Mental Health Parity Legislation:
A Review

Lauren O'Reilly, BS,[1] Stephen McCaffrey, JD,[2] Brian M. D'Onofrio, PhD[1]

[1]Department of Psychological and Brain Sciences, Indiana University, Bloomington, IN
[2]Mental Health America of Indiana, Indianapolis, IN

Mental Health America of Indiana holds the view that all individuals and families should have access to a broad scope of medically appropriate, evidence-based interventions in the continuum of behavioral health services and supports.

The Patient Protection and Affordable Care Act (PPACA) has expanded health care coverage through a combination of state-based private insurance exchanges and a Medicaid expansion in the form of the Healthy Indiana Plan (HIP). In addition, the law includes a number of reforms to curb harmful insurance company practices as well as provisions to slow the growth of health care costs and improve quality of care.

ACA takes groundbreaking steps toward improving access to mental health and substance use disorder treatment services. Significantly, it includes mental health and substance use disorder services as well as rehabilitative services as components of the essential benefits package that must be offered through this federal initiative to cover the uninsured. With the enactment of the ACA, we have the ability to create a reformed health care system that provides a comprehensive, culturally and linguistically appropriate behavioral health system of services and supports.

MHAI supports the State of Indiana's HIP program in an effort to provide mental health and addiction services to the ACA Expansion population. In particular, MHAI supports the inclusion of individuals with Serious Mental Illness or chronic Substance Use Disorders with access to the "Medically Frail" exclusion, providing access to the Medicaid Rehabilitation Option. In addition, MHAI supports CMHCs ability to make presumptive eligibility determinations under the Medicaid Program to ensure timely access of services.

Mental Health America of Indiana will work to educate Hoosiers through public relations and other means of advocacy regarding the mental health and addiction benefits of ACA and HIP. MHAI will also work with local, state, and federal decision makers to ensure adequate representation of behavioral health interests in the implementation of the Affordable Care Act and HIP. Additionally, MHAI will be engaged with employers, insurers, and providers to ensure that the implementation provides for meaningful access to behavioral health coverage and services.

Mental Health and Substance Abuse Parity has yet to fulfill its vision and its administrative implementation remains a critical advocacy initiative for Mental Health America of Indiana. Understanding the history of parity is critical to the future health of our state and country.

List of Abbreviations (in order of appearance):

DSM = Diagnostic and Statistical Manual of Mental Disorders
QTLs = Quantitative treatment limitations
NQTLs = Non-quantitative treatment limitations
GDP = Gross Domestic Product
FEHBP = Federal Employees Health Benefits Program
MHPA = Mental Health Parity Act
ERISA = Employee Retirement Income Security Act
MHPAEA = Mental Health Parity and Addiction Equity Act
ACA = Patient Protection and Affordable Care Act
CHIP = Children's Health Insurance Program
FPL = Federal Poverty Level
EHB = Essential Health Benefits

Introduction

Mental disorders are the leading cause of years lost to disability around the world.[1] With the growing shift from infectious to noninfectious diseases globally, mental health disorders and substance use disorders are increasingly accounting for a larger portion of the global burden of disease[2] (i.e., 10.4% of disability-adjusted life years as of 2010).[1] Within the United States in 2016, 44.7 million adults, or 18.3% of the US adult population, had at least one mental disorder.[3] Compared to those without a mental disorder, individuals with a mental disorder experience significantly lower quality of life and more days lost at work.[4] For example, mental disorders were the third leading cause of reduced work productivity, costing employers $246 per employee annually in 2004 dollars.[5]

The Substance Use and Mental Health Services Administration conducted a report in 2016 and found that only half of adults with a mental disorder received any type of mental health treatment during the previous year,[3] with consistently lower estimates among African American and Hispanic populations.[6,7] Approximately 72% of those with a mental disorder reported at least one structural barrier to seeking mental health treatment, such as insufficient or lack of health insurance.[6] The World Health Organization National Comorbidity Study suggested that among structural barriers to treatment, financial barriers were often cited as the most common.[8] Not surprisingly, those who were uninsured reported significantly more structural barriers to receiving treatment compared to those with health insurance.[6] The former US Surgeon General David Satcher stated in an influential report in 2000, that the lack of health insurance and inability to pay for services are among the primary reasons individuals with mental health disorders did not seek care.[9]

When combined, mental health disorders and substance use disorders are significant public health problems in the US and around the world, and there is a substantial gap between the prevalence of, and treatment for, mental illness. Given the complexity of these mental health problems, a multi-faceted approach is required to address the mounting national and global burden.[10] One such approach can be derived from Urie Bronfenbrenner's ecological systems theory, which asserts that an individual is situated within a set of concentric systems (e.g., family, neighborhood, society) that proximally or distally influence, or are influenced by, an individual through social, cultural, and attitudinal processes.[11] Therefore, optimal prevention and intervention strategies must capitalize on these varying systems and develop targeted approaches unique to each. Psychological and psychiatric research has largely focused on the individual and proximal systems, such as friends and family, with little attention to the outermost system (i.e., chronosystem). This system accounts for large-scale changes over time that can exert powerful influence over the individual, either directly or indirectly, through the other systems. Included in

the chronosystem are policy changes, which are vital to consider in prevention and intervention approaches to improve mental health.

