

# Health Policy Brief

NOVEMBER 9, 2015

## **Enforcing Mental Health Parity. Five years after the Mental Health Parity and Addiction Equity Act took effect, access to equal benefits and qualified providers remains elusive for many insured Americans.**

### WHAT'S THE ISSUE?

Traditionally, insurance providers and employers have covered treatment for mental health and substance use conditions differently than treatment for other medical conditions. Coverage for mental health care and substance use disorders 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 and substance use benefits substantially less generous than benefits for other health conditions.

Over the past decade, Congress has enacted several laws to end this inequity. As a result, nearly all insured Americans are now entitled to receive their mental health and substance use benefits at the same level as their benefits for other medical care. Enforcing those rights, however, has not been consistent, and many patients are left to fend for themselves. The following brief provides an update to a previously published brief on [Mental Health Parity](#), now with a focus on enforcement.

### 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. The push for equal benefits for substance use treatment is a more recent development.

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 fifty or more 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

# 17%

An estimated 17 percent of low-income adults in states that expanded Medicaid have a mental health condition.

MHPA did not mandate coverage for mental health treatment; instead, it only applied to group health plans that offered mental health benefits.

The 1996 law, while providing some important financial protections, had numerous holes. The law did not address treatment limits, limitations on the types of facilities covered, differences in cost sharing, or 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. Plans could also have stricter prior authorization requirements for mental health treatment than for other types of treatment.

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 and some including treatment for substance use. The state laws vary substantially in scope and do not apply to self-insured group health plans, which are outside the scope of state law and include the majority of large-employer plans. In 1999 President Bill Clinton directed the Office of Personnel Management to implement mental health and substance use treatment parity in the FEHB program. The directive included parity with respect to cost sharing, as well as the 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 that this is not 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 spending for mental health or substance use treatment but did provide consumers important financial protections. These research findings played a key 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, Con-

gress 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 insured and self-insured. The MHPAEA went beyond the MHPA and included Medicare Advantage plans offered through group health plans, state and local government plans, Medicaid managed care plans, and state Children's Health Insurance Program (CHIP) plans.

The MHPAEA went much further than the MHPA in providing patients parity. The MHPAEA prohibited differences in treatment limits, cost sharing, and in- and out-of-network coverage. Like the FEHB directive, the MHPAEA also applied to the treatment of substance use disorders, which the MHPA did not address. This was a historic law applauded by consumer advocates and the provider community. It is important to note that the MHPAEA did not mandate mental health or substance use treatment, but if treatment for these conditions is included as a benefit, plans have to provide it under the same terms and conditions as other medical treatment.

The Affordable Care Act (ACA) applied the MHPAEA to issuers in the individual market and qualified health plans offered through a Marketplace, including the Small Business Health Options Program known as [SHOP](#). Importantly, the ACA specified coverage of mental health and substance use treatment as one of its ten essential health benefits. As a result, all health insurance plans in the individual and small-employer market—both inside and outside the 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 instead of requiring parity only if coverage is provided. In order to satisfy the essential health benefit requirement, issuers must comply with the MHPAEA.

## WHAT'S 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 and surgical benefits. As under the MHPA, group health plans may not impose higher annual or aggregate lifetime limits on coverage for mental health and substance use disorders than those that are in place for medical and surgical benefits.

**“One common critique of parity is that by expanding coverage, it could drive up costs, but research has shown that this is not the case.”**

The MHPAEA eliminated treatment and visit limits that differed between mental health and substance use benefits and medical and surgical benefits. Financial requirements—such as deductibles, copayments, and coinsurance—cannot be greater for mental health and substance use benefits than for medical and surgical benefits. Health plans that give patients the option to go out-of-network for medical and surgical benefits must do so for mental health and 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 and 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.

The Departments of Health and Human Services (HHS), 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 and 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 outpatient benefits (office visits versus other outpatient visits) as long as the subclassifications are applied consistently. Tiered provider networks are also allowed, but separate deductibles and out-of-pocket limits for mental health and substance use and medical and surgical benefits are not.

