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Behavioral Health Parity and the Affordable Care Act

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Abstract

Prior to the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) and the ACA, about 49 million Americans were uninsured. Among those with employer sponsored health insurance, 2 % had coverage that entirely excluded mental health benefits and 7% had coverage that entirely excluded substance use benefits. The rates of non-coverage for mental and substance use disorder care in the individual health insurance markets are considerably higher. Private health insurance generally limits the extent of these benefits. The combination of MHPEA and ACA extended overall health insurance coverage to more people and expanded the scope of coverage to include mental health and substance abuse benefits.

Keywords

co-occurring disorders; disability economics; disability policy; health care; mental health; mental illness; policy; substance abuse

On October 3, 2008, Congress enacted the Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act (MHPAEA). MHPAEA extended the Mental Health Parity Act of 1996, which had prohibited the use of aggregate lifetime and annual dollar limits for mental health benefits in private insurance plans. Regulations implementing MHPAEA were published on February 2, 2010. A month later, the Patient Protection and Affordable Care Act (hereafter the Affordable Care Act or ACA) was enacted. In combination, these two laws serve to fundamentally alter the terms under which care for mental and substance use disorders are paid for in the United States. In this paper we describe how these two laws interact and affect insurance coverage for tens of millions of Americans.

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In 2009, prior to the passage of MHPAEA and the ACA, about 49 million Americans were uninsured (Garfield, Lave, & Donohue, 2010). Among those with employer sponsored health insurance, 2% had coverage that entirely excluded mental health benefits and 7% had coverage that entirely excluded substance use benefits. The rates of non-coverage for mental and substance use disorder care in the individual health insurance markets are considerably higher. Private health insurance that included mental health or substance use benefits generally limited the extent of these benefits. The combination of MHPEA and ACA extended overall health insurance coverage to more people, expanded the scope of coverage to include mental health and substance abuse benefits, and improved the coverage provided through those benefits.[1]

This paper is organized into four sections. In the first section, we review the provisions of MHPAEA and explain how it affects coverage under large group insurance plans. We also discuss what the Act does not do and the segments of the insurance market that are not affected. The second section of the paper explains the structure of coverage expansion provisions of the ACA. We focus first on private insurance coverage. This includes a review of the key elements of health insurance reform including the individual mandate, the development of exchanges, the design of the Essential Health Benefit and the low income subsidies that will enable people to afford coverage and care. This section also describes the expansion of coverage via Medicaid. In the third section of the paper, we examine how the two laws interact and the quantitative impact of those interactions. The fourth and final section offers concluding observations.

Background on The Mental Health Parity and Addictions Equity Act (MHPAEA)

People with behavioral health problems (mental and substance use disorders) are disproportionately represented among the uninsured population.[2] Thus coverage expansion will potentially have an especially important impact on those with mental and substance use disorders. Prior to the implementation of MHPAEA in 2010, nearly two-thirds of people with employer sponsored coverage had special limits on inpatient behavioral health coverage and about three-quarters faced limits on outpatient behavioral health coverage (Barry, Gabel, Frank, Hawkins, Whitmore, & Pickreign, 2003). About one-quarter of those with employer sponsored health insurance had coverage that required higher levels of cost sharing for behavioral health care. Thus prior to MHPAEA, the behavioral health coverage held by most privately-insured Americans offered limited coverage of catastrophic expenses. The historical efficiency rationale for such limits involved concerns about excess costs or what is termed “moral hazard”. Yet in a world where private insurers and state Medicaid programs make extensive use of managed behavioral health care, there is abundant evidence showing that costs can be well controlled even alongside the types of coverage expansions spurred by parity for behavioral health care (Goldman, Frank, & Burnam, 2006).

[1]Bureau of Labor Statistics (2012), Unpublished tabulations from National Compensation Survey.
[2]Tabulations from the National Household Survey on Drug Use and Health (2010).

What Does Parity Require and What Does It Not Do?

