Mental Health Parity:
Where Have We Come From? Where Are We Now?

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Introduction

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008¹ has an underlying premise that seems straightforward: If insurers choose to offer mental health and substance use disorder (MHSUD) benefits, this must be done in parity with medical and surgical benefits. Though several years have passed since MHPAEA was signed into law, equal coverage for MHSUDs is seen as lagging by many observers, and confusion regarding key elements of the law persists. This white paper reviews the background, timeline, and evolution of mental health parity. Challenges in attaining mental health parity also are discussed, including ways in which physical and mental health differ in terms of systems of care, diagnostic methods, and resources.

The History of Mental Health Parity

While MHPAEA was signed into law on Oct. 3, 2008, federal efforts to address mental health parity have a much longer history. The Federal Mental Health Parity Act (FMHPA) of 1996² prohibited payers from having differences in annual and lifetime dollar limits for mental health and medical/surgical conditions, but did not address substance use disorder treatment. MHPAEA maintained the FMHPA prohibition on differences in annual and lifetime dollar limits, and though it applied only to large group health plans, it broadened parity efforts in many important ways.

MHPAEA required payers who offer mental health benefits to also provide coverage for substance use disorder treatment. It expanded restrictions on quantitative (numeric) limits to include other types of financial limitations (e.g., co-pays), as well as non-financial quantitative limitations (e.g., visit numbers). It also addressed the role of non-numeric, non-quantitative treatment limitations (NQTLs) and their potential impact on the duration and scope of MHSUD services. Finally, MHPAEA promoted greater transparency of factors used in making coverage determinations through increased disclosure requirements.
Since MHPAEA addressed parity in a more comprehensive way than FMHPA, which had focused on parity related to annual and lifetime dollar limits, direction on how to structure care to meet these new obligations was necessary. This led to the issuance of the 2010 Interim Final Rule (IFR)\(^3\), the 2013 Final Rule\(^4\), and numerous subsequent guidance statements from the Departments of Health and Human Services, Labor, and Treasury – all of which were designed to support appropriate implementation of MHPAEA. The expansion of the concept of parity, and the elements of care necessary to achieve this goal, required both a format to allow for comparison of medical/surgical and MHSUDs, as well as clarification as to what would constitute limitations on treatment. The IFR addressed these issues by defining 6 benefit classifications and providing further detail on treatment limitations, including guidance on limitations that potentially could represent parity violations.

The six benefit classifications described in the IFR – inpatient and outpatient care (in- and out-of-network), emergency care, and prescription drugs – provided a framework for determining if benefits were being provided in parity. Determinations were expected to be made by comparing care within the same benefit class for MHSUDs and medical/surgical care (e.g., inpatient, in-network care for an MHSUD would be compared to how inpatient, in-network care for medical/surgical benefits were handled by the organization).

**Levels of Care**

The levels of care described in the IFR were intended to facilitate evaluation of mental and physical health services, but the categories that were included highlighted one of the challenges involved in making these kinds of comparisons. While inpatient and outpatient levels of care are common to both MHSUDs and physical health conditions, there is a divergence in how intermediate levels of care (e.g., services less intensive than would be available in an inpatient hospital setting, but more expansive than care that could be provided in most outpatient clinics) are managed.

While intermediate levels of care, such as pulmonary rehabilitation, are available to treat physical conditions, acute care decisions for medical and surgical patients tend to be binary – admit to inpatient care or treat in an outpatient clinic. Intermediate levels of care for medical/surgical conditions are designed to improve functional status among people with impairments that, while potentially significant, generally are not acute, and are not offered as alternatives to inpatient admission. As an example, the presence of an acute pulmonary...
infection, such as pneumonia, likely would lead to a denial of admission to a pulmonary rehabilitation program.

In contrast, intermediate levels of care for MHSUDs are designed to support acute management of patients with MHSUDs. They often serve as alternatives to inpatient care, and are intended to have the ability to address acute symptoms or provide crisis stabilization, and some instances may be preferable to inpatient care, in particular by allowing for maintenance of community-based psychosocial supports and structures (e.g., school attendance). Practice guidelines and standards for intermediate levels of care for MHSUDs have been issued by many professional organizations, including, but not limited to, the Association for Ambulatory Behavioral Healthcare (AABH), and the Level of Care Utilization System (LOCUS) developed by the American Association of Community Psychiatrists (AACP). Best practices for MHSUD intermediate levels of care are specific, and address appropriate multidimensional admission assessment, number of days per week and hours per day of services, staffing models, and documentation.

**Treatment Limitations**

In addition to outlining benefit classifications, the IFR also addressed two types of treatment limitations: quantitative treatment limitations and NQTLs. Quantitative, or numeric, treatment limitations include a variety of financial limitations (e.g., annual and lifetime dollar caps on services, co-pays), as well as other types of quantifiable treatment limitations (e.g., limits on the number of days of coverage for a condition). The IFR did not mandate that quantifiable limitations for medical/surgical and MHSUDs had to be exactly the same, and instead provided 2 methods to allow systems to address parity as it related to quantitative limitations – “predominant” and “substantially all.”