The February 2010 interim final regulations made a distinction between quantifiable treatment limitations, such as visit limits and copayments, and nonquantifiable treatment limitations, such as prior authorization, and clarified that both were subject to parity. Other examples of nonquantifiable treatment limitations include medical management standards; prescription drug formulary design; standards for provider admission to networks; determination of provider reim-

bursement rates; requirements for step therapy, also known as “fail first” (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 nonquantifiable treatment limitations for mental health and substance use benefits than for medical and surgical benefits if the limitations were based on “recognized clinically appropriate standards of care.” Many commenters argued that this was another way for plans and issuers to treat coverage for mental health and substance use disorders differently than medical and surgical coverage.

As a result, the November 2013 final rule eliminated the specific exemption for different nonquantifiable treatment limitations based on “recognized clinically appropriate standards of care.”

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

### WHAT’S THE DEBATE?

Patients, providers, and consumer advocates allege that health plans may appear in compliance with the MHPAEA, but the pattern of denials of mental health and substance use treatment and lack of access to network providers tell a different story. They claim that plans are using more subtle ways to make mental health and substance use treatment less available than treatment for other conditions, including more frequent utilization review, “fail first” requirements, and applying stricter medical necessity criteria. In addition, patients report having trouble getting

timely access to network providers for mental health and substance use treatment.

### *Enforcement*

Compliance with the parity law is monitored by a patchwork of regulatory authorities, depending on how and where an individual is insured. Individuals who purchase insurance on their own—either through the Marketplace or on the individual market—or who have insurance through an employer that is fully insured file complaints with their state department of insurance. If HHS determines that a state is not “substantially enforcing” the law, it can step in with enforcement authority.

Officials in Alabama, Oklahoma, Missouri, Texas, and Wyoming have determined that they lack authority under state law to enforce the MHPAEA, so individuals in those states must file complaints with HHS. Individuals who have employer-based insurance in which the employer is self-insured file complaints with the federal Department of Labor. Individuals covered by Medicaid go to the state Medicaid agency, while those who work for a state or local government that self-insures must turn to HHS.

Perhaps resulting from this patchwork, enforcement on the state and federal levels has been minimal, with a few exceptions. According to a [Kaiser Health News](#) story, the Department of Labor has reported receiving relatively few complaints of MHPAEA violations from consumers. Since 2010 the Department of Labor reported just 140 potential parity violations. The complaints were all resolved through voluntary compliance by the plans, no fines were imposed, and no further action was deemed necessary. Similarly, Kaiser Health News reports that HHS found 196 possible violations from September 2013 to September 2014. All complaints were resolved through voluntary changes by the plans.

This experience stands in contrast to that reported by many patients, advocacy organizations, researchers, and some state agencies. The National Alliance on Mental Illness (NAMI) conducted an [online survey](#) of individuals and family members who needed mental health or substance use care, receiving feedback from more than 2,700 respondents. While the survey methods limit its generalizability to the overall population, it does provide a snapshot from people who have tried to access their benefits.

According to the survey, patients were twice as likely to be denied mental health care (29 percent) based on “medical necessity” than other medical care (14 percent). Supporting the anecdotal evidence from the NAMI survey, researchers who reviewed health plan documents for qualified health plans in two unnamed state Marketplaces found that 25 percent of plans appeared inconsistent with the MHPAEA. The violations included the types of financial arrangements used (for example, copayments for medical and surgical stays versus coinsurance for mental health stays), discrepancies in how financial arrangements were applied, and more stringent use of prior authorization for mental health and substance use services than medical and surgical services.

A few states—notably California and New York—have taken enforcement actions against plans for violating the states’ mental health parity laws. For example, patient complaints in New York alleging that Excellus Blue Cross Blue Shield violated the parity law led to an investigation by the state’s attorney general. The investigation found that the plan issued 64 percent more claim denials for behavioral health claim treatment than other types of treatment.

