross of Idaho

August 27th, 2009

Blue Cross of Idaho

Overview Federal Mental health Parity Act

- Signed into law 10/3/08 as part of "bail out" bill.
- 1996 Mental Health Parity Act required parity only for lifetime and annual limits.
- Clearly allowed plans to limit annual visits or number of treatment days and apply distinct cost sharing requirements.
- The current Act addresses disparities in treatment and financial limits for mental health and substance use disorder benefits.

What the Act does *NOT* do

- It is not a mandate to provide mental health or substance abuse benefits
- It does not mandate coverage of all mental health conditions
- It does not eliminate medical management.
- It does not affect small employers (50 or fewer employees)

New Parity Requirements

- Mental Health/Substance Abuse (MHSA) provisions must be no less restrictive than the medical/surgical benefits
- Financial parity requires the same deductibles, co-payments, coinsurance and out-of-pocket expenses.
- Health Plans may still have an aggregate lifetime limit and aggregate annual limit that is applied to both medical and MHSA benefits

Out-of-Network Benefits

- Plans are required to provide out-of-network mental health and substance abuse benefits if the plan provides out-of-network medical/ surgical benefits.
- Health plans would match out-of-network medical/surgical benefit with out-of-network mental health and substance abuse benefit
- Does not prevent plans from using certain out-of-network medical management techniques that do not conflict with parity requirements.

Mental Health and Substance Abuse Coverage

- Plans may define covered services for mental health and substance abuse treatment. For example, a plan might limit the definition of mental health to exclude a set list of disorders
- This provision of choice allows plans to control scope and cost
- For insured plans, state laws that define mental health benefits generally not preempted

Medical Management

- The Act does not expressly limit medical management or mandate parity in medical management techniques
- Plans must now disclose medical necessity criteria to participants, beneficiaries or providers
- Plans are allowed to preserve the rule of construction that permits the definition of policy terms and conditions

Groups Affected

- All insured or self-insured group health plans with a few exceptions
- All group health plans regulated by Employee Retirement Income Security Act (ERISA)
- "Carve-out" plans (MHSA are managed by a separate vendor)
- Medicaid managed care plans

Groups Exempted

- An ERISA group health plan with 50 or fewer employees
- An ERISA plan is exempt for one year if they can show its total plan costs of coverage for MHSA and medical benefits increase by at least 2% in the first year of coverage after the effective date of the act
- Disability and long-term supplemental care plans
- Government- sponsored non-ERISA health plans
- Indemnity plans (hospital or other fixed indemnity plans)

Timeframe

Effective date

Generally effective for plan years beginning on or after October 3, 2009 (for calendar year plans = Jan 1, 2010)

Timeframe

Regulations

- Instructs the Department of Labor, Health and Human Services and Treasury to issue regulations within one year
- Health plans may need to implement before regulations are issued therefore numerous implementation issues may not be resolved
- Interim final regulations expected between late summer and fall 2009

Blue Cross of Idaho

Unanswered Questions

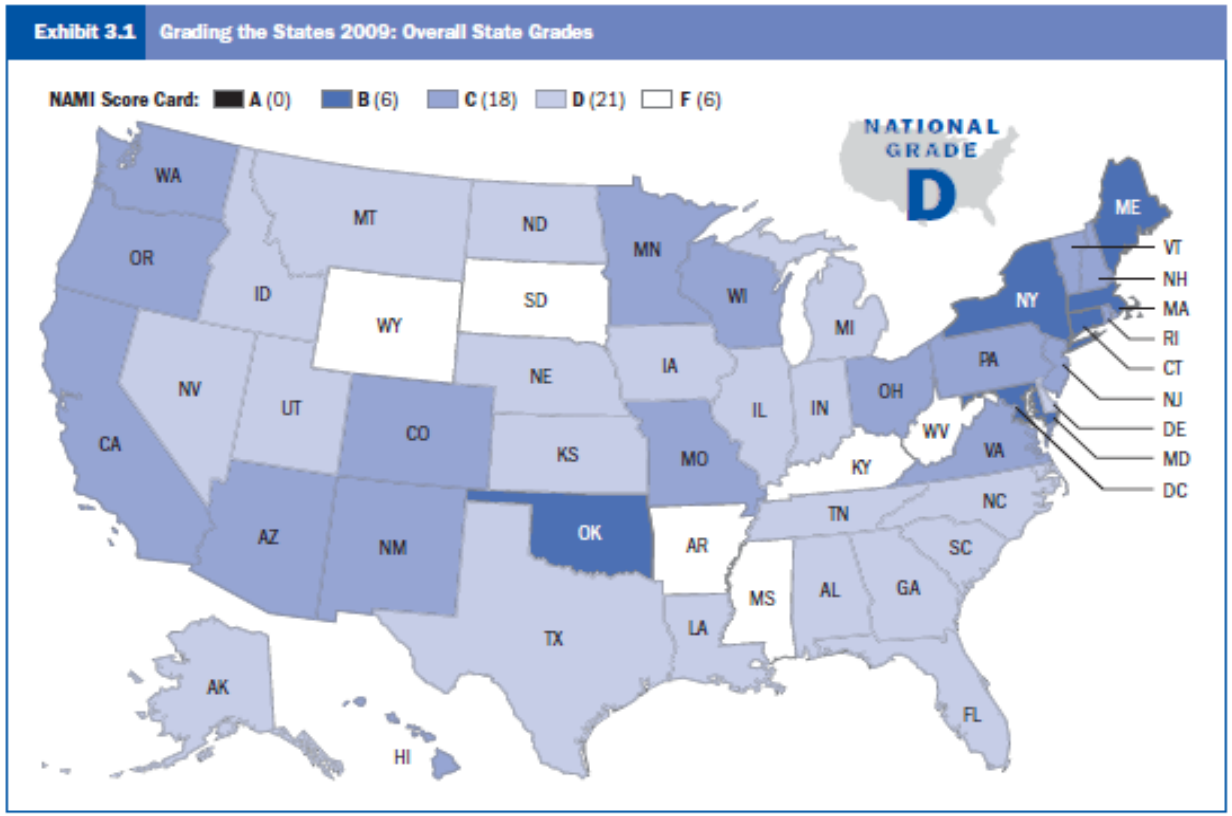
- Applicability of the Parity Act to Employee Assistance Programs
- Clarification as to whether other treatment limitations will be included in the law
- Specifics of the interplay between state parity mandates and federal parity
- Details of the process for filing the cost-based exemption
- Will adherence requirements be lessened the first year to allow plans to match benefits to the final rules