One of the most directive legislative actions to address inequalities within the health care system for individuals with mental disorders is known as **parity**, or equal health insurance coverage for mental health as for physical health. This paper aims to: 1) introduce and review the foundations of parity and relevant health insurance components, 2) review the history of principal parity legislative actions, and 3) identify remaining gaps in parity the require continued advocacy and research efforts.

Foundations of Parity and Health Insurance Components

The Primary Components of Parity

The overarching goal of parity laws is to "even the playing field" in the sense that mental health disorders have traditionally been underinsured (e.g., through lack of coverage or minimal coverage), thereby increasing barriers for individuals with mental health disorders to seek and receive treatment.[12,13] To achieve this goal, legislation aims to make parallel components of health care coverage for mental health as for physical health. While parity is broadly aimed at equitable mental health insurance coverage, the interpretation and implementation of parity varies in its comprehensiveness, which is most apparent across states. Namely, states may differentially apply parity to types of mental disorders, ranging from all mental health disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM) to only specific, "biologically-based" mental health disorders (i.e., often considered to be schizophrenia, bipolar disorder, panic disorder, obsessive-compulsive disorder, major depressive disorder, and more recently, autism spectrum disorder).[14,15] States also vary in the types of treatment that are included, such as coverage for treatment that only also applies to physical conditions (i.e., outpatient and inpatient) as compared to all treatments deemed "medically necessary" for mental health conditions (e.g., intensive outpatient, partial hospitalization, or residential treatment).[16,17] States also vary on whether mental health benefits are mandated to be offered or covered at parity by health insurance companies, as compared to requiring only a minimum set of mental health benefits that are not necessarily at parity.[18] Finally, states differ in the application of their respective parity legislation to different populations, such as only pertaining to large group employers (i.e., over 50 employees).[19]

Insurance Benefit Applications of Parity

In order to understand how federal parity has addressed gaps in benefits, this paper will briefly review the three major areas to which parity is applicable depending on the legislation, which include 1) financial requirements, 2) quantitative treatment limitations, and 3) non-quantitative treatment limitations.[20] First, financial requirements (or cost-sharing) refer to payments by the insurance plan beneficiary and include *deductibles* (i.e., the fixed dollar amount paid out of pocket before insurance begins to cover a proportion of the costs, excluding certain preventive services), *copays* (i.e., a fixed dollar amount paid at the point of service contact), *coinsurance* (i.e., the percentage paid for healthcare costs after the deductible is met), *out-of-pocket maximums* (i.e., the upper limit paid through deductibles, copayments, and coinsurance after which the insurance company pays 100% of costs), and *annual or lifetime dollar limits* (i.e., a maximum limit on the aggregated costs paid by the insurance company). Secondly, *quantitative treatment limitations* (QTLs) refer to numerical restrictions, such the number of days in inpatient care and the number of outpatient visits. Third, non-quantitative treatment limitations (NQTLs) refer to non-numerical restrictions, such as *prior authorization* (i.e., requirement that a beneficiary must receive approval from a medical provider in order to initiate treatment), and *step and fail-first therapies* (i.e., requirement for medical providers to implement the least expensive therapy and documenting its ineffectiveness before implementing a more expensive therapy). Additional considerations include *determination of medical necessity* (i.e., insurance coverage for services that are deemed to be necessary for the diagnosis and treatment of disorders), *reimbursement rates* (i.e., the rate of payments made by insurance companies to network providers), *in- and out-of-network design* (i.e., cost-containment practice to encourage

beneficiaries to utilize services from select providers who accept discounted reimbursement rates from insurance companies), and *prescription drug formulary design* (i.e., tiered selection of drugs increasing in copayments to encourage the prescription of inexpensive, generic drugs). NQTLs also include disclosure from the insurance company to the beneficiary regarding the reason for any denial of coverage and the requirements for medical necessity. Refer to **Table 1** for a summary of the above definitions.

Arguments Against and For Parity

Arguments Against Parity

The primary argument against parity is increased cost for beneficiaries, employers, and/or insurance companies through increasing medical costs via two economic principles known as adverse selection and moral hazard.[21,22] First, insurance companies are primarily concerned that individuals who are in greater need of health care services, such as mental health services, will seek out and purchase health insurance plans that do not accurately reflect their increased risk (i.e., adverse selection). Therefore, these beneficiaries engage in more health services and are more expensive to the insurance companies.[23] Because insurers have not adequately matched the cost of the health care plan to the risk of the individual, such health care plans may no longer be profitable. Insurance companies may increase premiums to cover increased costs, which causes healthier individuals to leave the plan and further increases the risk and cost of the beneficiary pool.[18,24] Adverse selection is particularly problematic in cases of chronic health conditions, such as mental health disorders,[25] because chronic conditions are, on average, more expensive than acute conditions.[26,27] In fact, one study suggested that mental health disorders had the highest year-to-year correlation of costs ($r = 0.385$) compared to other chronic conditions (on average, $r = 0.168$),[26] lending further support for the economic rationale of narrowing the benefits covered for mental health disorders. Opponents of mental health parity often cite the impact of the Federal Employees Health Benefits Program in the mid-1980s, which allowed employees to choose from over 150 plans and did not permit the prevention of coverage based on pre-existing conditions, including mental health disorders.[28-31] Therefore, individuals with costlier conditions purchased plans that were more comprehensive. In turn, this adverse selection increased premiums 21% for family coverage and 23% for single coverage in 1984.[28] Notably, the Federal Employees Health Benefits Program covered all DSM disorders; many opponents of parity were concerned about increased costs associated with coverage for all disorders.

