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Behavioral Health Parity Efforts in the US

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Effective delivery of mental health and substance use disorder services is a critical problem in the United States, with less than half of adults with mental health diagnoses receiving treatment for their illness.[1] For patients with schizophrenia, bipolar disorder, or other more serious mental health conditions, less than two-thirds received care for their illness, according to data from the Substance Abuse and Mental Health Services Administration's 2018 National Survey on Drug Use and Health, which included more than 65 000 respondents.[1] Perhaps of most concern, in a time of tens of thousands of annual overdose deaths from the opioid epidemic, the same study found that only 1 in 5 people with an opioid use disorder obtained any treatment.[1]

The underpinnings of these unsettling statistics are complex. First, mental health and substance use disorders remain stigmatized in the US. Additionally, for many patients, access to care is limited by cost, the uneven geo-graphic distribution of clinical resources, and the overall scarcity of clinicians treating patients with mental health and substance use disorders.[2] In addition, certain insurance arrangements (eg, restrictive care management practices) and the tendency of clinicians who treat mental health and substance use disorders to practice individually (resulting in minimal administrative support for insurance claim management)[2] discourage clinicians from joining insurance networks. These factors compound the difficulty of finding a clinician willing to accept patients associated with only "in-network" payments for their services. A 2014 study using data from the National Ambulatory Medical Care Survey found that in 2009–2010, nearly half of psychiatrists surveyed did not accept network commercial insurance payment or Medicare, and more than half did not accept Medicaid.[3] Psychiatrists have one of the lowest Medicaid participation rates among medical specialists.

This has contributed to disproportionate receipt of out-of-network treatment for patients with mental health and substance use disorders. One recent study using 2012–2017 data

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from the Truven Health MarketScan found that, relative to individuals with chronic medical conditions such as diabetes, commercially insured patients with mental health and substance use disorders were significantly more likely to use out-of-network benefits when accessing outpatient services.[4] The results showed that, among beneficiaries in the top25th percentile of total health care spending (N = 1531759 person-years for mental health conditions and N = 869 545 person-years for diabetes), approximately 45% of outpatient care for mental health conditions was delivered out of network compared with approximately 30% of diabetes care.[4] For substance use disorders, the differences were more pronounced: 55% for alcohol use disorders and 60% for drug use disorders compared with 30% for diabetes.[4] This is in part because insurance coverage of substance use disorders by many health plans, including Medicaid, is relatively new and many substance use disorder treatment programs still do not meet insurers' credentialing requirements (often because of their lack of clinicians with professional degrees).[5] Combined with limited service delivery capacity and increasing demand, this deficiency has aggravated the access problem for substance use disorder treatment of insured individuals.

Out-of-network care is associated with higher out-of-pocket costs, posing an additional possible barrier to treatment. The above-mentioned study also demonstrated that, relative to diabetes care, out-of-network mental health care among beneficiaries with top 25th percentile total spending was associated with higher mean annual cost-sharing amounts (including co-payments, co-insurance, and deductibles associated with out-of-network clinicians and facilities): $1382/person per year for mental health compared with $963 for diabetes.[4] As with out-of-network delivery proportion comparisons, these differences were more pronounced in the treatment of substance use disorders: $2882 per person per year for drug use disorders and $2660 for alcohol use disorders compared with $963 for diabetes.

Although limitations on access to care for patients with mental health and substance use disorders are concerning in the context of aforementioned challenges,[1] these findings do not represent anything new. For decades, insurance markets have had an especially unfavorable effect on the delivery of services for mental health and substance use disorders. This is primarily because of incentives for competitive health plans to avoid insuring patients with high-cost complicated diseases, such as those with mental health and substance use disorders. The mechanism for avoiding such patients has often been to limit coverage that might attract them to join a health plan.[6] Because the mental health and substance use disorder treatment systems have depended more on public insurance and government budgets for funding than the rest of medical care, clinician revenues have been more constrained and there has been persistent underinvestment in treatment capacity.