The Mental Health Parity and Addictions Equity Act (MHPAEA) requires group insurers to ensure that the "financial requirements" and "treatment limitations" that are applicable to mental health and substance use benefits are no more restrictive than the predominant financial requirements and treatment limitations for medical and surgical benefits covered by the plan. This simple summary highlights four key features of the MHPAEA:

- First, the MHPAEA does not mandate coverage for mental and substance use disorder services. It only requires that financial requirements and treatment limitations are no more restrictive conditional on behavioral health services being covered.
- Second, the MHPAEA only addresses larger employer group insurance arrangements (those with 51 employees of more).
- Third, the MHPAEA regulates behavioral health insurance benefits by analogy. That is, the statute requires that coverage for behavioral health be judged against the standard of coverage for medical-surgical services.
- Fourth, it identifies a range of methods for rationing care that are used by health plans to limit use of services. These include copayments, coinsurance, and deductibles under the heading "financial requirements."

The law also refers to "limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment" in defining what must be no more restrictive. This encompasses familiar benefit design parameters such as day and visit limits that have long been prevalent features of behavioral health coverage. It also pertains to management of behavioral health services that fall under "other similar limits on the scope and duration of treatment."

As noted, the statute explicitly recognizes that there are other ways to limit the "effective" level of coverage by using care management and other administrative mechanisms to ration care. Research has shown that care management can be applied so as to accomplish ends similar to results stemming from high copayments and strict treatment limits (Frank & McGuire, 2000). For this reason the MHPAEA regulations define what are termed Non-Quantitative Treatment Limits (NQTLs). NQTLs include medical management standards, prescription drug formulary structure, standards for including providers in a network, methods for establishing fees among other techniques. The regulations specify that a health plan may not impose an NQTL on mental health and substance use disorder services unless any processes, strategies, evidentiary standards or other factors used to create the NQTL are comparable to and applied no more stringently for medical surgical services. This means that the management of behavioral health care must be based on the same clinical and management processes used for management of medical-surgical care. This is complex to administer in practice, but it extended parity to all types of rationing mechanisms, which was clearly the intent of the statute.

At the time of this writing, final regulations have not been issued and thus there are some issues that were left unaddressed by the regulations issued in February 2010. Most

significant were issues related to the scope of services. Key to setting out what is to be included in the scope of services is the way that certain analogous services are viewed. For example, in most medical-surgical coverage, so-called intermediate services are defined. They include post-acute hospital care, post-acute Skilled Nursing Facility (SNF) care, and home health care. In each case they are time limited (30 to 60 days). An important question for the final regulations is what are the analogous services in the behavioral health area? Some have proposed these to include partial hospital care, intensive outpatient care, and residential services.

The Affordable Care Act and Behavioral Health

The foundation of increased insurance coverage under the ACA is built on redesign and expansion of the small group and individual health insurance market and the expansion of Medicaid. The Congressional Budget Office (CBO) (2013) estimates that the ACA will result in 37 million uninsured Americans gaining coverage (Congressional Budget Office, 2013). The ACA will expand coverage by providing subsidies for purchase of coverage in the non-group market and expanded eligibility for Medicaid, and it will change the nature of coverage available in the non-group and small-group markets.

Private Insurance Expansion and Reform

The redesign of the small group and individual health insurance market consists of several key components. These include the individual mandate, low income subsidies for premiums and cost sharing, the establishment of health insurance exchanges, and the definition of the essential health benefits.

Private insurance subsidies come in two forms, one for premiums and another for cost sharing. Individuals with incomes that are less than 400% of the federal poverty line (FPL) will be eligible for subsidies that defray premium costs and cost sharing obligations. These subsidies are only available if the insurance is purchased through health insurance exchanges. The premium subsidy reduces premium costs through a tax credit. Subsidy levels are based on a sliding scale tied to income. The subsidy is also linked to a specific benefit design (the second lowest cost silver plan). Insurance sold through the exchanges also sets a cap on out-of-pocket costs for health care. This too varies with income level.

The individual mandate requires individuals to maintain “minimum essential coverage.” Individuals that are permanent residents or citizens, have incomes that require filing a tax return ($9,350 for an individual and $18,700 for a family in 2010), and face out-of-pocket premium costs that amount to less than 8% of income must purchase health insurance or they can be assessed a tax penalty. The penalties are quite modest. In 2014, the penalty is $95 per adult and $47.50 per child or 1% of family income, whichever is greater. By 2016, they will be $695 per adult and $347.50 per child or 2.5% of family income, whichever is greater.

Health insurance exchanges reorganize the individual and small group health insurance market. Exchanges implement and enforce standards that certify health plans as “qualified” to sell health insurance through exchanges. To qualify for participation in the exchanges,

health plans must meet essential health benefit (EHB) requirements and other marketing and quality requirements. For example, an exchange must ensure that a qualified health plan or QHP offers a sufficient choice of providers. Issuers must be licensed and in good standing in each state in which coverage is offered. The term "good standing" means that the issuer has no outstanding sanctions imposed by a State's Department of Insurance.

