

Health Insurance Providers Are Offering Behavioral Health Care on Par with Medical/Surgical Health Care



Behavioral health and physical health go hand in hand – that’s why health insurance providers offer mental health and substance use disorder benefits **on par with medical and surgical benefits**



Insurance providers use evidence-based criteria to ensure access to quality, affordable care and improve patient outcomes



Insurance providers are **working with other health care stakeholders** to address key challenges, including the national shortage of behavioral health providers and the need for better ways to assess the quality of behavioral health care

INTRODUCTION

Untreated behavioral health conditions, which includes both mental health and substance use disorders (MH/SUD), have a significant impact on individuals, families, communities, our economy, and society. Individuals with mental health conditions and/or substance use disorders need access to evidence-based care, coordination with their primary medical care, and assistance with community support services such as housing, transportation, and job training. Health insurance providers recognize the importance of these services in contributing to the overall well-being of consumers and are committed to implementing programs that ensure patients have affordable access to quality, evidence-based treatments and care.

MH/SUD Parity

The Mental Health Parity and Addiction Equity Act (MHPAEA) was first enacted in 1996. It was expanded in 2008 and amended by the Affordable Care Act and the 21st Century Cures Act. This federal mental health and substance use disorder parity law requires that insurance providers that offer MH/SUD benefits offer them on par with medical/surgical benefits.¹ This means that patient out-of-pocket costs (such as deductibles and copays) and quantitative treatment limitations (such as number of visits or days of coverage) for mental health and substance use disorder benefits are on par with and no more restrictive than the out-of-pocket costs and quantitative treatment limitations for medical/surgical benefits the insurance provider offers.²

MHPAEA regulations also address non-quantitative treatment limitations (NQTLs), which are factors that limit the scope or duration of covered services. This may include medical management standards, formulary and network tier designs, and step therapy, among others. Under MHPAEA, the “processes, strategies, evidentiary standards, or other factors” used in applying an NQTL to MH/SUD benefits in a benefit classification³ must be “comparable to, and applied no more stringently than, those used in applying the NQTL to medical/surgical benefits in the same benefit classification.”

In addition to the federal parity law, many states have put in place their own parity laws, some of which go beyond the federal requirements. Some private accreditation programs have standards that assess health plan behavioral health programs’ use of evidence-based practices to ensure quality care, access and consumer protections. There are also efforts underway to include compliance with parity in some accreditation programs.

Health Insurance Providers’ Commitment to Parity

AHIP and its members support and implement the protections established by MHPAEA. Insurance providers have worked diligently to ensure compliance with MHPAEA by involving clinical and administrative personnel across medical, behavioral, pharmacy, legal and compliance departments to promote understanding and implementation of parity rules. As a result, individuals and families throughout the country have gained access to MH/SUD benefits on par with medical/surgical benefits. In fact, reports issued by both state and Federal governments, including the U.S. Department of Labor (DOL)⁴, have repeatedly shown progress made by plans in recent years, while at the same time recognizing the complexity of implementation.⁵

In addition to offering behavioral health benefits on par with medical and surgical benefits, insurance providers are working to seamlessly coordinate and integrate care to promote a more holistic approach to patient care. Insurance providers have demonstrated strong leadership in pioneering innovative programs to meet the health care needs of individuals with mental health and substance use disorders, often through partnerships with behavioral health care organizations. These programs are designed to raise patient awareness of the importance and availability of behavioral health care, encourage discussions with providers, and focus on proactive identification of behavioral health needs. Leveraging evidence-based criteria helps guide coverage decisions and ensure proven quality metrics are used to track and improve patient outcomes.