Secondly, because the function of health insurance is to lessen the burden of health care costs for beneficiaries, the reduction of these costs may result in increased utilization of health care (i.e., moral hazard). Stated differently, beneficiaries do not bear the full cost of health care services, which results in increased consumption as compared to beneficiaries paying for all health care services out of pocket.[18] The RAND Health Insurance Experiment conducted from 1971 to 1986 fundamentally altered how stakeholders view health insurance legislation, because this study is one of the few experimental designs to examine health insurance coverage. Across the US, 2,500 families were randomly assigned to one of five plans ranging in comprehensiveness and cost-sharing. Results suggested that those with full coverage for mental health benefits, compared to those without any coverage cost the insurance companies approximately four times more in mental health-related expenses.[32] Additionally, the demand curve for outpatient mental health care was twice as elastic (i.e., responsive) to the price of services as compared to physical health.[33] As the price of services decreased, the demand for services increased as a greater rate for mental health services than for physical health services. Given the existence of increased moral hazard for mental health services, the authors of the RAND Health Insurance Experiment suggested that limiting coverage for mental health would help curb insurance costs.[33] This recommendation was further supported by observational studies demonstrating similar demand curve elasticities for mental versus physical conditions.[34-38] In regards to state-level parity laws, research has suggested that 12 months after enacting mental health parity laws, usage of mental health care increased, on average, 1.5% among mild and moderate mental health problems.[39]

Increasing medical costs also raised additional concerns about the impact of parity. Throughout the late 1970s and 1980s, the growth rate for medical spending was at a record high.[40] Health care expenditures as a percentage of the total Gross Domestic Product (GDP) have been rapidly increasing since the 1970s and continue to grow compared to other countries; in 2010, health expenditures accounted for 17.9% of the GDP.[41] For each decade from 1970 to 1990, health care costs increased from $356 to $1,110 to $2,854 per capita.[42] Of note, the rate of spending on mental health care was half that of physical conditions from 1970 through 2000.[43] As of 2010, mental health and substance use disorders accounted for approximately 8% of total health expenditures, and is projected to decline to 6.5% by 2020.[44] These trends may indicate that biases against parity legislation may be rooted in economic principles and formative studies conducted in the 1980s, as more recent studies and projections show reduced costs of mental health compared to physical health spending.

To mitigate against the potential for increased costs due to covering "riskier" beneficiaries who may utilize more care, insurance companies either increased the costs for employers and beneficiaries (e.g., increasing premiums 20-50%),[15] or reduced costs by limiting (e.g., days or visit limitations) or eliminating mental health coverage altogether.[31,45] Throughout the 1990s, insurance companies increasingly restricted mental health coverage.[25,46] By 2000, 87% and 94% of health care plans differentially covered inpatient and outpatient care, respectively, for physical versus mental health.[47] These practices, in turn, resulted in an inefficient market for mental health insurance due to the reduced supply and increased demand for insurance.

It is worth noting that while the arguments against parity are certainly economic in nature, it is likely that stigmatizing beliefs about mental illness affect the discussions about the feasibility of parity legislation.[13,27] Such negative attitudes may include the ineffectiveness of mental health treatment,[9,48] the lack of validity of mental health diagnoses,[49] and the moral deficiencies of those with mental disorders, especially substance use disorders.[15,50]

Arguments for Parity

Given that cost-related arguments against parity centered on studies conducted in the 1970s and 1980s, studies analyzing the impact of parity on cost with more recent legislation were critical to parity advocates. More recent studies have demonstrated that parity policy may not increase costs due to mental health or substance use disorder treatment[22,31,51,52] and reduces out-of-pocket spending and the financial burden on families with children with mental health problems.[25] For example, results from the Federal Employees Health Benefits Program (FEHBP) from 2000 to 2002 suggest that out-of-pocket spending was reduced for those with major depression, adjustment disorders, and bipolar disorder.[53] Interestingly, the FEHBP is often cited as supporting anti-parity arguments due to studies analyzing data from 1980 through 1990 that suggested increased adverse selection.[28-31] However, more recent studies analyzing data from the early 2000s suggest reduced costs. The different estimates in these studies analyzing the same program likely reflect a changing health care landscape. Despite numerous studies and economic theory demonstrating adverse selection and moral hazard associated with mental health disorders, the reduced costs associated with parity appeared to be primarily due to the shift from fee-for-service to managed care. Managed care transfers the containment of costs from the consumer to the supplier through the use of administrative strategies, such as network design, reviews of utilization, and physician incentives.[54] Managed care can reduce costs through reduced reimbursement prices to in-network providers and by incentivizing beneficiaries to utilize inexpensive care, for example. As of 2007, 78% of Americans received coverage through managed health care plans.[55] Prior to managed care, the only way to reduce insurance costs was to adjust the design of benefits by limiting coverage.[56] In the era of managed care, many insurance companies eliminate (i.e., carve-out) their coverage for mental health benefits and contract coverage through outside organizations, known as managed behavioral care organizations.[57] The carve-out benefit design has demonstrated effectiveness in reduction of costs specific to mental health care.[58] When accounting for managed care structures in projections of premium increases due to parity,

estimates dropped from approximately 10% to 0.4%.[31] Another study suggested that after the introduction of managed care, mental health-related costs decreased by 40% in the first year.[58,59] These estimates had a significant impact on the viability of mental health parity legislation.[13]