Health plans must comply with quality improvement standards under the ACA. Plans may vary premiums for a QHP or multi-state QHP by geographic rating area. Plans must charge the same premium rate for a plan, regardless of whether the plan is offered through the Exchange, directly to a consumer, or through an agent. Health plans must cover all of the following groups using one or more combinations including, individuals, two-adult families, one-adult families with a child or children, and all other families.[3]

The Essential Health Benefit (EHB) requirements govern the basic level of coverage. The ACA defines 10 components of coverage under the EHB that in effect define the mandated components of private insurance coverage. They include ambulatory services, emergency, hospitalization, maternity/newborn care, pediatric care, prescription drugs, preventive/ wellness, rehabilitative/habilitative and mental health and substance abuse care. The cost sharing arrangements are set out in the statute under the bronze, silver, gold and platinum options. The scope of services is defined by the typical private plan. Regulations have given states considerable discretion in choosing a benchmark for the EHB. The recent regulation governing the EHB allows states to choose among the following potential benchmark plans. They may select one of the three largest small group insurance plans in the state, the largest commercial HMO plan, one of the three largest health plans options for state employees, or one of the three largest plans that are part of the Federal Employees Health Benefit Program (FEHBP).[4] The rationale for this regulatory strategy is primarily two-fold. First, because the coverage is aimed at individual and small group markets, using small group plans as a benchmark allows for a standard that is compatible with many small group plans. This is important because under the ACA, a state may require additional coverage beyond the EHB minimum for plans offered in the exchanges and in general, state laws governing small group and individual plans will apply to plans offered in the exchanges (as well as those offered outside the exchanges). However, states will have to cover the costs of any requirements beyond the EHB minimum. Second, health care varies dramatically across the country and some recognition of the heterogeneity of local conditions was seen as desirable. Several important implications stem from the reform of private health insurance markets.

One surprising finding is that only about 7% of the population under age 65 would be affected by the individual mandate provision in the ACA. This is a surprising finding given the rancor of the political debate around this provision of the law (Blumberg, Buettgens, & Feder, 2012). It is also important to recognize that the tax consequences of failing to adhere to the individual mandate are modest relative to the full cost of insurance. This means that the subsidies are likely to be the most important factor in affecting the level of program

[3]Note that the ACA also prohibits pre-existing condition exclusions for all Americans starting in 2014. It requires guaranteed issue and renewability in 2014. It decouples premiums from measures of health status in 2014. Lifetime caps on benefits were prohibited in September 2010 and annual limits are restricted and prohibited in 2014.

[4]45 CFR Parts 147, 155 and 156 (CMS-9980-P)

participation among people with incomes over 138% of the FPL (those above the Medicaid eligibility standard). Finally, the EHB provisions of the law mandate coverage of mental health and substance abuse services which means that unlike MHPAEA, the ACA requires plans to cover care for mental and substance use disorder care (M/SUD).

Medicaid Expansion

The ACA creates a new mandatory eligibility group for Medicaid. It creates a simple income eligibility standard set at 133% of the FPL, with an additional 5% income allowance effectively making the standard 138% of the FPL. This amounted to $15,415 and $26,344 for individuals and a family of three respectively in 2012. Meeting the income standard qualifies one for Medicaid regardless of other eligibility criteria for other categories; there is no asset test. The expansion is optional until 2014 and then is mandated. The Supreme Court decision created a situation where there are no consequences of failing to implement the Medicaid expansion beyond foregoing federal subsidies for expansion. In effect this makes expansion optional. The ACA creates enhanced federal funding for the Medicaid expansion. The federal government pays for 100% of the costs of the expansion in the years 2014-2016 and then phases down its participation to 90% by 2020.