Challenges and Opportunities

Insurance providers support mental health and substance use disorder parity, recognize the importance of robust MH/SUD benefits for overall patient health, and have worked diligently to ensure compliance with parity requirements. However, there remain very real differences between MH/SUD and medical/surgical treatment infrastructures that must be addressed to continue to improve parity and ensure that patients have affordable access to quality, evidence-based MH/SUD treatments and care. Policy recommendations include the following:

INCREASE BEHAVIORAL HEALTH WORKFORCE CAPACITY

There is a well-documented shortage of behavioral health providers in the U.S.⁶ As a result, it is not always possible to have identical provider networks for behavioral health and medical/surgical health. A focus on network size ignores the fact that the behavioral health workforce shortage is a factor outside a plan's control. Insurance providers have put in place ways to enhance access to behavioral health providers, such as telehealth, and assisting members in securing in-person appointments, but additional action is needed. Policymakers should explore ways to increase the capacity of the behavioral health workforce to give patients better access to these providers.

FOCUS ON CLINICALLY APPROPRIATE, EVIDENCE-BASED CARE

The quality and strength of available medical evidence and the standards for assessing quality related to MH/SUD treatment trail behind available data for medical and surgical treatment. For example, accepted laboratory indicators for the diagnosis and treatment of MH/SUDs are not readily available and diagnosis and treatment is more multidimensional for MH/SUD. As a result, it is not always possible nor appropriate to have identical NQTLs for MH/SUD and medical/surgical benefits. A focus on clinically appropriate standards of care protects patients from poor quality and possibly harmful care. Additionally, policymakers should look for ways to improve the behavioral health quality infrastructure to support better quality assessment of behavioral health care.

PROMOTE COORDINATION OF CARE BY REMOVING BARRIERS TO SHARING SUD TREATMENT INFORMATION

Current federal regulations (42 CFR Part 2) are a barrier to whole-person, integrated approaches to care that produce the best health outcomes for patients. Under current law, access to critical patient substance use disorder information is limited which can impede the integration of patient services and support. This, in turn, can lead to patient harm, including limiting the ability to provide coordinated behavioral and medical care, and problems with contraindicated prescriptions and medication adherence. Policymakers should continue to work towards aligning these federal regulations specific to substance use disorder information with the Health Insurance Portability and Accountability Act's (HIPAA) existing privacy requirements for uses and disclosures of individuals' health information for treatment, payment, and health care operations. This alignment would ensure that the medical records of patients with substance use disorders are treated exactly the same as the medical records of patients with other chronic illnesses.

PROVIDE CONSUMERS WITH USER-FRIENDLY INFORMATION

Patients deserve access to their health information without an overload of confusing documentation or voluminous materials filled with medical and technical terminology. Any disclosure requirements should focus on making sure that consumers receive user-friendly information in an easy-to-read format to inform them about how mental health and substance use disorder benefits are developed on par with their medical/surgical benefits.

Conclusion

Insurance providers are committed to working with policymakers and other stakeholders to build on the progress that has already been made on MH/SUD parity by advancing these policies that address the key challenges to successful implementation of MHPAEA.

Endnotes

- 1 Under the Mental Health Parity Act of 1996, large group health plans were prohibited from imposing annual or lifetime dollar limits on mental health benefits that were less favorable than any such limits imposed on medical/surgical benefits. MHPAEA maintained those provisions, extended them to substance use disorders, and included additional parity provisions with respect to financial requirements and treatment limitations.
- 2 Specifically, MHPAEA requires that financial requirements, including patient out-of-pocket costs (such as deductibles and copays) and quantitative treatment limitations (such as number of visits or days of coverage) that apply to MH/SUD benefits a plan or issuer provides, are no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits the plan or issuer provides.
- 3 The benefit classifications are: inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network; prescription drugs; and emergency care.
- 4 Improving Health Coverage for Mental Health and Substance Use Disorder Patients: Including Compliance with the Federal Mental Health and Substance Use Disorder Parity Provisions: Report to Congress. January 2016. <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/improving-health-coverage-for-mental-health-and-substance-use-disorder-patients.pdf>
- 5 Report to Congress: Compliance of Group Health Plans (and Health Insurance Coverage Offered in Connection with Such Plans) With the Requirements of the Mental Health Parity and Addiction Equity Act of 2008. January 1, 2012. <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mhpaea-report-to-congress-2012.pdf>
- 6 Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues. U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. January 24, 2013. <https://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>