In addition to updated cost evaluations, the argument for parity is strengthened by cost-effectiveness estimates of mental health treatment. Savings produced by adequate treatment may offset the slightly increased costs associated with parity. For example, outpatient mental health services aid the prevention of severe symptomatology, loss of productivity, inpatient care, and early mortality.[60] While there is a wide variety in the treatments offered for mental health problems,[60] the World Health Organization found that for every one dollar invested in mental health treatment broadly, four dollars were saved due to improved work productivity and health outcomes.[61]

Parity advocates have also argued that lack of equal coverage is discriminatory, as those with mental health disorders do not receive adequate treatment.[56] The limitations on mental health coverage reinforces and furthers stigmatizing beliefs about those with mental health disorders. Representative Patrick Kennedy stated that "equal treatment of those affected by mental illness is not just an insurance issue. It's a civil rights issue. At its heart, mental health parity is a question of simple justice."[62] With the widespread adoption of managed care, the role of parity is three-fold from a parity advocacy perspective: 1) address market inefficiencies that result from insurance companies attempting to reduce their risks and costs, 2) reduce the economic burden on the health care system due to mental disorders, and 3) redistributes health care resources to achieve equitable insurance for those with mental disorders.

A Historical Review of Parity Legislation

The history of parity laws in the US can be divided into six major actions, including the following: 1) the Mental Health Parity Act of 1996, 2) time-varying, state-level parity legislation, 3) the Federal Employees Health Benefits Program of 2001, 4) the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 5) the Patient Protection and Affordable Care Act, and 6) the 21st Century Cures Act. A historical overview is necessary to understand how each parity law has built upon the previous, as well as to identify the continued gaps in achieving equitable mental health coverage. See **Table 2** for a summary of the pertinent benefits and the reach of the federal legislative actions to specific groups.

Mental Health Parity Act of 1996

The deinstitutionalization of state-run mental health care hospitalization beginning in the 1960s[63] increased the saliency of the lack of sufficient and accessible mental health care services, and catalyzed an increase in public interest in and advocacy for parity legislation that came to fruition at the federal level three decades later.[27] After a failed attempt in 1992,[13] the first federal parity legislation passed by Congress was signed into law on September 26, 1996 and took effect on January 1, 1998.[18] The Mental Health Parity Act (MHPA) applied parity to annual and lifetime dollar limits and, thus, protected those with severe mental health disorders from bankruptcy. Prior to the enactment of the MHPA, among plans that offered benefits for mental health coverage, average lifetime limits for mental health were $50,000 compared to $1 million for physical health.[24] Importantly, parity was only applicable in the presence of existing mental health care coverage by an insurer (referred to as "mandated if offered"), and did not mandate insurance companies to cover mental health-related benefits.[13] While symbolically monumental, the impact of the federal legislation on mental health parity proved to be minimal because its scope was only applicable to dollar limits. In fact, approximately only 20% of employees were affected by the MHPA, as the majority of employers were compliant with parity for annual and lifetime limits.[24] The MHPA did not include substance use parity or address other financial requirements, numerical restrictions (QTLs), or non-numerical restrictions (NQTLs). Additionally, the MHPA only applied to large employers of more than 50 employees, thereby excluding approximately 28% of the workforce in 1996.[64] Given

concerns about increased costs due to the legislation, the MHPA allowed insurers who expected more than a 1% increase in costs to be excluded from the law's effect.[55] Due to the difficulty of passing parity legislation, the MHPA did not restrict health insurance companies from enacting alternative cost-containment strategies (e.g., limiting inpatient days or outpatient visits, or eliminating mental health coverage from plans entirely), and thus the potentially positive impact of the MHPA was significantly constrained.[65,66] Research suggests that after the enactment of the MHPA, the average number of plans limiting inpatient days and outpatient days actually increased.[66]

State-level Parity Legislation

While researchers maintain that the MHPA itself was largely ineffective, the federal legislation served to stimulate state-level legislation;[14,66,67] the MHPA was met by a dramatic increase in state-level parity laws from 11 to 48 states from 1996 to 2007.[55,68-70] Research suggests that the surge in state-level parity is best interpreted as reverse causation, such that states lagging behind the federal parity responded by crafting legislation to offer further protections.[66] Despite this trend, the landscape of mental health parity continued to be highly disjointed for two primary reasons. First, the interpretation of parity varied widely by state, such as the type of diagnoses and the benefits included.[27,57,63] For example, in 2007, only five states offered parity laws that were inclusive of all mental health disorders.[55] Secondly, the Employee Retirement Income Security Act (ERISA) greatly reduced the impact of state-level legislation, as self-insured employer-sponsored plans were exempt from state-level legislation under ERISA.[14] In fact, in 2000, one-third of employees received employer-sponsored self-insurance.[64] Therefore, despite the positive momentum towards equality in coverage for mental health conditions with state-level parity legislation and managed care increasing the feasibility of parity through decreased costs,[31] insurance companies continued to curb costs through mental health care benefit restrictions. While the vast majority of employers (i.e., from 93% to 99%)[47,57] offered mental health coverage in the late 1990s and early 2000s, coverage for mental health continued to be limited.[71] In regards to limitations on outpatient visits and inpatient days, employers that limited these services in any capacity increased from 65% to 74% and from 57% to 65% in 1999 to 2002,[57] respectively. Insurance companies commonly used treatment limitations as a primary cost-containment strategy, although 35% of insurers also implemented high-cost sharing for mental health benefits compared to physical health.[57]

