CARNEVALE ASSOCIATES LLC

INFO BRIEF

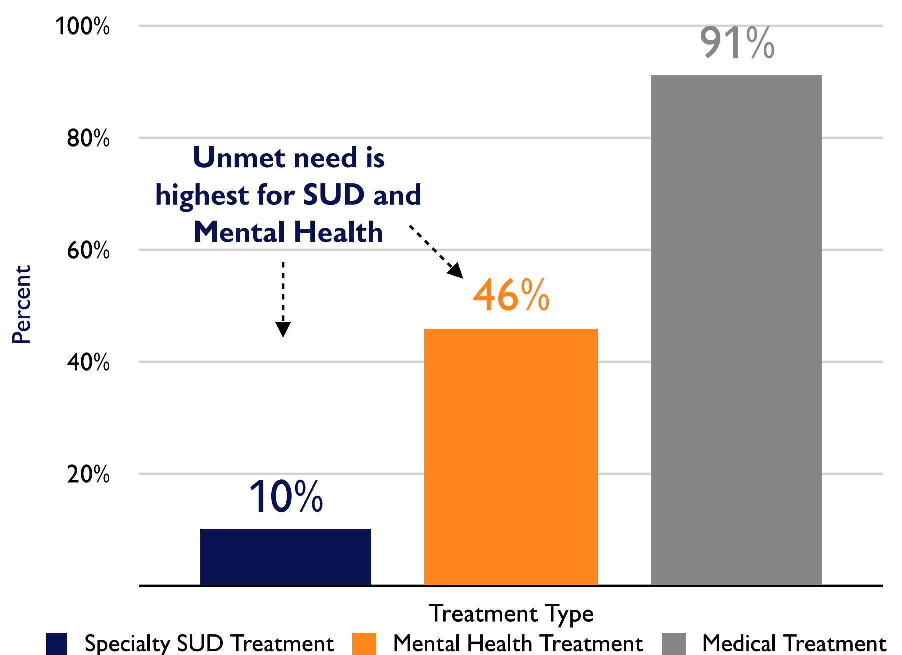
Behavioral Health Insurance Has Not Yet Achieved Parity

"Parity" refers to insurance coverage for behavioral health that is equivalent to physical health coverage. For decades, developing parity has been a key component of the expansion of affordable, comprehensive health insurance to ensure access to high-quality care. Yet despite recent parity improvements, access to and use of behavioral health services lag behind physical health services – all while behavioral health outcomes have continued to worsen over the last 20 years. Achieving true parity could help address the serious behavioral health issues facing the country.

FEDERAL PARITY LAWS

Since 2000, the two most important federal parity laws have been the **Mental Health Parity and Addiction Equity Act of 2008** (MHPAEA) and the **Patient Protection and Affordable Care Act of 2010** (ACA). Under MHPAEA, many health plans that cover behavioral health services must ensure that this coverage is "no more restrictive" than coverage of physical health services. Meanwhile, under the ACA, many plans are required to cover "mental health and substance use disorder services, including behavioral health treatment" as one of ten essential health benefits (EHBs). Taken together, these laws were expected to substantially expand access to behavioral health services.[1]

Figure 1. Percentage of Adults In Need of Treatment Who Receive It, By Treatment Type[4,5]



CONTINUED UNDERUTILIZATION & LIMITED ACCESS

Several reports have found that behavioral health coverage did not expand to the extent anticipated after MHPAEA and the ACA were passed.[2] In fact, the opposite occurred. Access to behavioral health services has become more difficult to obtain for people with some types of coverage. Underinsurance rates have increased, even as uninsurance rates continue to drop.[3] Underinsurance, which is common for behavioral health coverage, can force consumers to more frequently resort to more expensive out-of-network care. In 2013, someone seeking inpatient behavioral health services was 2.8 times more likely to be sent out-of-network than someone seeking equivalent physical care – by 2017, that figure increased to 5.2 times. For substance use treatment or a child behavioral health office visit, the situation is even worse. In 2017, both were 10 times more likely to go out-of-network compared with their physical health equivalents. Research has shown that underinsurance is significantly associated with reduced access to care and a greater likelihood of having unmet treatment needs.[4] Overall, 90 percent of people who need specialized substance use disorder treatment do not receive it, and 53 percent of people with any mental illness do not receive specialized treatment. By comparison, only 9 percent of people in need of medical services do not receive those services.[5]

THE COMPLEXITY OF HEALTH INSURANCE MARKETS

Much of the gap between expectation and reality likely stems from the complex health insurance markets in the United States, which pose numerous challenges for reform efforts – including enforcing parity regulations. Coverage falls into several categories, and each law's parity-relevant provisions apply in different ways.

On its own, MHPAEA does not apply to individual or small group plans, traditional Medicare, or Medicaid fee-for-service plans. It applies only to large group employer-sponsored insurance plans, Medicare Advantage plans, Medicaid managed care and alternative benefit plans, and Children's Health Insurance Program (CHIP) plans. Under MHPAEA, if behavioral health benefits are offered by a covered plan, then they must be at a general equivalence to medical and surgical benefits. Effectively, MHPAEA requires that affected plans that already cover behavioral health services do so at parity.[6]

The ACA's EHB requirements apply to small group employer-sponsored plans, individual plans, and Medicaid alternative benefit plans.[7] They do not apply to any other plans, including large group plans. But federal regulations create a synergy between the two laws by requiring individual and small group plans affected by the ACA's EHB requirements to provide EHB coverage in adherence with MHPAEA. So, while MHAPEA does not explicitly cover individual or small group plans, regulations have expanded the law to reach them.

