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Federal Parity In The Evolving Mental Health And Addiction Care Landscape

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ABSTRACT The intent of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 is to eliminate differences between health insurance coverage of mental health and substance use disorder benefits and coverage of medical or surgical benefits. The Affordable Care Act significantly extended the reach of the Wellstone-Domenici law by applying it to new insurance markets. We summarize the evolution of legislative and regulatory actions to bring about federal insurance parity. We also summarize available evidence on how the Wellstone-Domenici law has contributed to addressing insurance discrimination; rectifying market inefficiencies due to adverse selection; and altering utilization, spending, and health outcomes for people with mental health and substance use disorders. In addition, we highlight important gaps in knowledge about how parity has been implemented, describe the groups still lacking parity-level coverage, and make recommendations on steps to improve the likelihood that the Wellstone-Domenici law will fulfill the aims of its architects.

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Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 to eliminate historical differences in health insurance coverage between mental health and substance use disorder benefits and medical or surgical benefits. The parity law requires that health insurers choosing to cover mental health and substance use disorder services offer these benefits at levels that are at least as generous as those of benefits for other medical conditions. In a floor statement during congressional debate on the legislation, Rep. Patrick Kennedy (D-RI), one of the legislation's chief architects, made the case for passage on the ground that "access to mental health services is one of the most important and most neglected civil rights issues facing the Nation."[1]

The Wellstone-Domenici law laid the foundation for additional progress toward mental health parity. Following on the heels of the law, the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 included parity provisions for CHIP. In addition, the Affordable Care Act (ACA) mandated coverage at parity for mental health and substance use disorders—consistent with the requirements of the Wellstone-Domenici law—as one of ten categories of essential health benefits in several other insurance markets.

While the Wellstone-Domenici law applied only to private insurance offered by firms with fifty or more employees, the ACA extended its provisions to health insurers offering individual and small-group health coverage through the new health insurance exchanges, also known as Marketplaces. Similarly, the Wellstone-Domenici law required parity in Medicaid managed care, and the ACA extended the requirement to non–managed care Medicaid alternative benefit plans. In March 2016 the Centers for Medicare and Medicaid Services (CMS) released the final

rule[2] implementing the provisions of the Wellstone-Domenici law and CHIPRA that require parity in Medicaid managed care, Medicaid alternative benefit plans, and CHIP. Thus, nearly a decade has elapsed between passage of the Wellstone-Domenici law and full regulatory implementation of parity for mental health and substance use disorder coverage.

Research is under way to understand the effects of federal parity on a range of outcomes, including total and out-of-pocket spending, access and service use, and insurance product design and benefit offerings. In addition, parity advocates and public officials have been tracking how the law is being implemented.

In this article we summarize the evolution of federal action on parity and examine the available evidence on how federal parity has addressed the problems of insurance discrimination and market inefficiencies that result from adverse selection. We examine how parity has affected utilization, spending, and health outcomes for people with mental health or substance use disorders. Finally, we highlight the numerous gaps in knowledge about how federal parity is operating and make recommendations on ways to improve the likelihood that these laws will fulfill the intent of their architects.

Evolution Of Insurance Parity

Limits on insurance benefits for mental health and substance use disorders date back to the inception of third-party payment in the United States.[3] Until recently, coverage for mental health and substance use disorder services required higher cost sharing (for example, coinsurance of 50 percent compared with 20 percent for medical or surgical services) and special annual service caps (such as twenty outpatient visits per year).[4,5]

The case for parity has been based on the fairness argument that insurance should not discriminate against people with mental illnesses. In addition to outright discrimination, economists have offered the following two reasons why benefits for mental health and substance use disorders have been more restrictive than medical or surgical benefits: moral hazard and adverse selection.

Moral hazard refers to the incentive that consumers with insurance have to use more health care services than they would if they were paying the full price out of pocket. The RAND Health Insurance Experiment, conducted from 1974 to 1982, found that the responsiveness of enrollees' demand to the out-of-pocket price was greater for outpatient mental health services than for outpatient medical services. Thus, a given reduction in price because of insurance would create more inefficiency in mental health care use than in medical care use.[6] This result suggested that coverage levels should not be the same for medical and mental health care. However, with the advent of managed care, moral hazard became less of a concern. Evidence from the 1990s on has consistently indicated that managed care cost-control techniques offer health plans alternative ways to control moral hazard, without using discriminatory benefit design.[7]

Adverse selection refers to the disproportionate enrollment of people with expensive health care needs in an insurance plan. Insurers can avoid adverse selection by underproviding (relative to competing plans in the same market) benefits needed by certain groups of enrollees. In the case of people who need mental health coverage, competing health plans may underprovide that coverage because of fears of attracting enrollees with high health care expenditures, even when potential enrollees value the coverage in excess of the insurer's costs of providing it.[8] By leveling the playing field, insurance parity requirements aimed to eliminate this type of inefficient market competition that was driven by plans' concerns about adverse selection.