Federal Employees Health Benefits Program of 2001

The Federal Employees Benefits Program (FEHBP) is the largest employer-sponsored health insurance in the US and provides health care to 8.5 million beneficiaries, retirees, and their dependents in 2001.[72,73] As previously mentioned in ***Arguments against and for Parity***, the FEHBP offered a large number of plans with generous mental health coverage, thereby attracting high-risk individuals throughout the 1970s. Given increased costs for insurers,[56] the FEHBP responded by restricting mental health benefits parallel with other private insurers in the US. However, under the direction of President Bill Clinton in 2001, the Office of Personnel Management incorporated mental health and substance use parity in the FEHBP. The FEBHP has a history of implementing legislation to determine its viability prior to national rollouts,[56] as is the case for parity. Under the FEHBP, parity was extended from the MHPA to include additional financial limitations (i.e., copays, deductibles, coinsurance) and QTLs,[56] although the program excluded parity for out-of-network coverage. The FEHBP parity legislation also specified that all disorders included in the DSM were eligible for parity-level coverage.[13,74] Studies investigating the impact of FEHBP parity suggested that premiums increased by 1%,[51] out-of-pocket costs decreased for beneficiaries, and the implementation of managed care increased.[56] In regards to the quality of care provided, parity appeared to either have no effect on or increased the quality of mental health care provided,[56] which was likely highly correlated with the trend toward managed care in general. Importantly, the increased costs associated with parity under the FEHBP were no greater than when compared to private insurance costs and reflected an increasing trend of mental health care costs in general.[56] The feasibility and lack of significant increased costs within the FEHBP after parity

implementation served as a monumental milestone for parity advocacy at the federal level and paved the way for the following major strides in addressing gaps in mental health coverage.

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Replicated studies indicating no increased costs due to parity, increased awareness of mental health disorders, and the growing prospect of a Democratic presidency in 2009[13] all operated as the impetus for the second federal legislative action regarding parity, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA). The MHPAEA was passed on October 3, 2008, took effect on October 3, 2009, and was implemented on January 1, 2010 via an Interim Law determined by the Department of Treasury, Labor, and Health and Human Services.[13,75,76] The MHPAEA was a significant piece of legislation, as it addressed numerous gaps in the MHPA and piecemeal state-level legislation. Building upon parity for annual and lifetime limits, the MHPAEA extended parity to additional financial requirements, QTLs, and NQTLs, thereby expanding parity to approximately 140 million Americans.[13,77] The MHPAEA interacted with state-level parity by serving as a minimum standard, such that states were permitted to implement more stringent parity legislation but not less.[13] Similar to the MHPA, the MHPAEA was a mandated-if-offered law, and applied parity to six categories (i.e., inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs). The inclusion of out-of-network parity was vital for those with mental health and substance use disorders due to the fact that behavioral treatment was often limited, especially within a network. For example, one report found that out-of-network utilization was four times higher for mental health compared to physical health care from 2013 to 2015. Additionally, 17% of mental health care occurs in out-of-network inpatient settings compared to 4% for physical health, and 32% compared to 6% in out-of-network outpatient settings.[78] While the FEHBP parity legislation in 2001 applied to all DSM disorders, the MHPAEA did not specify similar stipulations and allowed plans to individually determine the types of disorders covered if not outlined by state-level laws.[19] However, the MHPAEA included parity for substance use treatment, which was the first legislation to do so at the federal level for all private insurance plans. Similar to the MHPA of 1996, the MHPAEA allowed the exemption of health insurance plans that projected costs to be greater than 2% in the first year and 1% in all following years to address apprehension associated with potential increased costs.

As determined by the Final Rules on November 13, 2013 that were effective on January 13, 2014 for plans beginning July 1, 2014,[79] the intention of parity as outlined by the MHPAEA was to be interpreted as financial requirements and treatment limitations being "no more restrictive than the *predominant* requirements applied to *substantially all* medical and surgical benefits covered by the plan." *Predominant* referred to the "most common or frequent type" of requirement, and *substantially all* referred to two-thirds of plans.[17,80] Research examining the impact of the MPHAEA suggested that it was effective at eliminating financial limitations and QTLs.[81-83] In regards to NQTLs, the Finals Rules outlined, but did not explicitly define, that the limitations were to be "comparable to, and applied no more stringently than" to physical health conditions.[84] The addition of NQTLs in the Final Rules and the extension of parity to include these treatment limitations were significant to the advancement of the goal of parity. However, NQTLs posed difficult for insurance companies using cost-containment practices, especially within a health care landscape ruled by managed care. Given that NQTLs refer to practices such as prior authorization and drug formulary design, some researchers have interpreted the extension of parity to NQTLs as a limitation on the scope of managed care and, advertently or inadvertently, negatively affecting coverage for mental health care.[19] While the White House Mental Health and Substance Use Disorder Parity Task Force determined that the majority of violations after the MHPAEA were due to NQTLs (penalized up to $100 per beneficiary per day),[51,84] no research has examined the impact of the MHPAEA on mental health care costs associated NQTLs.