The benefit design for those individuals newly covered under the Medicaid expansion will not necessarily be the states' existing Medicaid benefit structure. The statute outlines a number of benchmark plans that states may choose from in defining the coverage they will offer to the expansion group and the Center for Medicare and Medicaid Services (CMS) has clarified that states may use their Medicaid state plan as one option for defining the coverage they will provide. The CMS has adopted the term "Alternative Benefit Plan" to refer to the coverage states may offer the expansion group. The ACA requires that the coverage states provide through these Alternative Benefit Plans must comply with the EHB requirements and federal parity requirements in order to qualify for the enhanced match.[5]

Following the admonitions in the ACA (Section 1937), the regulations allow states to design specialized benefit packages to address the special needs of target populations. Thus there may be different Alternative Benefit Plans (ABPs) that apply to different population segments. The regulations also require that the full range of preventive services be included in the ABP's coverage with no cost sharing. The regulations also allow for greater state flexibility in allowing cost sharing for services other than drugs, emergency room and preventive services. In the case of prescription drugs, greater flexibility is given to ABPs in creating tiered drug formularies.

The implications of the Medicaid expansion are several. A key result is that it is projected that roughly 65% of the newly covered people with M/SUD will be covered by the Medicaid expansion and Medicaid will become an even more significant source of coverage for people with mental health or substance use conditions (Donohue, Garfield, & Lave, 2010). A second implication is that because single childless adults will now be eligible for Medicaid, there will be many among the newly eligible with severe and persistent mental disorders that live in extreme poverty (less than 50% of the FPL), experience unstable housing, and have

[5]Proposed 42 CFR 440.315

co-occurring SUDs. The flexibility provided to states under the ACA and through the regulations allows for the design of benefits that target the unique needs of people with significant impairments arising from SPMI (Serious and Persistent Mental Illness).

The Interaction of the ACA and MHPAEA

The ACA and MHPAEA interact in a number of very important ways that serve to greatly extend the reach of the MHPAEA legislation. In particular, the ACA legislation and the regulations that pertain to both the EHBs and ABPs require that benefit designs conform to the provisions of MHPAEA. The interaction between MHPAEA and the ACA operates through four channels. The inclusion of mental health and substance abuse services as one of the 10 required components of the EHB serves to mandate M/SUD coverage in both small group and individual private insurance (in and outside the exchanges) and in the Medicaid expansion coverage (all of which are subject to the EHB requirements under the ACA). The ACA also extended the MHPAEA requirements to qualified health plans, individual plans, and the coverage provided to the Medicaid expansion group. The regulations incorporated MHPAEA into the M/SUD components of the EHB. As a result, the requirement to cover M/SUD benefits in compliance with MHPAEA extends to small group and individual plans both inside and outside the exchanges. The rationale for this was to prevent creating the opportunity for less generous coverage outside the exchanges that would steer the better health care risks to plans outside the exchanges.

Together these features of the ACA and its implementation mean that MHPAEA protections are extended to small group and individual health insurance plans that were exempted from the MHPAEA provisions. Finally, the ACA and the proposed Medicaid expansion regulations state the MHPAEA provisions apply to the benefit designs of ABPs. Thus in combination, the four channels through which the ACA and MHPAEA interact mandate coverage at parity for all those gaining coverage through the exchanges and the Medicaid expansion, and extend parity requirements to existing plans in the small group and individual market.

Estimated Impact

The quantitative implications of these interactions are profound. These are summarized in Table 1. There are roughly 32 million people that currently do not have any insurance coverage for M/SUD care. Five million, of that total, currently have health insurance coverage that does not cover M/SUD care. Those people benefit from the extension of MHPAEA to the individual and small group market. About 27 million people are currently uninsured and will gain coverage through either the exchanges or via the Medicaid expansion (as noted earlier this is the lower end of the CBO impact estimate). That coverage will be at parity with medical-surgical coverage. In addition, another 30 million people that currently have private insurance coverage that includes M/SUD services through individual and small group plans will see their coverage for M/SUD expanded. Thus a total of 62 million people will see a gain in coverage for M/SUD care as a result of the interaction of MHPAEA and the ACA.

In addition to offering individuals and households new financial protection against the financial consequences of needing M/SUD care, the ACA also offers important budgetary benefits to the states. As already noted the federal government will pay for about 93% of the cost of the Medicaid expansion between 2014 and 2022 (Center on Budget & Priorities, 2012). Because states pay for public mental health systems that support people that are uninsured or underinsured for mental health care, the Medicaid expansion will offer states funds that would replace existing outlays from state general funds.