STATE AND FEDERAL EFFORTS TO MOVE TOWARD PARITY Beginning in the early 1990s Sen. Pete Domenici (R-NM), Sen. Paul Wellstone (D-MN), and others began pushing for federal parity, and parity language was included in failed health reform efforts in 1993–94.[9] The Mental Health Parity Act of 1996 required certain group health plans that offered mental health benefits to apply the same lifetime and annual dollar caps to mental health benefits as those applied to medical or surgical benefits. The change in dollar caps was designed to give patients with costly illnesses some important protections from bankruptcy. Importantly, however, this law did not equalize other restrictions on mental health benefits, such as copayments and limits on inpatient days and outpatient visits. Nor did the 1996 law apply to substance use disorder benefits. Health plans circumvented the law by limiting mental health benefits—for example, reducing the number of covered annual inpatient days and outpatient visits and charging higher copays.[10]

After passage of the 1996 law, most states enacted parity laws. These varied in scope, but all were limited in reach because they applied only to a subset of a given state's privately insured population. This is because the Employee Retirement Income Security Act (ERISA) of 1974 exempts from state parity laws "self-insured" firms, which contract with plans only to administer employee benefits and not to pool risk—and roughly half of the privately insured people in

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the United States are covered by self-insured firms.[11]

In 1999 President Bill Clinton directed the Office of Personnel Management to implement comprehensive mental health and substance use disorder parity for in-network care in the Federal Employee Health Benefits program.[12] In July 2008 the Medicare Improvements for Patients and Providers Act phased out the requirement that beneficiaries pay higher coinsurance for outpatient mental health treatment services than for most other outpatient services.

IMPLEMENTATION OF THE WELLSTONE-DOMENICI LAW The Wellstone-Domenici law, which took effect in 2010, built on the Mental Health Parity Act of 1996 and the Clinton administration's federal employee parity directive in various ways. Importantly, it expanded the application of federal parity to cost sharing, deductibles, and limits on inpatient days and outpatient visits for services both in and out of network. It also extended the reach of parity to additional insured groups and to substance use disorder benefits (for a fuller description of the provisions of the law, see online Appendix A).[13]

An interim final rule released in February 2010 clarified various areas of potential ambiguity, including prohibiting separate deductibles and out-of-pocket limits for mental health and substance use disorder benefits and for medical or surgical benefits.[14] The rule clarified that the parity requirement applied to both quantitative treatment limits (financial requirements such as deductibles, copays, and caps on the number of outpatient visits) and nonquantitative treatment limitations. Specific examples of nonquantitative treatment limitations include the following: medical management standards that limit or exclude benefits based on medical necessity; standards for allowing a provider to participate in a network; plan methods for determining usual, customary, and reasonable charges; exclusions based on failure to complete a course of treatment; and certain formulary designs for prescription drugs.

The application of parity to nonquantitative treatment limitations was intended to address the long-standing concern that insurers would respond to parity in standard published benefit packages by imposing more stringent managed care practices on mental health and substance use disorder benefits than on medical or surgical benefits—which would mean that removal of quantitative treatment limits would not lead to more equitable coverage.[15]

The final rule[16] for the Wellstone-Domenici law released in November 2013 was similar to the interim final rule in most respects, but there were three important differences. First, the final rule dropped a provision that allowed differences in nonquantitative treatment limitations based on "clinically appropriate standards of care." This provision was determined in the final rule to be "confusing, unnecessary, and subject to potential abuse."[17] Second, the final rule clarified the application of parity to benefits for intermediate levels of mental health and substance use disorder care (that is, residential treatment, partial hospitalization, and intensive outpatient care). Third, the rule clarified disclosure rights requiring that reasons for denials, reimbursements, or payments be made available automatically.