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA, also simply referred to as ACA), which was signed into law on March 23, 2010, served to fill another significant gap in mental health coverage. Whereas the MHPAEA addressed financial requirements, QTLs, and NQTLs, the ACA widened the reach of insured populations by expanding parity as established by the MHPAEA to include small group and individual plans, Medicaid, and Children's Health Insurance Program (CHIP).[17,85] A set of Final Rules effective May 31st, 2016 were determined for Medicaid benchmark benefit plans, Medicaid managed care plans, and Children's Health Insurance Program (CHIP) plans.[86] Of note, both Medicaid and CHIP are state-run programs that provide free or low-cost insurance to adults and children of low income. To widen the scope of parity, the ACA created Health Insurance Exchanges (i.e., marketplaces) in which individuals and small employers could purchase insurance plans that were subsidized by the federal government for those below 400% of the Federal Poverty Level (FPL). Among those in small group plans, the ACA extended mental health and substance use benefits at parity to 1.2 million Americans who had no prior mental health coverage and 23.3 million with some mental health coverage. Among those who were insured through individual plans, the ACA extended benefits to 3.9 million who did not previously have insurance and 7.1 million who had some form of mental health care coverage.[85] The ACA also offered funding for states to expand Medicaid to 138% of the FPL (i.e., $16,105 for one-person family, $32,913 for four-person family, in 2014).[85,87] As of 2020, 37 states have officially adopted Medicaid expansion under the ACA.[88] In regards to mental health treatment, research estimated that approximately 3.1 million individuals received mental health treatment as a result of the creation of individual marketplaces, and 2.8 million individuals as a result of the Medicaid expansion.[89] Because parity legislation was historically limited to private insurance,[90] the expansion of parity to Medicaid and CHIP was a major milestone for parity advocates. Because the prevalence of mental health and substance use problems are higher in low-income populations,[91-93] individuals who were insured through public programs or were uninsured prior to the ACA may not have been affected by both the MHPA and MHPAEA. Prior to the ACA, 44 million Americans were uninsured,[94] with approximately 30% of whom were diagnosed with a mental health or substance use disorder.[85]

Two of the most significant additions of the ACA to mental health and substance use coverage were the establishment of Essential Health Benefits (EHB) and the elimination of prohibiting coverage based on preexisting conditions. Beginning on January 1, 2014, all non-grandfathered health plans (i.e., created after March 23, 2010) available both on and off the individual and small group marketplaces were required to cover ten essential benefits, including mental health and substance use treatment. As delineated by the Department of Health and Human Services in 2011, the extent of coverage for mental health and substance use disorder treatment was to be determined by each state based on "benchmark" plans.[95,96] By state, benchmark plans included three of the largest small group plans, three of the largest government employee plans, the largest health maintenance organization plan, or the three largest FEHBP plans.[85] Therefore, the goal of benchmark plans was to allow for state-to-state flexibility in the construction of benefits to account for market variation. While the ACA did not apply EHB to large employers, the vast majority already offered some form of mental health and substance use coverage and were affected by prior parity legislation. Additionally, the ACA aimed to address the insurance practice of medical underwriting, in which insurance companies would ask a series of question when enrolling individuals, such as "Are you getting counseling?" and "What medication are you taking?"[15] Based on the answers and estimated risk, insurers would adjust costs (e.g., 25-50% premium increases) and limit or eliminate mental health benefits.[97] In response to this practice, all non-grandfathered health plans could no longer prohibit or limit coverage based on preexisting conditions, including mental health and substance use disorders.[98]

21st Century Cures Act

Finally, the 21st Century Cures Act, passed on December 13, 2016, further emphasized the importance of clarifying enforcement policies for the MHPAEA. To do so, the 21st Century Cures Act required a public meeting of stakeholders to garner feedback regarding parity implementation, a publically-available action

plan summarizing the public meeting to provide strategies for compliance, the US Government Accountability Office to conduct research on compliance with the MHPAEA, and disclosure to the public regarding federal parity violations.[99] Additionally, the 21st Century Cures Act specifically addressed the importance of increasing public awareness and updating public information on eating disorders.[99] While the 21st Century Cures Act did not alter the benefits or populations covered, it further solidified the implementation of the MHPAEA to advance the goal of parity.