Insurance and Financing Issues

MHPAEA regulates insurance and care management under health plans by analogy. That is, MHPAEA requires that the terms of coverage and care management for M/SUD care be no more restrictive than those for medical-surgical care. Thus the regulatory standards are based on a notion of comparability, and not on notions of clinical impact or financial risk protection that are typically at the heart of many benefit design considerations. This means that the binding constraints on M/SUD include the scope of services for a medical-surgical benefit. For example, long-term care is typically not covered under private health insurance. While many health plans cover post-acute services like those in a Skilled Nursing Facility or a Rehabilitation hospital, these are typically of very limited time duration (e.g. 20-30 days). Thus, many treatments for severe mental and substance use disorders that require long term services and supports (LTSS) that have been shown to be effective, like Assertive Community Treatment, would not be required under MHPAEA.

The implication is that by setting a regulatory standard that depends on the structure of insurance for an analogous set of services, the coverage for M/SUD is only as comprehensive as the medical-surgical benefit. This fact is captured in Figure 1 that illustrates the potential gaps in coverage that may result from implementation of parity via the EHB and AHP coverage provisions in the ACA. Figure 1 highlights the fact that there will be a set of important services that are unlikely to be covered by many states' EHB and AHP benefit packages. So ACT, supported employment, supported housing, and long-term residential services are unlikely to be included in many state EHB and AHP designs.

The reality that there will be coverage gaps implies that paying for LTSS to meet the needs of low income people with M/SUD will continue to make claims on state general funds and federal block grants. The recent recession has resulted in several years of declines in the budgets of state mental health programs. Many within and outside the federal government have begun to discuss the possibility of repurposing federal block grants used to pay for M/SUD services. While it is clear that the coverage expansion of the ACA in the context of MHPAEA will direct new resources towards the care of people with M/SUD, it is equally clear that some important services for impaired low income segments of the population will not be insured.

The confluence of the coverage expansion and the remnants of the budgetary impacts of the recession may have particular import for the supply of treatment for SUDs. The parity provisions in the ACA are especially significant for the coverage of care for SUDs (Buck, 2011). This is because people with SUDs are overrepresented among the uninsured and coverage of SUDs in both Medicaid and private health insurance has been considerably

more limited than even the mental health benefit. This means that one should expect significant increases in demand for SUD treatment. However, because many of the services for SUD care have been financed by state grants and contracts, many of these providers have not had to meet the medical or administrative requirements for health care providers that bill private insurance and Medicaid. For this reason, there is a risk that at the very time that demand is expanding, the capacity to supply services will be less available. In fact it is estimated that close to 30% of substance use providers have never billed either Medicaid or private health insurance for services provided. The implication is that the combination of state cutbacks in support for SUD care, coupled with the likelihood that a segment of existing providers will not qualify for reimbursement by public or private insurance, suggests potential shortages of SUD providers.

Finally, MHPAEA has been seen as a threat by segments of the managed behavioral health care (MBHC) industry. In fact several MBHC firms brought suit against the government when the MHPAEA regulations were issued. MHPAEA requires a close alignment of financial requirements, like deductibles, care management and medical necessity criteria for M/SUD care and medical surgical services. This is more difficult to accomplish under carve-out arrangements. The ACA, in addition to weaving MHPAEA into the fabric of health reform, also contains provisions with respect to delivery system reform that encourages integration of M/SUD with general medical care. Together these forces may force a shift in the carve-out model as it has evolved. While the specialized expertise of the MBHC industry is clearly valued by purchasers, the need to better coordinate and integrate M/SUD and general medical care is seen as central to improving quality of care and making care more efficient. The carve-out model might further evolve to meet that need by adapting its care management systems in order to unify information and bolster communication between specialty M/SUD care and general medical care.

Concluding Remarks

The enactment of Medicare and Medicaid served to fundamentally change the delivery of mental health care in the U.S. It turned out to be far more powerful in driving mental health care changes than mental health specific policy efforts (Frank & Glied, 2006). The ACA drives new resources and financial protection towards M/SUD care. The intersection of the ACA and MHPAEA accomplish longstanding policy goals that date back to President John F. Kennedy. Like prior changes in payment and coverage, those brought about by the ACA will force important institutional change and will alter the roles of government agencies in overseeing the delivery of care. That is, M/SUD policy will become even more the purview of Medicaid and private insurance regulators than it is today. However, because coverage is necessarily incomplete, an important new policy challenge will be the continued financing of LTSS for people with M/SUD needs and the continued responsibility for true public health aspects of M/SUD like prevention and early intervention programs.