HOW THE AFFORDABLE CARE ACT EXTENDED WELLSTONE-DOMENICI The ACA expanded the reach of the Wellstone-Domenici law to new categories of health insurers in 2014. It required health insurance sold on the individual and small-group markets through exchange plans to cover ten essential health benefits—including mental health and substance use disorder benefits at parity—except for grandfathered policies (Exhibit 1). In states that expanded eligibility for Medicaid under the ACA, the law required Medicaid managed care plans and Medicaid fee-for-service alternative benefit plans to cover the ten essential health benefits, including mental health and substance use disorder benefits at parity.[18] CMS also clarified that parity extends to other types of Medicaid plans, such as Prepaid Inpatient Hospital Plans and Prepaid Ambulatory Health Plans, which some states use to provide a limited set of state plan services. The intent was to ensure that the principles of parity applied across the entirety of Medicaid managed care, including when mental health and substance use disorder services are supplied by a separate carved-out portion of the insurance package.[19]

Evidence On Effects Of Parity

An extensive literature exists on the effects of parity policies before the enactment of the Wellstone-Domenici law (for studies examining

EXHIBIT 1

Summary of applications of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 to coverage under the Affordable Care Act (ACA)

Coverage type	Application to ACA coverage
INDIVIDUAL MARKET COVERAGE	
Not grandfathered	Under the essential health benefits rule, policies must include coverage for mental health and substance use disorders, and that coverage must comply with the federal parity requirements beginning on or after July 2014 (or January 2015 for calendar year policies).
Grandfathered	Policies are not subject to the essential health benefits rule and therefore not required to include coverage for mental health and substance use disorders. However, if those benefits are covered under the policy, that coverage must comply with the federal parity requirements for policy years beginning on or after July 2014 (or January 2015 for calendar year policies).
SMALL-GROUP MARKET COVERAGE	
Not grandfathered	Under the essential health benefits rule, policies must include coverage for mental health and substance use disorders, and that coverage must comply with the federal parity requirements beginning in July 2014 (or January 2015 for calendar year policies).
Grandfathered	Polices are not required to comply with either essential health benefits provisions or the requirements of the Mental Health Parity and Addiction Equity Act.

SOURCE Authors' analysis of data from Employee Benefits Security Administration. FAQs about Affordable Care Act implementation (part XVIII) and mental health parity implementation [Internet]. Washington (DC): EBSA; 2014 Jan 9 [cited 2016 May 6]. Available from: http://www.dol.gov/ebsa/faqs/faq-aca18.html. **NOTE** Grandfathered coverage is coverage provided through a small-group health plan or individual insurance policy in which an individual was enrolled on March 23, 2010, and that has not made certain changes in coverage since that time.

effects of parity policies from this era, see Appendix B).[13] The primary takeaway lesson from this literature was that parity conferred important financial protections but had little impact on total spending in the context of managed care. These studies paved the way for the Wellstone-Domenici law by reassuring members of Congress worried about health care spending growth that a federal parity law could be enacted in a manner that would increase fairness without driving up premiums.[20]

Published research on the effects of the Wellstone-Domenici law and the parity provisions of the ACA is limited. We reviewed this literature to investigate what is known about the effects of these laws on insurance discrimination; adverse selection; and utilization, spending, and health outcomes for individuals with mental health and substance use disorders.

A 2013 report from the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services (HHS) found that health plans made substantial changes to their standard published benefits and that very few employers dropped coverage for mental health and substance use disorders.[21] Using plan survey data, Constance Horgan and coauthors also examined changes in quantitative and nonquantitative treatment limitations and found that most plans offered improved financial protection and did not drop coverage.[22] However, the HHS report also documented that a sizable minority of plans were offering benefits inconsistent with the law.[21] For example, one in five large employers still required higher copays for in-network outpatient mental health and substance use disorder services than for similar medical or surgical services.

Kelsey Berry and colleagues examined parity compliance based on publicly available health plan benefit information on two state health insurance exchange websites and found similar inconsistencies in the quantitative and nonquantitative treatment limitations of the parity requirement for exchange plans.[23] On one state's exchange, a potential enrollee could expect to encounter products that appeared inconsistent with parity law more than half of the time—especially products with discrepancies in prior authorization requirements for mental health and substance use disorder benefits versus medical or surgical benefits. These findings raise concerns that discrepancies in exchange plans' marketing materials could prompt consumers with mental health and substance use disorders to avoid enrolling in plans that list more restrictive benefits than those offered for medical or surgical services. No studies to date have looked empirically at selection patterns under federal parity.

Only a few studies have been published that examine how federal parity has affected service use and spending outcomes, and we are aware of no studies that assess the effect of the Wellstone-Domenici law on health. An inherent challenge in studying federal parity is that it is national in scope, which makes it difficult to identify an appropriate comparison group.

