NAAG BH Parity Panel
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• Historical Context of Parity (my point of view)
  – Movement to push for BH parity legislation began in early to mid 1990’s.
  – Initially was Mental Health parity
  – Substance Use treatment parity joined the efforts about 15 years ago
Trends in BH Parity

– Focus at the beginning of advocacy efforts was on quantitative standards
  • Elimination of separate deductibles, annual limits, lifetime limits for BH benefits
  • Same and shared deductibles, co-pays as physical health
  • Examples of families needing to take out second mortgages or consider bankruptcy if child was diagnosed with serious mental illness, while if it would have been cancer, health plan would cover...
Trends in BH Parity

– Opposition to parity legislation included employer groups, business groups and health plans, delayed traction on parity for a decade
  • Viewed as employer mandate
  • Concerns over premium hikes and increase costs
  • BH viewed as a “black box” difficult to manage compared to physical health and other medical conditions that were guided by more well defined, evidence based protocols
Trends in BH Parity

- Parity gained traction and was finally supported by opposition groups because of managed care approaches to BH
  - Advocates pointed to examples of MH parity being implemented in states and health plans with little to no increase in premium (Vermont, Georgia, Federal Employees plan)
  - Parity legislation included the premium caps factor (2% first year 1% succeeding years)
Trends in BH Parity

- By 2003, BH parity was supported by bi-partisan majority in both Houses of Congress and White House
  - House Speaker opposition prevented legislation from reaching a vote
  - Passed in 2008 with new majority in House and President Bush signed it into law
Trends in BH Parity

- Public Sector BH Managed Care Medicaid contracts as source for informing parity implementation
  - Contracts included access standards to mental health services for people with serious mental illnesses (SMI), children with serious emotional disturbances (SED) and people with addictive disorders
  - Contracts outlined the array of services required to have an adequate continuum of care
Trends in BH Parity

– First decade of implementation of Pennsylvania BH Health Choices demonstrated:
  • Access to treatment exceeded national benchmarks for persons with SMI
  • Increased capacity for substance use treatment (500 additional providers)
  • Less restrictive alternative services increased by 400%
  • Quality measures showed improvement
  • Provider networks expanded
Trends in BH Parity

• Future Trends in BH managed care and addressing parity
  – Managed Care Organizations moving from Utilization Management to Care Management
    • Focus on active care management to assure people are at right level of care as early as possible
    • More individualized approaches
    • Value based purchasing
Trends in BH Parity

- Example of Review Conducted on the Interim Mental Health Parity & Addiction Equity Act (MHPAEA) in 2012; final rule issued and effective July 1, 2014

Applies to:
- Medicare Advantage
- Medicaid Managed Care
- Commercial
- New/proposed Medicaid rules will apply to FFS Medicaid

- Statutory Requirements
  - Processes, evidentiary standards, strategies must be comparable for Mental/Behavioral Health (MH) and Physical Health (BH)
  - Quantitative treatment limitations, e.g. day and visit limitations, deductibles, etc.
  - Non-quantitative treatment limitations, e.g. formulary design, network adequacy, etc.
  - Benefit Plan Design
    - Inpatient & out of network
    - Outpatient & out of network
    - Emergency Care
    - Prescription Drugs
    - Intermediate levels of care must match for MH and PH

- Risk/fines for non-compliance - states have primary enforcement
Trends in BH Parity

- **Claims** - higher denial rates for MH vs. PH; need for fuller explanations
- **Utilization Management** - no pre-authorizations required on routine PH outpatient, required for MH
- **Appeals & Grievance** - in-house MH advocates; continued coverage during appeal
- **Benefit Design** - MH financial requirements (co-insurance, co-pays & deductibles) cannot be significantly different from PH
- **Network** - provider networks & on-line directories accurate; must assist members with transitions
- **Pharmacy** - higher out of pocket for MH than PH prescriptions
Trends in BH Parity

– Current and future innovative medications/technologies protocols
  • Will yield predictable BH clinical outcomes
  • Make compliance with parity more possible to:
    – Increase access
    – Improve quality & consumer satisfaction
    – Bend the cost curve
Loyola Recovery Foundation
SAMHSA Grant

Example of protocol yielding predictable positive clinical outcomes

• Developed treatment protocol for Veterans with serious alcohol dependence (3 hospitalization prior 18 months)
• Protocol included screening, detox, outpatient treatment, medication assisted treatment (extended released injectable Naltrexone), online/mobile technologies, peer support
• Resulted in significant decrease in relapse and hospitalizations (See graph below)

Source: CSAT BIANNUAL PROGRAMMATIC REPORT, Program Reporting Period: September 1, 2012 through March 31, 2013
• BH as a leverage to bring down overall healthcare costs incents parity
  – Health Choices/Health Connections example in Pennsylvania
  – Central Kansas Foundation example
Trends in BH Parity

Behavioral Health / Physical Health Percent Change in Utilization Post Consent

Source: Data from Bucks, Delaware and Montgomery Counties in Pennsylvania
Trends in BH Parity

Central Kansas Foundation

Impact of Effective BH Parity and Integration

2015
Total Number of Stormont-Vail SUD-ED Visits by Payer Source

- Uninsured: 505 (50% Decrease)
- Commercial Insurance: 176 (75% Decrease)
- Centene-MCO: 130 (68% Decrease)
- VA Benefits: 9 (89% Decrease)

ED Visits Prior to Consult (Since January, 2015)
ED Visits-Post Consult
QUESTIONS?

THANK YOU!

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