“Predominant” refers to financial requirements within the same benefit classification (e.g., prescription drugs). If a financial requirement such as a co-pay was applied to an MHSUD, then the “predominant” standard generally would be met if it also applied to at least half of all covered medical/surgical conditions (within the same benefit classification). If this one-half threshold was not met, this could represent a potential parity violation.

“Substantially all” was used for other types of quantitative limitations, and was set as a two-thirds standard. Any quantitative, but non-financial, limitation on MHSUD coverage was required
to also apply to two-thirds of medical/surgical conditions (in the same benefit classification), or potentially run the risk of a parity violation.

While there were some structural challenges in making “predominant” and “substantially all” determinations, addressing NQTLs proved far more complicated. NQTLs are factors that limit the scope or duration of covered services. Just as the IFR did not require a one-to-one alignment for quantitative limitations (as indicated by the “predominant” and “substantially all” thresholds), it did not indicate that the presence of an NQTL should be seen as an automatic violation of MHPAEA. The IFR gave examples of NQTLs, such as differences in pre-authorization requirements, as well as other factors such as “fail-first” requirements (e.g., requiring that someone first “fail” a lower level of care or less expensive medication before being allowed to receive more intensive services or a costly drug therapy).

NQTLs are common in the management of both medical/surgical conditions and MHSUDs. As an example, a likelihood of clinical improvement would be a typical expectation for most inpatient medical admissions. Similarly, for patients who are not severely ill, a trial of outpatient antimicrobial therapy, as part of initial management of an infection, and admission only if outpatient therapy was deemed to have “failed” are common clinical practices (NB: A 2015 study of adults being treated as inpatients for pneumonia found that 22% had received a trial of outpatient antibiotics prior to admission5). Given this context, the IFR allowed for exceptions to NQTL requirements if these were made using “established clinical rationale.” These exceptions, while favored by some providers, were not without controversy, and were seen by some advocates as a loophole that would lead to restrictions on care.

Disclosure Requirements

Finally, the IFR addressed the issue of disclosure of medical necessity criteria. Two types of disclosures were mandated under the IFR. The IFR indicated that any current or prospective members of an insurance plan (or their proxies or providers) who wished to review the medical necessity criteria used for MHSUD coverage should be given this information. In addition, if a plan subscriber wished to receive information about a coverage determination (including, but not limited to, a denial of service), the IFR allowed for the subscriber to request not just the criteria that were used in the determination, but the reason for the determination as well. In cases in which an NQTL factored into the determination, the IFR specified that the “processes,
strategies, evidentiary standards, and other factors used to apply the non-quantitative treatment limitation” should also be provided.

Though the IFR expanded disclosure requirements, there was significant confusion as to what types of disclosures were required. While the IFR indicated that MHSUD medical necessity criteria had to be disclosed to both current and potential plan members, there was concern about the utility of only disclosing the MHSUD content vs providing the corresponding medical/surgical content as well (to allow for comparison of the criteria). At the time the IFR was issued, MHPAEA applied only to certain large group plans. Other types of insurance plans (e.g., plans subject to Employee Retirement Income Security Act (ERISA) rules) had different disclosure requirements (e.g., ERISA-covered plans were required to disclose both MHSUD and medical/surgical criteria within 30 days of any request by a participant or plan administrator), and these different models led to uncertainty as to how to apply disclosure policies in a general manner.

The Final Rule for MHPAEA

The IFR was followed by the Final Rule for MHPAEA, which was issued in 2013. While the Final Rule kept intact the key financial requirements and formulae for their application that had been established in the IFR (“predominant” and “substantially all”), it also included notable changes. The Final Rule clarified that in addition to inpatient and outpatient benefit classification levels, coverage for intermediate level-of-care services for MHSUDs (e.g., residential, partial hospital, and intensive outpatient) also was required (NB: intermediate levels of care had not been excluded from the IFR, but the Final Rule made the requirement to include them explicit).

The Final Rule expanded disclosure requirements, and the reason for any denial of service was required to be provided to the member automatically (rather than disclosure only to members who had requested this information). In addition, the Final Rule emphasized that disclosure requirements that were more expansive than those defined under MHPAEA (e.g., ERISA-covered plans, state laws), could supersede federal MHPAEA requirements.

The Final Rule also removed the “established clinical rationale” exception for NQTLs, ostensibly because this exception had created some confusion as to which sorts of NQTLs might represent a parity violation. The Final Rule, as well as subsequent guidance statements from the Departments of Health and Human Services, Labor, and Treasury, attempted to clarify this issue, albeit with little success. These documents provided numerous examples of “warning
signs” that were described as potential violations of parity. These “warning signs” were not absolute, nor were limitations on treatment described as inherently being in violation of parity. And while “warning signs” of potential violations were provided, positive models (e.g., examples of organizations whose utilization management practices were within the bounds of parity) were not provided.