The attorney general alleged that Excellus applied more vigorous and more frequent utilization review to mental health benefits than to medical and surgical benefits and that Excellus applied a “fail first” requirement to mental health and substance use treatment that was not applied to medical and surgical treatment. This investigation led to a settlement, that resulted in more than 3,000 patients being given the right to a new appeal.

Enforcement actions by states are not common, however. Patients, sometimes partnering with advocacy organizations, have begun to take matters into their own hands and are suing health plans for their denied benefits. Suits seeking class action status on behalf of patients for parity violations are pending in California, Illinois, and New York. The New York State Psychiatric Association filed suit on behalf of its members and patients against UnitedHealth Group for violations of the MHPAEA. The suit alleged that UnitedHealth, acting as a plan administrator on behalf of large-group health plans, used different algorithms, prior authorization rules, and concurrent review policies for mental health claims than for other types of claims. The suit was initially dismissed by the district court, which ruled that the plaintiff

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lacked standing to file a lawsuit and that UnitedHealth was not responsible for any damages because it was the plan administrator, not the employer. On appeal, the US Court of Appeals for the Second Circuit overturned the dismissal and remanded the case back to the federal district court.

The appellate court’s decision was praised by patients and advocates for several reasons. It may be difficult for individual patients to bring a lawsuit while in the midst of a mental health or substance use crisis, much less a lawsuit against their employer. Providers are the ones who submit claims to insurance companies for reimbursement and may be better positioned than patients to see a pattern in claim denials. Giving providers standing to file suits over parity violations takes the burden off of patients.

Finally, this is a landmark ruling because it allowed the suit to proceed against the third-party administrator acting on behalf of an employer. The plaintiffs argued that the administrator was responsible for making the treatment decisions, not the employer. A similar case from Connecticut goes to the same appellate court later this fall.

#### Access

While there have been some improvements since the law passed, access to timely, in-network mental health and substance use providers remains a problem. In the [NAMI survey](#), more than one in five respondents reported that they had trouble finding an in-network therapist, counselor, or psychiatrist. A Maryland-based study of qualified health plans sold on the state Marketplace found that only 14 percent of psychiatrists listed in the plans’ provider networks were accepting new patients and had an appointment available within forty-five days.

A [similar study](#) in New Jersey found accurate contact information for only 59 percent of the psychiatrists listed in the plans’ network. Of the physicians researchers were able to contact, 51 percent were accepting new patients, and only half of those had an appointment in less than four weeks. In California, Kaiser Permanente was found in violation of the state’s parity law for a second time, in part for not providing timely access to network mental health providers.

One of the important rights of the MHPAEA was the application of parity to out-of-network

providers. If a plan allows patients to see out-of-network providers for medical and surgical care, it must do so for mental health and substance use treatment under the same terms and conditions. A [recent study](#) published in *Health Affairs* examined whether out-of-network services were used more frequently for substance use treatment after the passage of the MHPAEA. The authors found an 8.7 percent increase for out-of-network inpatient substance use services and a 4.3 percent increase for out-of-network outpatient substance use services compared to what would have been expected without the parity law. The authors concluded that the parity law broadened access to substance use services by extending the parity protections to out-of-network services. While the parity law may have increased access to a wider array of providers, going out of network and paying the associated higher cost might not be an option for all patients.

Not only are many mental health providers not in plans’ networks, but a significant percentage do not accept insurance at all. Another [recent study](#) found that the percentage of psychiatrists who accepted private insurance declined 17 percent during the five-year study period and was significantly lower than that of physicians in other specialties. In 2009–10 only 55.3 percent of psychiatrists accepted insurance, compared with 88.7 percent of physicians in other specialties. A similar disparity was found in mental health providers who accept Medicare and Medicaid.

The study’s authors speculate that low reimbursement (especially for psychotherapy services relative to medication management), a shortage of psychiatrists, and the prevalence of solo practices without the office staff to support insurance reimbursement may explain why many psychiatrists do not accept insurance. This is an access problem that is beyond the MHPAEA.