Remaining Gaps and Difficulty of Enforcement

Since the 1970s, the interpretation and reach of federal and state-level parity legislation has expanded tremendously to include a wide variety of benefits and privately- and publically-insured individuals. A changing health care landscape has been vital to the success of parity legislation. In relation to the ecological systems theory, many researchers have discussed that progress in mental health parity may have assisted or been assisted by increasing comfort in discussing mental illness. While this does not necessarily equate to destigmatizing beliefs about mental illness, researchers are hopeful that changing attitudes about mental illness will be a downstream consequence of more comprehensive legislation.[27,63]

While the disparity in mental health versus physical health coverage has lessened considerably over the past three decades, gaps still remain. As of 2016, there were 27.6 million uninsured individuals below age 65 in the US,[94] which was nearly half compared to 2010, but the lack of insurance remains a significant limitation to improvements in mental health and substance use disorders. Given that the ACA only applied EHB to non-grandfathered plans, mental health benefits continue to be limited among plans created before March 23, 2010. While the MHPAEA extended parity to out-of-network providers, which was especially vital for mental health treatment, recent research suggested that the reimbursement rates for mental health and substance use services were considerably lower than for physical health, despite the MHPAEA addressing such disparities in NQTLs.[78] While noncompliance or difficulty in compliance with all aspects of parity continue to prove problematic, an underlying issue may be due to the lower percentages of psychiatrists accepting insurance compared to other physicians (i.e., 55.3% versus 88.7%, respectively).[100] As previously mentioned, the MHPAEA applied parity to six categories (i.e., inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs). However, in addition to outpatient, emergency, and inpatient settings, mental health services are provided in other ways. These intermediate services include intensive outpatient, partial hospitalization, and residential treatment, and may be interpreted differently by insurance companies as to whether these services are inpatient or outpatient.[17] Finally, federal parity only applies to Medicaid managed plans, and therefore excludes those insured through fee-for-service plans.[17]

Despite the efforts of the 21st Century Cures Act, federal parity legislation continues to struggle significantly with enforcement and lack of oversight. Individuals may be unaware of parity legislation or unsure if their plan is in violation of parity. Because the majority of violations are non-quantitative in nature (e.g., preauthorization required for behavioral health treatment but not for medical treatment) as determined by the White House Mental Health and Substance Use Disorder Parity Task Force in 2016, it can be particularly difficult for beneficiaries to be aware of such violations.[84] When an individual is aware of a potential parity violation, filing a formal complaint may be particularly burdensome. Additionally, given that states are responsible for individual and small group plans, large group plans, and Medicaid plans, parity enforcement remains disjointed. At the federal level, enforcement is also divided across bodies including the Department of Health and Human Services, Department of Labor, and Internal Revenue Service.[101] Penalties for violations are inconsistently implemented and/or may be too low to foster parity compliance. Of note, implementation of parity also appears to be particularly difficult for some disorders, such as eating disorders. NQTLs (e.g., fail first therapies, lack of coverage for residential treatment, exclusion of Binge Eating Disorder, and inconsistent decisions and limits to medical necessity and length of inpatient treatment)[102] continue to be applied to those with eating disorders. Taken together,

the process of identifying and penalizing parity violations is not conducive to achieving the primary goal of parity.[103]

At an individual level, an online report conducted by the National Alliance on Mental Illness in 2016 concluded that many still face disparities in physical versus mental health. Interestingly, in regard to out-of-network care, 28% of individuals seek outpatient mental health therapy and 21% for medication, as compared to 7% for medical specialty and 3% for primary care. Of individuals seeking care, 34% reported difficulty finding a mental health therapist, and 33% reported difficulty finding a medication prescriber. Comparatively, 13% of people reported difficulty finding a medical specialist and 9% had difficulty finding a primary care physician. Inpatient care follows a similar trend as outpatient care.[104]

Current plans set forth by President Donald Trump may limit the scope of EHB under the ACA. As issued by the Department of Health and Human Services on April 9, 2018 in a Final Rule effective in 2020, the administration aims to allow states to define their benchmark plan based on other states rather than their own, create their own benchmark plan entirely, or exchange EHB benefits used in another state as long as the actuarial value is unchanged.[15,105] Additionally, states that aim to expand mental health benefits beyond those offered under the benchmark plan will be required to limit these benefits, as the Final Rule calls for a "generosity analysis." Thus, the Final Rule sets a maximum on plans' benefits and will allow plans to limit the scope of EHB,[106] having potentially negative consequences for mental health and substance use coverage.

Conclusion

In 2011, a consortium of researchers, advocates, and clinicians outlined 25 grand challenges that aim to reduce the burden of mental health. One such proposed goal was to specifically study the impact of parity laws on mental health.[107] Over the past seven years, the vast majority of research on parity legislation has been cost and utilization analyses,[76] with relatively minimal focus on the impact on mental health outcomes. Given the significant public health impact of mental health, research examining the impact of parity legislation on mental health is critical to inform the debate regarding the structure of the current health care system. In particular, parity research is needed in Medicaid populations, especially given the higher burden of mental illness in this group.[17]

As detailed by Mental Health America, continued advocacy efforts are vital at the state level to promote the implementation of parity legislation.[108] Increasing awareness of parity legislation to consumers, promoting and streamlining complaint processes, and effective and consistent regulation via penalties will aid parity implementation. Additional state laws that address the gaps of federal parity may be necessary in numerous states. States including Connecticut, Maryland, Minnesota, Vermont, and Oregon[108] may serve as models for Indiana to develop more comprehensive legislation around behavioral health parity and parity regulation.