Current Landscape

- 2009 NAMI report gives Idaho a "D" in MHSA
- Prior limited MHSA benefit created inaccurate billing, unbundling and poor provider communication
- Lack of integration of behavioral health services prevented holistic patient care approach
- Distribution of MHSA services/providers insufficient in rural Idaho
- Current levels of care often not adherent to "best practices"/evidence-based guidelines

Blue Cross of Idaho

NAMI State Scorecard



Key NAMI Findings

- States not focusing on wellness and survival for people with serious mental illness
- Private insurance plans often lack sufficient coverage
- States not adequately providing services that are the lynchpins of a comprehensive system of care such as integrated MHSA treatments
- States are not creating a culture of respect
- Stigma of mental health remains a major concern

Blue Cross of Idaho

Mental Health / Substance Abuse
Inpatient Blue Health Intelligence Data

All BHI Plans			
Commercial PPO			
Claims Incurred 10/1/2007 to 9/30/2008			
Average Length of Stay			Admissions Per 1000	
P25	4.79		P25	0.69
4	4.86		P31	1.46
P21	5.82		P1	1.65
Idaho	5.82		P21	2.17
4	5.85		P21	2.27
4	6.00		P34	2.33
P2	6.14		Idaho	2.38
P16	6.15		P39	2.55
P22	6.22		P2	2.63
P31	6.33		P10	2.65
P21	6.51		P22	2.71
P34	6.65		P16	2.90
6	6.80		P33	2.94
P10	6.86		10	2.99
P33	6.88		6	3.00
10	6.95		4	3.03
10	6.98		10	3.16
P15	7.05		4	3.25
3	7.06		3	3.26
P39	7.17		P15	3.29
10	7.26		4	3.34
P1	7.94		P18	3.54
P30	8.17		10	3.71
P26	8.33		P26	3.79
P18	16.18		P30	5.11

Those Plans with parity have a "P" designation preceding their number. Rows with the same number represent States with more than one BCBS Plan.

Average Length of Stay

Idaho should anticipate an increase in length of stay. A majority of the Parity plans have longer lengths of stay compared with Idaho.

Admissions Per 1000

Idaho ranks toward the midpoint of Parity plans in Admissions Per 1000.

4-5% of inpatient MHSA cases exceed the 30 day inpatient maximum seen in many health plans

Blue Cross of Idaho

Mental Health / Substance Abuse

Professional Blue Health Intelligence Data

All BHI Plans				
Commercial PPO				
Claims Incurred 10/1/2007 to 9/30/2008				
Professional				
Visits Per 1000			Visits Per Patient	
P25	122.60		P25	2.3
4	138.44		P21	2.5
P1	139.05		P31	3.0
P31	182.41		P33	3.3
P16	203.57		P2	3.3
P21	204.50		4	3.4
P33	213.72		P1	3.5
P2	221.74		10	3.7
6	251.66		P22	4.1
P34	272.76		P21	4.2
10	306.93		P39	4.2
Idaho	351.16		Idaho	4.2
P22	373.47		6	4.4
P21	402.68		P34	4.5
4	426.07		P26	4.8
P10	432.19		4	5.1
P39	433.37		4	5.3
10	476.46		10	5.4
4	506.24		10	5.4
P26	536.59		P10	5.9
10	546.48		P16	5.9
P18	670.13		P18	6.1
3	682.10		P30	7.1
P30	1066.36		P15	8.6
P15	1132.23		3	9.1

Those Plans with parity have a "P" designation preceding their number. Rows with the same number represent States with more than one BCBS Plan.

Professional Visits

Both Visits per 1000 and Visits per Patient are positioned in the center of the rankings.