Legislative Efforts: The MHPAEA and ACA

Important pieces of legislation such as the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and the Patient Protection and Affordable Care Act have sought to improve access and outcomes by making parity in coverage of medical-surgical care and mental health and substance use disorders care a national priority. The MHPAEA mandated that treatment limitations for mental health and substance use disorder insurance benefits provided by large employers and managed Medicaid plans be no more stringent than those

for analogous medical-surgical treatments. The MHPAEA also placed the burden of parity demonstration on insurers instead of regulators. Enforcement was left to the federal and state governments.

In 2010, the Patient Protection and Affordable Care Act expanded treatment access by requiring Medicaid, individual, and small group plans to provide comparable benefits for medical-surgical and mental health and substance use disorder services. Although the combined reach of MHPAEA and the Patient Protection and Affordable Care Act has affected insurance coverage for more than 170 million people,[7] these well-intentioned interventions have yet to fully achieve their aims.

Implementation and Enforcement Barriers

The MHPAEA regulates both the terms of coverage (cost sharing, treatment limits, deductibles, etc) and operational management of care. Its enforcement has been challenged by the inherent complexity of medical-surgical and mental health and substance use disorder benefit management. Occasionally, for cases in which treatment limitations are in place for mental health and substance use disorder services but not medical-surgical analogues, disparities are conspicuous and easily identified. Uncovering parity violations in the management of care, however, is much more difficult because they often involve clinical judgments that may be sensitive to context.[7]

Most contemporary parity analyses determine whether specific medical-surgical and mental health and substance use disorder benefit management policies are comparable in writing and in practice. By regulation, these are divided into 2 groups: quantitative treatment limitations, such as visit caps or hospital day restrictions, and nonquantitative treatment limitations, such as concurrent review procedures and prior authorization requirements. Some nonquantitative treatment limitations are more quantitative than qualitative (eg, differential physician reimbursement rates). Generally, quantitative treatment limitations are more readily defined, measured, and compared across similarly classified services than nonquantitative ones.

After the MHPAEA, most payers updated their benefit design policies on quantitative treatment limitations to ensure compliance. However, the data are less clear for efforts to address nonquantitative treatment limitations.[8] This is in part due to clinical process complexities and challenges associated with establishing indicators of compliance with nonquantitative treatment limitation provisions, such as prior authorization, which have both quantitative and qualitative components. In such cases, insurers must demonstrate that the processes, procedures, evidence, and clinical considerations that underpin prior authorization are comparable for mental health and substance use disorders and medical-surgical services.

Emerging Progress

Despite these difficulties, several positive developments have been noted in recent years, particularly in the realm of nonquantitative treatment limitations. In 2015, the US Department of Labor began publishing annual reports on MHPAEA investigations and violations, with the most recent results demonstrating that more than 3500

claims were investigated between 2010 and 2018.[9] Furthermore, of the 21 confirmed MHPAEA violations in fiscal year 2018, more than half were predicated on disparities in nonquantitative treatment limitations, including findings of overly stringent prior authorization and benefit access requirements.[9]

The judicial system has also begun to make unique and influential contributions to parity efforts. In the class action lawsuit *Wit v United Behavioral Health* (2019),[10] United Behavioral Health was found to have unlawfully restricted beneficiary access to mental health and substance use disorder services. The court did not base its decision on MHPAEA parity principles. Instead, it determined that United Behavioral Health's benefit management did not meet generally accepted standards of care, setting a powerful precedent.

At the same time, the *Wit* decision may also be heightening states' interest in parity enforcement. Some state-level insurance commissioners are now compelling major carriers to analyze policies, procedures, and claims data in novel ways to demonstrate parity. Rather than the quantitative treatment limitation–heavy analyses of the past, these more recent assessments tend to focus on the effects of nonquantitative treatment limitations on clinicians and treatment delivery for patients. Despite inherit difficulties, insurers have the expertise to internally assess their plans for parity, share their findings, and make necessary changes to improve access. Once this occurs, it will be up to state and federal authorities to hold them accountable regarding nonquantitative treatment limitations, quantitative treatment limitations, and all other facets of insurance benefit management.

While a great deal has improved in insurance coverage for mental health and substance use disorders, the goal of providing equal access to high-quality services for mental health and substance use disorders and medical-surgical treatments remains elusive. Although regulation of health insurance alone will not guarantee parity in service provision, it is an essential first step.

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