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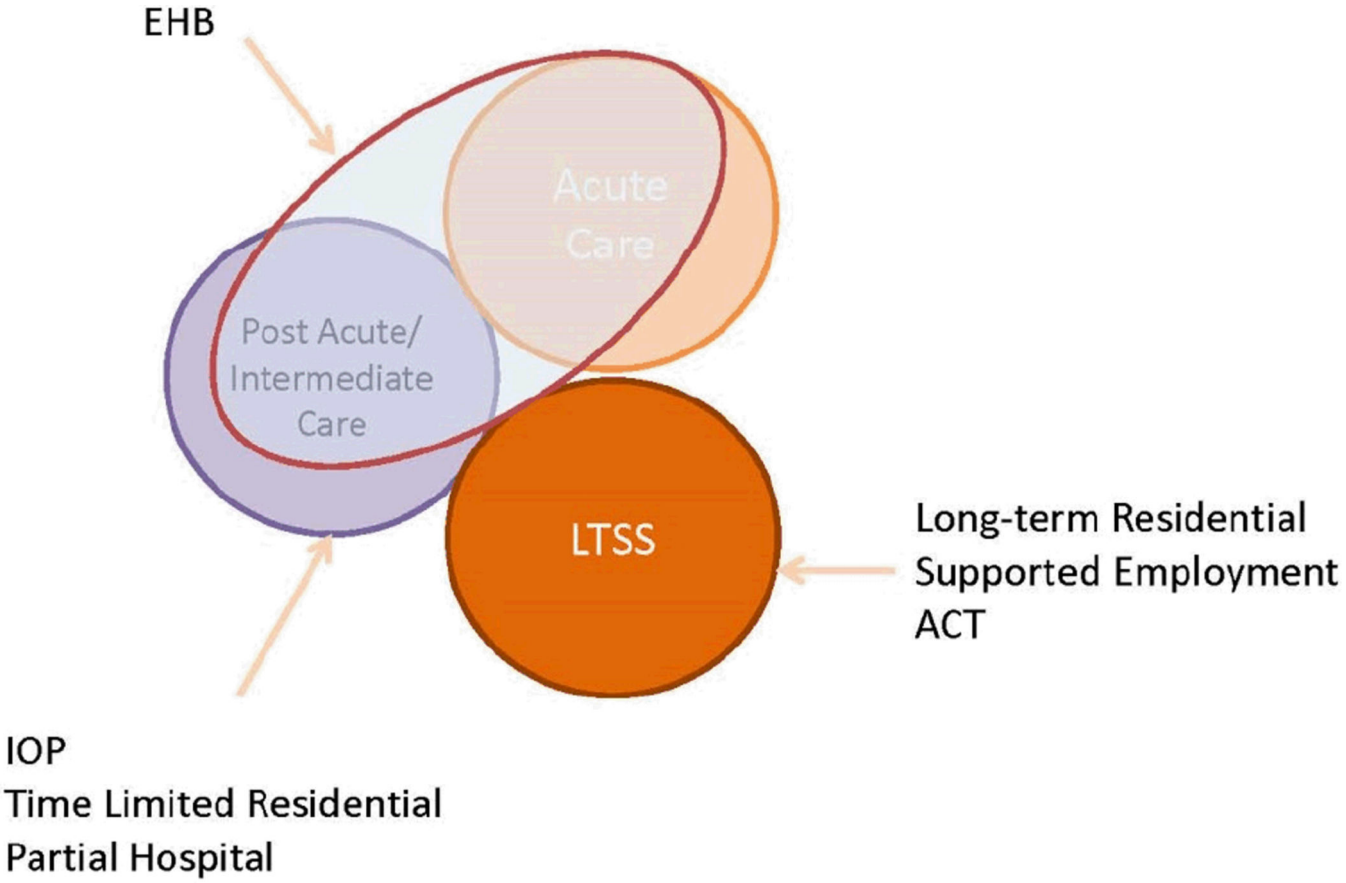

Figure 1.
What are the Limits of Coverage?

Table 1

Impact of Interactions of ACA and MHPAEA

	New Coverage for M/SUD Care	Expanded M/SUD Care Coverage	Total
Individuals Currently Holding Individual Coverage	3.9	7.1	11
Individuals Currently with Coverage under Small Group Plans	1.2	23.3	24.5
Uninsured	27	--	27
Total	32.1	30.4	62.5

Source: ACA Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for Over 62 Million Americans, *ASPE Brief*, February 2013.