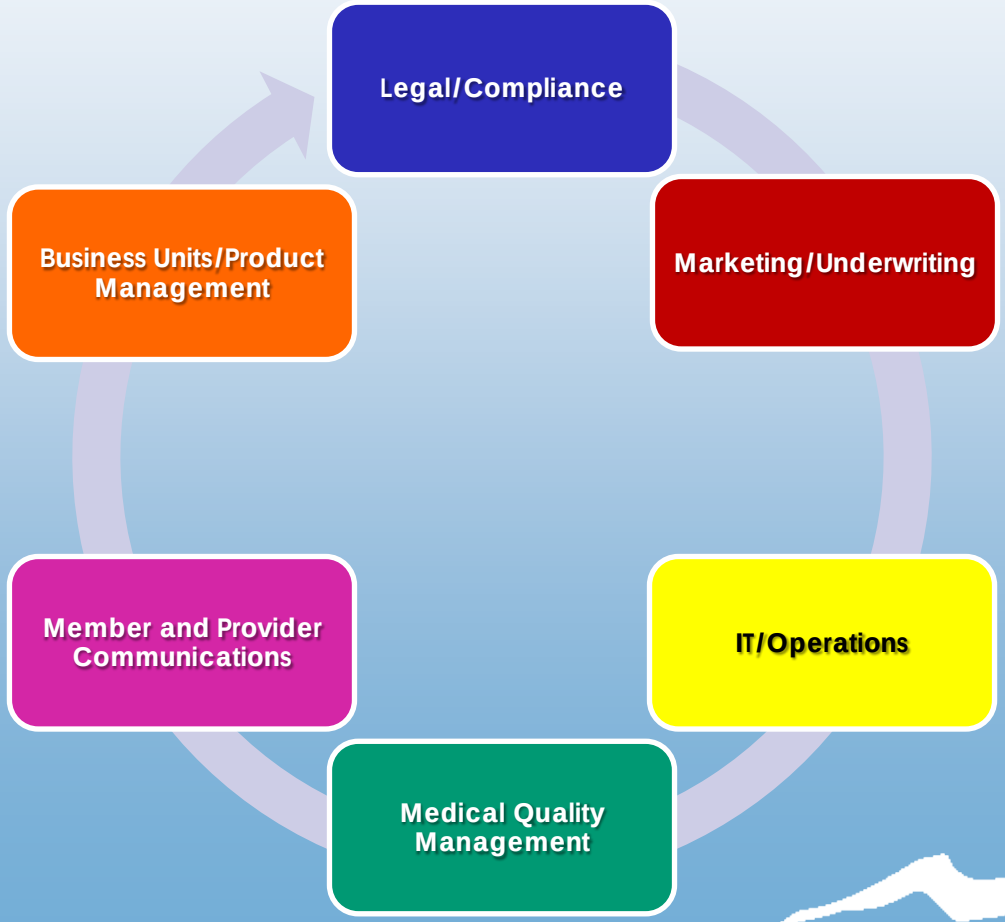
10-15% of outpatient MHSA visits exceed the 20 visit maximum seen in many health plans and these tend to be the most expensive ($30,000 or more/year)

Best in Class Programs

- Use of data driven algorithms to identify outlier cases and inconsistent care
- Robust program reporting / accountability
- Appropriate application of medical necessity and utilization management results
- Network management
- Provider Education/Plan Partnership
- Integration of medical & behavioral to address high cost medical populations

Blue Cross of Idaho

BH Unit Implementation
A year-long project



Blue Cross of Idaho

BCI Behavioral Health Unit

Fully-staffed unit integrated within BCI MQM division providing –

- Uniform systems platform for claims, case management and reporting on entire medical/surgical and MHSA benefit
- Utilization management
- Complex case management
- Accreditation and continuous quality improvement functions
- Provider advisory panel
- Pharmacy benefit management/medication adherence program
- Depression disease management

Blue Cross of Idaho

BCI Behavioral Health Unit

- Complex Case Management
  - Care coordination for MHSA inpatients
  - Coordination with medical/surgical acute and complex case managers for cross referral
  - Identify gaps/barriers to optimal outcomes
    - Assess community support services
    - Assess provider availability
    - Decrease emergency room utilization
    - Coordinate care with primary physician

Blue Cross of Idaho

BCI Behavioral Health Unit

- Disease Management for Depression
  - Significant number of cases not optimally managed by primary care provider
  - High prevalence of depression in Medicare/Medicaid population often undiagnosed/undertreated
  - Medication adherence critical to treatment success
  - Care coordination proven to maintain medication compliance and improve outcomes
  - 8-10% of workforce affected annually with depression resulting in significant absenteeism

Blue Cross of Idaho

BCI Behavioral Health Unit

Special initiatives

- Define provider distribution gaps within Idaho
- Explore concept of Telepsychiatry and its applicability for rural behavioral health care
- Contract and credential out-of network/state providers to augment coverage gaps
- Empower Provider Advisory Panel to address provider shortages and facilitate remedies
- Work with advisory panel to strengthen best practices for Idaho MHSA