**Key Differences Between Medical/Surgical Conditions and MSHUDs**

Why did understanding NQTLs prove to be so difficult? The way diagnoses are made for medical/surgical conditions vs MHSUDs is illustrative when considering the challenges in making these kinds of comparisons. As an example, diabetes is diagnosed based on blood sugar levels. Similarly, quality indicators for diabetes management are based on tests of blood sugar control. When determining the severity of a complication of diabetes, such as diabetic ketoacidosis, specific acid/base and electrolyte levels are used in making this assessment. By no means does this reliance on objective laboratory findings mean that other factors – motivation to participate in care, compliance with recommended therapies, or formation of a therapeutic alliance with a healthcare provider – are unimportant in diabetes management. But while these factors may impact the management of a medical condition, they are not intrinsic to the disease process itself. There are people with brittle diabetes who may develop severe complications of diabetes, despite optimal compliance with recommended therapies, and others who are relatively unengaged in care who have a disease course that is mild (and may even be completely asymptomatic).

Objective, widely accepted laboratory parameters available for the diagnosis and ongoing management of MHSUDs are not presently available. Instead, the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), provides a method in which diagnoses are made based on a combination of symptoms and functional impairment. Similarly, the American Society of Addiction Management (ASAM) does not describe grading the severity of addiction based on a blood test or imaging study; rather, ASAM provides a structure in which multiple dimensions of care are considered to determine the substance use severity and appropriate placement.

Federal and state guidance statements have indicated that consideration of factors such as “likelihood of improvement” or “compliance with recommended therapies” represent “warning signs” that a potential MHPAEA violation may be present. While acknowledging that many of
these “warning signs” represent typical standards of care for medical/surgical conditions, mental health advocates have made the case that these sorts of factors have been used in the past to discriminate against patients with MHSUDs. Providers are left balancing legitimate concerns related to past discrimination with efforts to align mental and physical healthcare in the context of evidence-based medicine.

Numerous best practice organizations, including ASAM, the AABH, the AACP, the American Psychiatric Association, and the American Academy of Child and Adolescent Psychiatry indicate that a multidimensional assessment is essential in determining the level of service intensity necessary to effectively manage MHSUDs. Factors such as evaluation of resistance to treatment and motivation to participate in care are standard elements of the evidence-based assessments recommended by these organizations. Put another way, many of the “warning signs” described by regulators may reflect features of the MHSUD disease process itself, and are required if the “right care, in the right place, at the right time” is to be delivered.

The Impact of Other Important Legislation

Along with the evolution of federal parity laws, other legislative efforts at the federal and state level also have helped shape the form in which parity efforts would be delivered. These include expansion of the types of plans subject to parity, an increase in the scope of services that plans are required to cover, and increased access to insurance coverage.

While MHPAEA originally only applied to large group health plans, the 2010 Patient Protection and Affordable Care Act (PPACA) and subsequent Health Care and Education Reconciliation Act (which will be referred to going forward as the Affordable Care Act, or ACA), led to an application of MHPAEA to all new small group plans and individual market plans. In addition, qualified health plans offered through state health insurance marketplaces also had to comply with MHPAEA.

Prior to passage of the ACA, plans had significant discretion in the types of services they could choose to cover. This limitation on the scope of services was narrowed by the establishment of 10 Essential Health Benefits, including MHSUDs. But from a practical standpoint, the ACA Medicaid arguably has had the greatest impact on mental health parity efforts.

There is a strong association between severe mental illness and poverty, and social withdrawal and limited community supports are more common among patients with mental health disorders
than in patients with chronic medical conditions. Medicaid serves as the single largest payer for behavioral healthcare services in the United States. While the annual prevalence of serious mental illness among privately insured adults is less than 5%, 33% of Medicaid beneficiaries who qualify for services based on disability have a serious mental illness. The impact on the treatment of MHSUDs that resulted from the expansion of Medicaid coverage in general, and more specifically, in terms of the application of MHPAEA to Medicaid beneficiaries participating in managed-care programs, cannot be overstated.

Conclusion

While differences in systems of care, diagnostic methods, and resources all have represented challenges in achieving the goals of the Mental Health Parity and Addiction Equity Act, an additional obstacle has been the difficulty of reconciling the terms “parity” and “equity.” Providing the same clinical services for people with medical/surgical and MHSUDs may be insufficient to address issues of fairness and injustice that too often impact healthcare. Discrimination, poverty, and disengagement from friends, family, and community are far too common among people with serious mental illness. For these people, even if the clinical services that are provided are objectively the same, it is unlikely that this will achieve equity in care. Despite these challenges there is hope. Integrated approaches for the management of behavioral health and medical services, such as collaborative care, are expanding, and are associated with improved outcomes. Ultimately, efforts to promote mental health parity stand to benefit the entire population by improving access to needed services and promoting a holistic model of care.

References


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