

Health Policy Brief

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Mental Health Parity. Historically, health insurance covered mental health care differently than other medical care. Recent laws have begun bringing them into balance.

WHAT'S THE ISSUE?

Traditionally, insurers and employers have covered treatment for mental health conditions differently than treatment for physical conditions. Coverage for mental health care had its own (usually higher) cost-sharing structure, more restrictive limits on the number of inpatient days and outpatient visits allowed, separate annual and lifetime caps on coverage, and different prior authorization requirements than coverage for other medical care. Altogether, these coverage rules made mental health benefits substantially less generous than benefits for physical health conditions.

WHAT'S THE BACKGROUND?

The push to make mental health treatment equal to treatment for other health issues has a long history in Congress, in state legislatures, and with the Federal Employees Health Benefits (FEHB) program. In 1996 Congress passed the [Mental Health Parity Act \(MHPA\)](#), championed by Senators Paul Wellstone (D-MN) and Pete Domenici (R-NM). This law applied to large employer-sponsored group health plans (those with more than fifty employees) and prohibited them from imposing higher annual or lifetime dollar limits on mental health benefits than those applicable to medical or surgical benefits. The law applied to

both fully insured group health plans (those that purchased insurance from an insurance company or issuer) and self-insured group health plans (those that retained the financial risk for health care claims). The law contained a cost exemption that allowed group health plans to receive a waiver, exempting them from some of the law's key requirements, if the plans demonstrated that costs increased at least 1 percent as a result of compliance. It is important to note that the MHPA did not mandate coverage for mental health treatment, rather, it only applied to group health plans that offered mental health benefits.

The 1996 law, while a beginning step toward mental health parity, had numerous holes. The law did not address treatment limits, limitations on the types of facilities covered, differences in cost sharing, and the application of managed care techniques that continued to make coverage for mental health benefits less generous than coverage for other health benefits. For example, a plan could set a limit of ten visits for therapy to treat major depression or charge a higher copayment for an outpatient visit for mental health treatment than for a physical ailment without violating the law.

In the decade after the passage of the MHPA, many states passed their own mental health parity laws, some going further than the MHPA toward full parity. The state laws vary

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substantially in scope and do not apply to self-insured group health plans, which include the majority of large employer plans. In 1999 President Bill Clinton directed the Office of Personnel Management to implement mental health parity in the FEHB program. The directive included parity with respect to cost sharing, as well as number of visits and length of treatment limits. Implementation of parity in the program was important not only from a political and equity standpoint, but also because it provided a concrete example for researchers to study.

One common critique of parity is that by expanding coverage it could drive up costs, but research has shown this not to be the case. The implementation of parity in key settings allowed researchers to do a large-scale evaluation of any potential cost increases associated with parity. [Research findings from the FEHB program](#) as well as studies conducted in [other settings](#) showed that parity did not increase mental health spending, but did bring consumers important gains in terms of financial protection. These findings played a role in making parity more politically feasible.

Motivated to cover the gaps in the original MHPA and riding a wave of greater acceptance by both the public and legislators, Congress passed the [Mental Health Parity and Addiction Equity Act \(MHPAEA\)](#) in 2008. Like the MHPA, the MHPAEA applied to large group health plans, both fully and self-insured, and included a cost exemption. The MHPAEA prohibited differences in treatment limits, cost sharing, and in- and out-of-network coverage. Importantly, the MHPAEA also applied to the treatment of substance use disorders, which the MHPA did not address. This was a historic step applauded by consumer advocates and the provider community.

The Affordable Care Act (ACA) applied the MHPAEA to issuers in the individual market and qualified health plans offered through an exchange or marketplace, including the small business exchange known as SHOP. Importantly, the ACA defined coverage of mental health and substance use treatment as one of the ten essential health benefits (EHBs). As a result, all health insurance plans in the individual and small-employer market—both inside and outside Marketplaces—must include coverage for the treatment of mental health and substance use disorders. In this way, the ACA went beyond the MHPAEA by mandating coverage rather than requiring parity only if coverage is provided. In order to satisfy the

essential health benefit requirement, issuers must comply with the MHPAEA.

WHAT'S IN THE LAW?