Susan Busch and coauthors used claims data

A subtle aspect of parity regulation is its requirement that parity be achieved in process, not outcome.

from a single national insurer, Aetna, to examine the effects of the Wellstone-Domenici law on substance use disorder service use and spending.[24] The study compared Aetna enrollees subject to parity for the first time under the law with enrollees who had coverage that had previously been subject to a state substance use disorder parity law. It found no effects of the Wellstone-Domenici law one year following implementation on the probability of using substance use disorder services, and it found that only a small increase in total substance use disorder treatment spending was attributable to the law.

Emma McGinty and colleagues used Truven Health Analytics MarketScan data to look at the Wellstone-Domenici law's impact on out-of-network substance use services three years before and three years after implementation.[25] The law was associated with an increase in the probability of using out-of-network substance use disorder services, a higher average number of out-of-network outpatient visits for substance use disorders, and a modest increase in average total spending on out-of-network substance use disorder services among users. The McGinty study used an interrupted time series research design without a comparison population, because of the law's national scope.

Most of the critical questions related to the impact of the Wellstone-Domenici law and its extensions under the ACA remain unanswered. A fuller understanding of the effects of these laws requires data from 2015 and beyond, given the timing of the release of regulatory guidance. Such data are not yet available.

Monitoring And Enforcement Of Parity

We identified four areas of concern in the monitoring and enforcement of federal parity under the Wellstone-Domenici law and the ACA.

PARITY IN LIMITATIONS ON TREATMENT There is ongoing concern about compliance with the federal parity requirements for both quantitative and nonquantitative treatment limitations. The latter limitations are potentially more vulnerable to violations because of the challenges associated with monitoring managed care processes.[26] The New York State attorney general's office, for example, has reached settlements with several plans regarding lack of compliance with parity after identifying plans that appeared to be managing utilization review processes more stringently for mental health and substance use disorder benefits than for medical or surgical benefits.[27] The office also found that denial letters were more likely to insufficiently explain the basis for the denial of mental health and substance use disorder services, compared with denial letters for medical or surgical services. In addition, concerns have been raised about network adequacy (having a sufficient number of providers) for providers of mental health and substance use disorder services, relative to other providers.[28]

Given research evidence that a sizable minority of plans were found not to be in compliance with quantitative treatment limit requirements, careful attention to standard published benefits—in particular, the "substantially all" test—is also warranted. Under the Wellstone-Domenici law, financial requirements for mental health and substance use disorder benefits, if the benefits are offered, must be no more restrictive than the predominant financial requirements applied to substantially all medical or surgical benefits. *Substantially all* has been interpreted by the regulatory agencies to mean at least two-thirds of medical or surgical benefits in the classification. For example, if a plan applies a $25 copay to at least two-thirds of outpatient in-network medical or surgical benefits, a copay higher than $25 could not be imposed on outpatient in-network mental health and substance use disorder benefits.[29]

Some concerns have been raised that insurers are pegging mental health and substance use disorder benefits to a particular medical or surgical service instead of rigorously applying the two-thirds rule to substantially all medical or surgical services. Better information on how comparators are determined would be useful.

A subtle aspect of parity regulation is its requirement that parity be achieved in process, not outcome. This means that health insurers choosing to cover mental health and substance use disorder benefits are required to offer them at levels at least as generous as those for other medical benefits, but it does not guarantee that enrollees will receive needed mental health and substance use disorder services and medical services at equivalent rates. More detailed information is needed on how insurers are making de-

terminations about whether mental health and substance use disorder benefits are at least as generous as medical or surgical benefits, and what types of circumstances result in disparate utilization patterns for the two types of services.

PARITY APPLIED TO CERTAIN DIAGNOSES AND TREATMENT TYPES When an insurer chooses to cover mental health and substance use disorder benefits, the Wellstone-Domenici law does not explicitly require that specific conditions be covered. Litigation challenges to the law include multiple cases in which plaintiffs have demanded—with mixed success thus far—that insurers cover autism and eating disorders.[30] Additional research is needed to understand whether there are conditions that meet generally recognized standards for mental health and substance use disorders but that are not being covered under the law.

Another area that has been litigated involves the application of parity to intermediate-level services (that is, residential treatment, partial hospitalization, and intensive outpatient care). The Wellstone-Domenici law final rule[16] requires that intermediate services be treated in a comparable manner to medical or surgical benefits based on the following six benefit classifications: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs. Horgan and coauthors found that 70 percent of commercial insurance products classified nonhospital residential treatment facility benefits for mental health and substance use disorders as comparable to medical or surgical inpatient benefits, 91 percent classified partial hospitalization mental health and substance use disorder benefits as outpatient benefits, and 95 percent classified intensive outpatient mental health and substance use disorder benefits as outpatient benefits.[22] No research is available on how the Wellstone-Domenici law affects the use of these intermediate-level services, and it is challenging to identify intermediate services accurately in claims data.