Overall, some health plans are de facto subject to both laws, others are subject to only one law, and still others are exempt from both laws. Further complicating matters, plans may be subject to state health insurance laws and older federal laws, such as the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments. There are also circumstances when plans may be exempt from some regulations. Determining which laws apply to any specific plan can be expensive and time-consuming, as can documenting and assessing parity compliance.

INADEQUATE ENFORCEMENT

Insurers have generally complied with major provisions of both laws, but inequalities remain. They have largely ended annual benefit limits, removed unequal copayments, and ended separate deductibles. But lower reimbursement rates, smaller provider networks, higher denial rates, and longer processing times have remained common in behavioral health. According to the U.S. Government Accountability Office, many of these issues may have worsened during the COVID-19 pandemic.[8]

COMMON PARITY BARRIERS

- Lower reimbursement rates
- Smaller provider networks
- Higher denial rates
- Longer processing times

Parity regulators were likely limited by lack of information. Federal and state officials generally rely on consumer complaints to identify parity violations.[9] But parity laws are complex. Consumers are often unaware of what violates federal laws or where to report violations. They may also keep quiet due to stigma. The Consolidated Appropriations Act of 2021 has placed new parity reporting requirements on insurers, but the long-term impact remains to be seen.

Changes to and differences in enforcement priorities also limited enforcement. Multiple states declined to participate in joint enforcement of MHPAEA or ACA provisions, leaving the task entirely to federal regulators. Participating states have also varied widely in establishing processes and allocating resources for parity enforcement.[10] In addition, the previous federal administration issued rule changes that weakened enforcement of EHB requirements.[11]

THE NEED TO ACT

From 2010, when the ACA was approved, to 2020, the number of fatal drug-involved overdoses increased by 140 percent, the number of alcohol-induced deaths increased by 90 percent, and the number of suicides

increased by 20 percent. Over the same time, rates of past-month illicit drug use increased from 8.9 to 13.5 percent. Past-year rates of any mental illness (19.9% to 21.0%) and serious mental illness (4.8% to 5.6%) among adults both increased as well, as did a variety of youth mental health disorder measures. The collective strain of COVID-19 has further worsened outcomes, with rates of stress, anxiety, and depression all substantially increasing and provisional data predicting that fatal overdoses increased even more in 2021.

Behavioral health providers have reported that other policy changes during the pandemic, such as expansions of telehealth, have facilitated greater access to services. However, access to treatment for substance use disorder and serious mental illness still declined in 2020 (notably, access for any mental illness increased). Although improving parity will not address all access issues, the further worsening of behavioral health outcomes underscores the need to take every possible step to improve access to and use of behavioral health services.

WHAT CAN BE DONE?

Lack of parity is not the only reason for insufficient access to behavioral health services, and underuse is not the only reason that behavioral health outcomes have worsened. But there is a clear throughline from the lack of parity to a lack of access, which has contributed to substantial underuse and worsening outcomes, ranging from frayed relationships to death. Improving parity enforcement is an area ripe with "low hanging fruit":

- **Federal lawmakers** can pass laws expanding parity requirements or enforcement
- **Federal agencies** can use rulemaking authority to strengthen parity enforcement
- **States** can use authority over their insurance markets to strengthen parity requirements beyond federal guidelines
- **Behavioral health providers** can report parity violations to enforcement agencies
- **Advocacy groups** can educate consumers about their rights and insurers about their responsibilities

NOTES:

1. Office of the Assistant Secretary for Planning and Evaluation (2013). Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for Over 62 Million Americans. https://aspe.hhs.gov/reports/affordable-care-act-expands-mental-health-substance-use-disorder-benefits-federal-parity-protections
2. Gold, J. (2019). Affordable Mental Health Care? It's Getting Even Tougher to Access. Kaiser Health News. https://khn.org/news/affordable-mental-health-care-its-getting-even-tougher-to-access/
3. Commonwealth Fund (2019). Underinsured Rate Rose From 2014-2018, With Greatest Growth Among People in Employer Health Plans. https://www.commonwealthfund.org/press-release/2019/underinsured-rate-rose-2014-2018-greatest-growth-among-people-employer-health
4. Healthy People 2030 (n/d). Health Care Access and Quality-Objective AHS-04. https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality
5. Specialty SUD Treatment & Mental Health Treatment: SAMHSA (2021). National Survey of Drug Use and Health. Tables 5.33A & 8.17B. https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables
6. Centers for Medicare & Medicaid Services (n/d). The Mental Health Parity and Addiction Equity Act. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet
7. The EHBs do not apply to CHIP due to redundancy; enrollees receive all the required services through the pre-existing Early and Periodic Screening, Diagnostic, and Treatment benefit.
8. U.S. Government Accountability Office (2021). Behavioral Health: Patient Access, Provider Claims Payment, and the Effects of the COVID-19 Pandemic. https://www.gao.gov/products/gao-21-437r
9. Huetteman, E. (2021). Mental Health Services Wane as Insurers Appear to Skirt Parity Rules During Pandemic. Kaiser Health News. https://khn.org/news/article/gao-report-mental-health-services-wane-as-insurers-appear-to-skirt-parity-rules-during-pandemic/
10. El-Sabawi, T. (2020). MHPAEA & Marble Cake: Parity & the Forgotten Frame of Federalism. Dickinson Law Review 124(3): 591-631
11. Keith, K. (2019). Unpacking The Final 2019 Payment Notice (Part 1). Health Affairs 10.1377/forefront.20180410.631773

This Info Brief is a publication of Carnevale Associates, LLC. Carnevale Associates brings strategic consulting solutions to governments, organizations, and communities as they confront the policy and program challenges of substance use, behavioral health, and criminal justice.

www.carnevaleassociates.com