The MHPAEA addressed many of the shortcomings of the MHPA and prohibited coverage requirements for mental health and substance use disorders from being more restrictive than those for medical/surgical benefits. As under the MHPA, group health plans may not impose higher annual or aggregate lifetime limits on coverage for mental health/substance use disorders than those that are in place for medical/surgical benefits. The MHPAEA eliminated treatment or visit limits that differed between mental health/substance use benefits and medical/surgical benefits. Financial requirements—such as deductibles, copayments, and coinsurance—cannot be greater for mental health/substance use benefits than for medical/surgical benefits. Health plans that give patients the option to go out-of-network for medical/surgical benefits must do so for mental health/substance use benefits as well.

The MHPAEA does not preempt state parity laws that are more stringent and does not require plans to offer benefits for mental health/substance use disorders; nor does it require specific conditions to be covered. In addition, the MHPAEA contains a one-year exception to the law's requirements if a plan's costs go up at least 1 percent as a result of parity. Finally, the MHPAEA applies to Medicare Advantage plans offered through group health plans, state and local government plans, Medicaid managed care plans, and state Children's Health Insurance Plans.

The Departments of Health and Human Services, Labor, and Treasury jointly released [interim final regulations](#) in February 2010 and [final regulations](#) in November 2013. The regulations establish a framework to determine equivalence by dividing benefits into six classifications: in-network inpatient; out-of-network inpatient; in-network outpatient; out-of-network outpatient; emergency care; and prescription drugs. Plans are prohibited from imposing a financial requirement or treatment limit restriction that is more restrictive than the “predominant” financial requirement or treatment limit restriction that applies to “substantially all” medical/surgical benefits in the same classification. Under regulation, “predominant” was defined as “more than half,” and “substantially all” was defined as “two-thirds.” Plans may further subclassify

1%

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outpatient benefits (office visits versus other outpatient visits) as long as they are applied consistently. Other subclassifications such as tiered provider networks are also allowed.

One issue left for regulation was whether or not plans could apply separate deductibles and out-of-pocket limits for mental health/substance use benefits and for medical/surgical benefits. Separate deductibles were fairly standard, in part, because most mental health/substance use benefits are provided through separate managed behavioral health care (MBHC) companies, an arrangement commonly described as a carve-out. For example, an employer might offer several different health plan options each with its own deductible but have one MBHC plan providing mental health/substance use benefits to all employees. Separate deductibles would force people who needed both types of services to satisfy a higher deductible than people needing only medical services and imposed a barrier to accessing benefits. As a result, the regulations clarified that plans cannot have separate deductibles and out-of-pocket limits for mental health/substance use and medical/surgical benefits.

The February 2010 interim final regulations made a distinction between quantifiable treatment limits, such as visit limits and copayments, and non-quantifiable treatment limitations (NQTLs), such as prior authorization, and clarified that both were subject to parity. Other examples of NQTLs include medical management standards, prescription drug formulary design, standards for provider admission to networks, determination of provider reimbursement rates, requirements for step therapy (for example, using lower-cost treatments first before trying others), and requirements to complete a course of treatment as a condition of benefits.

The interim final regulation allowed plans and issuers to have different NQTLs for mental health/substance use benefits than for medical/surgical benefits if the limitations were based on “recognized clinically appropriate standards of care.” This exception proposed in the interim final regulation resulted in a number of comments asking for clarity. Other comments argued that this was another way for plans and issuers to treat coverage for mental health/substance use disorders differently than medical/surgical coverage.

The November 2013 final rule eliminated the specific exemption for different NQTLs

based on “recognized clinically appropriate standards of care.” Plans and issuers can still take into account clinically appropriate standards of care when determining coverage as long as they apply any NQTLs for mental health/substance use benefits comparably and no more stringently than those with respect to medical/surgical benefits. The final rule adds several examples of NQTLs such as network tier design and restrictions based on geographic location, facility type, and provider specialty, but noted that this is not an exhaustive list. The rule also clarifies that plans cannot discriminate in provider reimbursement rates as a way of discouraging mental health providers from participating in their network. Finally, in an effort to improve transparency, the regulations require plans and issuers to disclose the medical necessity criteria used, as well as any reason for a denial of a mental health or substance use claim, upon request.