FINANCIAL PROTECTION AND PARITY A fundamental goal of parity is to improve financial protection against the often high and at times catastrophic costs of treating mental health and substance use disorders. Before the 1996 parity law, people with serious mental illnesses who had private insurance bore nearly full financial responsibility for treatment. While research has consistently demonstrated gains in terms of financial protection, these gains have been modest.

A recent study examined how the federal employee parity directive, requested in 1999 and issued in 2001, affected spending on the very sickest children using the highest-cost services.[31] Spending reductions attributable to parity among this group of children were much smaller than anticipated: an average annual reduction of about $178 in mental health and substance use disorder spending per child, or a 5-percentage-point decrease in the share of total mental health and substance use disorder spending paid out of pocket. A spending reduction of this magnitude is unlikely to meaningfully improve financial protection for a family struggling to obtain health care services for a very sick child.

Parity has become the law of the land, for all intents and purposes, but it has yet to reach certain groups.

MULTI-AGENCY ENFORCEMENT One challenge in enforcing the Wellstone-Domenici law is the division of responsibility among multiple federal and state governmental agencies. For example, the US Department of Labor and the Internal Revenue Service have enforcement responsibilities for private, self-insured employer-based health plans, and state insurance commissioners have primary authority over plans sold in the individual and small-group markets. HHS and the Department of the Treasury also have regulatory responsibilities over certain types of plans. In some states, most visibly New York, attorneys general have investigated potential compliance issues.

While it is appropriate that different agencies have authority over different aspects of monitoring, this regulatory web may create some confusion for the typical consumer. In addition, these agencies have been charged with monitoring and enforcing federal parity at a time when they are also grappling with managing the burden of other significant ACA-related regulatory demands. To aid with the coordination of monitoring and enforcement, in March 2016 President Barack Obama established an interagency parity task force to "identify and promote best practices for executive departments and agencies, as well as State agencies, to better ensure compliance with and implementation of requirements related to mental health and substance use disorder parity, and determine areas that would benefit from further guidance."[32]

Conclusion

Parity has become the law of the land, for all intents and purposes, but it has yet to reach certain groups. Importantly, federal parity does not apply to the approximately three million disabled US adults who have traditional fee-for-service Medicaid, a group with high rates of mental illness and substance use disorder. Yet under fee-for-service Medicaid, some states continue to impose limits on mental health and substance use disorder services that do not apply to other service types.[33]

No published research has examined the effects of parity in Medicaid. This makes sense given the slow roll-out of the Medicaid managed care parity regulations[2] and the relatively recent ACA expansion of Medicaid eligibility. Understanding the effects of parity in Medicaid should be a priority since, on average, Medicaid enrollees have greater need of mental health and substance use disorder services than enrollees with private insurance do.[34] In addition, since many states have shifted their Medicaid enrollees to managed care, including those with severe and disabling mental illnesses, it will be important to investigate how nonquantitative treatment limitations are being implemented under Medicaid managed care.

Parity as a policy tool is not equipped to solve all of the challenges facing the financing and delivery system for mental health and substance use disorder services. It is too blunt a policy instrument to meaningfully drive needed improvements in care quality, service integration, prevention, or patient-centeredness. Nonetheless, parity confers a guarantee that mental health and substance use disorder benefits, if offered, will not be more restrictive than other benefits. This guarantee has the potential to improve financial protection and secure a nondiscriminatory pathway to needed services, with the goal of improving health and well-being. In this manner, federal parity serves as a foundation that other financing and delivery system reforms, such as health homes and accountable care models, can build on.

One interesting question is whether parity can reduce societal stigma. National public opinion research indicates that the public views of people with mental illness and addiction remain quite negative.[35] Time will tell whether parity's shift toward nondiscrimination in insurance contributes to changing public discourse about mental illness and addiction to lessen stigma.

It is worth emphasizing that the incentives for health plans to avoid adverse selection do not go away in the presence of federal parity, since there will still be variation across plans with respect to the generosity of the mental health and substance use disorder benefits offered. The next five years will be critical to gaining a detailed picture of the extent to which parity is improving the health and well-being of people diagnosed with a mental health or substance use disorder, and to better assessing what new policies are needed to build on the Wellstone-Domenici law's achievements. ■

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