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Table 1. Summary of relevant insurance benefits related to parity coverage.	
Benefit Category	**Definition**
Financial requirements (or cost-sharing)	Payments paid by the insurance plan beneficiary
Deductible	Fixed dollar amount paid out-of-pocket before insurance begins to cover a proportion of the costs, excluding certain preventive services
Copays	Fixed dollar amount paid at the point of service contact
Coinsurance	Percentage paid for healthcare costs after the deductible is met
Out-of-pocket maximums	Upper limit paid through deductibles, copayments, and coinsurance after which the insurance company pays 100% of costs
Annual/lifetime dollar limits	Maximum limit on the aggregated costs paid by the insurance company, either annually or over the beneficiary's lifetime
Quantitative treatment limitations (QTLs)	Numerical restrictions imposed by the insurer
Number of days in inpatient care	N/A
Number of outpatient visits	N/A
Non-quantitative treatment limitations (NQTLs)	Non-numerical restrictions imposed by the insurer (most common in managed care organizations)
Prior authorization	Requirement that a beneficiary must receive approval from a medical provider in order to initiate treatment
Step and fail-first therapies	Requirement for medical providers to implement the least expensive therapy and documenting its ineffectiveness before implementing a more expensive therapy
Determination of medical necessity/denial of coverage	Insurance coverage for services that are deemed to be necessary for the diagnosis and treatment of disorders; if not deemed medically necessary, insurance companies may deny coverage for specific services
Reimbursement rates	The rate of payments made by insurance companies to network providers
In- and out-of-network design	Cost-containment practice to encourage beneficiaries to utilize services from select providers who accept discounted reimbursement rates from insurance companies
Prescription drug formulary design	Tiered selection of drugs increasing in copayments to encourage the prescription of inexpensive, generic drugs

Table 2. The scope of federal parity legislation.	Federal Legislation				
Parity in regards to the following:	Mental Health Parity Act of 1996	Federal Employees Health Benefit Program of 2001[51,74]	Federal Parity Law of 2008 (Mental Health Parity and Addiction Equity Act)[109]	Affordable Care Act of 2010	21st Century Cures Act of 2016[a]
Mandate to cover mental health/substance use related expenses				✓ [b]	✓ [b]
Annual and lifetime limits	✓	✓	✓	✓	✓
Financial requirements (deductibles, copayments, coinsurance)		✓	✓	✓	✓
QTLs (days in inpatient care, number of outpatient visits)		✓	✓	✓	✓
NQTLs			✓	✓	✓
Out-of-network services			✓	✓	✓
Substance use disorder-related expenses		✓ [c]	✓	✓	✓
Parity law applicable to the following:					
Large employers (> 50 employees) offering group insurance plans	✓ [d]		✓	✓	✓
Small employers (2-50 employees) offering group insurance plans				✓ [e]	✓ [e]
Large employers offering self-insurance plans[f]	✓ [d]		✓	✓	✓
Small employers offering self-insurance plans[f]				✓ [e]	✓ [e]
State and local governments employees[g]	✓ [d]		✓	✓	✓
Federal employees		✓			
Individuals purchasing insurance through online marketplace				✓	✓
Small employers purchasing insurance through online marketplace				✓	✓
Purchasers of plans that project 1% increase in costs due to parity[h]					
Retired beneficiaries					
Medicaid beneficiaries			✓ [j]	✓ [k]	✓ [k]
CHIP beneficiaries[i]				✓	✓
Medicare beneficiaries[m]					

[a] The 21st Century Act articulates enforcement regulations in order to aid compliance with mental health and substance use parity, as well as explicitly extends parity to eating disorders.[110] [b] The ACA considered mental health and substance use disorders as an Essential Health Benefit (EHB) among small group and individual plans effective January 1, 2014. Prior to this, 19 states mandated coverage of mental health benefits (CA, CT, DE, DC, HI, KS, ME, MD, MT, NV, NJ, OH, RI, SD, VT, VI, WA), and 8 of those were limited to biologically-based mental illness of severe mental illness.[66,111] Note that the EHB mandate does not apply to large group insurers.[85] [c] Applied to all disorders listed in the DSM-IV-TR. [d] Originally applied to employers with ≥ 26 employees, although amended to 50. [e] Applies only to non-grandfathered plans (i.e., created after March 23, 2010) offered through the online marketplace. [f] Note that as per the Employee Retirement Income Security Act of 1974, employers that provide self-insurance plans are exempt from state level parity laws (which often functioned as more restrictive legislation to address gaps in federal legislation).[13] [g] Note that state and local government employers may opt out of coverage if self-insured.[82,112] [h] For the MHPAEA, health plans that projected a 2% increased cost in the first year, and 1% in all following years were exempt; these exemptions expire after one year, and insurers must notify beneficiaries.[79] Increased costs only include costs due to coverage determined from claims data, and not from premiums.[24] [i] CHIP represents Children's health Insurance Program, and parity provisions were included in the Children's Health Insurance Program Reauthorization Act in 2009. [j] Applies only to Medicaid managed (i.e., not fee-for-service) plans. [k] Extends coverage to Medicaid Alternative Benefit Plans and Prepaid Inpatient/Ambulatory Health Plans.[17] [m] Medicare (both Advantage and fee-for-service) has traditionally been excluded from parity; some parity provisions, such as QTLs, were included in the Medicaid Improvements for Patient and Providers Act of 2008.[113]