Part of the impetus for eliminating the “clinically appropriate standard of care” exemption in NQTLs was the results of a study commissioned by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health and Human Services (HHS). Simultaneously with the publication of the final regulations, HHS released the [ASPE study of large employers’ compliance with MHPAEA](#). The study found that employers and group health plans made substantial changes to their mental health/substance use benefits as a result of MHPAEA and by and large were in compliance. However, the report found that plans routinely used stricter NQTLs for mental health/substance use benefits than for medical/surgical benefits including in the application of precertification requirements, medical necessity criteria, routine retrospective review, and lower provider reimbursement rates.

WHAT’S THE DEBATE?

Increasing access to mental health and substance abuse care. Critics have argued that parity legislation alone is not enough to fix other underlying problems in how our health system provides access to treatment of mental health and substance use disorders.

The supply and availability of mental health providers has been the subject of numerous research articles. A [2009 Health Affairs article by Peter Cunningham](#) found that two-thirds of primary care physicians reported that they were unable to get outpatient mental health services for their patients—more than twice

2/3

Of physicians

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the percentage who reported trouble finding specialist referrals, nonemergency hospital admissions, or imaging services. Mental health professionals tend to be concentrated in high-population, high-income areas, and the lack of mental health care providers in rural areas as well as in pediatrics has been well documented. Finally, there is still a stigma associated with receiving mental health or substance use treatment. Eliminating the stigma and increasing the availability of high-quality providers are two keys to increasing access to care.

Determining equivalence of services. Much of the debate in implementing parity is around determining equivalence of services between mental health/substance use benefits and medical/surgical benefits. Some of the treatments for mental health and substance use disorders do not have an equivalent medical/surgical treatment, particularly with respect to treatment settings. For example, intensive outpatient programs often used to treat substance abuse do not have an equivalent in internal medicine. Similarly, it is difficult to determine the medical/surgical equivalent for a rehab stay for an acute schizophrenic episode. Full parity demands that standards of evidence be applied consistently across mental health/substance use and medical/surgical treatments. As one health insurance executive noted, “How to provide coverage for care levels and treatment venues that are unique to behavioral health, and aligning these with medical and surgical benefits, is a continuing discussion within health plans and between plans and regulators.”

Reducing fragmentation of the health care delivery system. Another obstacle to care that persists despite passage of parity legislation is the fragmentation of the American health care delivery system. Arguably, one reason patients with mental health and substance use disorders experience fragmentation is due to the use of carve-outs for providing mental health/substance use benefits. One challenge for group health plans is to integrate and coordinate mental health and substance use care with medical care despite using separate administrators. In addition to different

benefits administrators, mental health and substance use services are usually provided by different health professionals than medical services, and care coordination does not always occur among various providers. Many people with mental health disorders have co-occurring physical disorders. Some medical conditions may place people at risk for mental disorders, mental health issues may lead to a medical condition, and both conditions share some common risk factors. All of these factors heighten the need for coordination in order to deliver high-quality care to people with mental health/substance use disorders.

Not everyone is subject to parity. While the ACA expanded the reach of the MHPAEA both by direct application to the individual market and to issuers in the individual and small-employer market through the EHB requirement, some plans and benefits are still excluded. Some fee-for-service Medicaid options, employers with fewer than fifty employees who self-insure, and self-funded non-federal governmental health plans that opt out are not required to provide equivalent coverage. Small employers are likely to purchase insurance from an issuer who is subject to the EHB requirement and therefore mental health/substance use parity. It remains to be seen whether small employers will self-insure at a greater rate, possibly by purchasing stop-loss coverage to limit their liability, in order to be exempt from EHBs and therefore parity. In addition, while Medicare coinsurance for mental health/substance use treatment is the same as for medical/surgical treatment beginning in 2014, Medicare still has a 190-day lifetime limit on inpatient psychiatric care that does not exist for inpatient medical care, although this affects a small number of people.

WHAT'S NEXT?

Enforcing compliance with the MHPAEA is a key issue to watch in the next few years. State insurance commissioners have primary enforcement authority over health insurance issuers, but they are busy with ACA implementation and enforcement activities, so MHPAEA compliance may be low on their priority list. ■

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