#### Equivalence, Quality, and Efficacy of Services

Much of the initial debate in implementing parity was around determining equivalence of services between mental health and substance use benefits and medical and surgical benefits, and this continues to be an issue. Some of the treatments for mental health and substance use disorders do not have an equivalent medical or surgical treatment, particularly with respect to treatment settings. For example, intensive outpatient programs often used to treat substance abuse and mental illness do not have an equivalent in internal medicine.

Similarly, it is difficult to determine the medical or surgical equivalent for a rehab stay for an acute schizophrenic episode.

Full parity demands that standards of evidence be applied consistently across mental health and substance use and medical and surgical treatments. Quality and efficacy may be difficult to determine for mental health and substance use treatment. Thomas Insel, the former director of the National Institute of Mental Health (NIMH), pointed out that while one can be reasonably assured that every dose of medication delivers the same treatment, it is unclear if the same can be said for every cognitive behavior therapy session.

To address some of these issues, the NIMH and other stakeholders asked the Institute of Medicine (IOM) to develop a framework for establishing evidence-based standards for mental health and substance use treatments. The recently released framework calls for strengthening the research base on efficacy and effectiveness of treatment interventions; identifying key elements that improve health outcomes; conducting systematic reviews to develop clinical guidelines; developing quality measures; and implementing the successful interventions across practice settings, all while continuing to engage the patients in this process. The framework developed by the IOM is a call to the federal government and other funders to invest in research that targets these goals.

### *Medicaid*

While the interim final regulations for most private and employer health plans were issued in 2010 and the final regulations published in 2013, the regulations for Medicaid and CHIP plans have lagged. The Centers for Medicare and Medicaid Services (CMS) did provide guidance under a [state official letter](#) in 2013, but patients and advocates have been waiting years for regulations to fully implement the law in the Medicaid program.

The lack of regulations implementing the MHPAEA in Medicaid affects millions of beneficiaries. Medicaid has the largest concentration of patients with serious mental illness and substance use disorders of any payer, and the numbers are growing. Prior to the ACA, most state Medicaid programs did not cover childless adults, and only a few covered parents. As a result of the Medicaid expansion option in the ACA, 4.6 million adults became eligible for Medicaid. A significant number of

newly eligible adults are likely to need mental health or substance use treatment.

In Oregon, one of the few states that covered adults prior to the ACA, [researchers](#) found that childless adults used mental health and substance use services three times as much as parents. According to a [Government Accountability Office report](#), an estimated 17 percent of low-income adults in states that expanded Medicaid have a mental health condition. An additional 14.6 percent of newly eligible adults are expected to need substance use treatment, according to CMS.

In April 2015 CMS released [proposed regulations](#) to implement the MHPAEA. The proposed regulations closely mirror the final regulations issued by the Departments of Health and Human Services, Labor, and Treasury for individual issuers and employer group health plans. These protections will not take full effect until eighteen months after the regulations are finalized. Many advocates have criticized the delay in protecting this vulnerable population.

### WHAT'S NEXT?

While it is fairly easy to determine whether or not plans are in compliance with quantifiable treatment limitations such as copayments, outpatient visits, or inpatient days, it is much harder to determine whether plans are using nonquantifiable treatment limitations to avoid compliance with the MHPAEA. Violations of the law regarding such limitations are likely to require more investigation than simply reviewing plan documents.

Public comments on the proposed regulations implementing the MHPAEA in Medicaid were due in June. As the single largest payer for mental health services, HHS is under pressure from advocates to quickly finalize the regulations and extend parity protections to millions of beneficiaries covered by Medicaid.

It remains to be seen whether states and the federal government are able to take on this level of effort. With states and HHS still busy with ACA implementation and enforcement activities, it is likely that we will see more cases going to court to enforce patients' rights under the MHPAEA, especially if courts continue to give standing to advocacy or member organizations and grant class-action status. ■

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**RESOURCES**

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