November 2013

ASPE RESEARCH BRIEF

HHS OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF DISABILITY, AGING AND LONG-TERM CARE POLICY

SUBSTANTIAL IMPROVEMENTS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE IN RESPONSE TO THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

A recent study commissioned by the Office of the Assistant Secretary for Planning and Evaluation has found that large employer-based plans made substantial changes to their benefit designs in response to enactment of the Wellstone-Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and issuance of the interim final rule (IFR). Most plans removed most financial requirements that did not meet the requirements of the federal parity statute and its implementing the IFR. In addition, the number of plans that applied unequal inpatient day limits, outpatient visit limits or other quantitative treatment limits for mental health or substance use disorder (MH/SUD) coverage had dropped significantly by 2011. Differences in cost-sharing for prescription medications and emergency care also declined, and by 2011 practically all large employer-based plans studied appeared to comply with MHPAEA for those benefits.

These shifts in benefit design were made without major disruptions in other aspects of MH/SUD or medical/surgical coverage. Only 1%-2% of employers dropped MH/SUD coverage and some evidence suggests that plans did not exclude more MH/SUD diagnoses from coverage in response to MHPAEA. There is no clear evidence that the small number of plans that did drop MH/SUD coverage did so because of MHPAEA, or that plans or employers reduced medical/surgical benefits to comply with parity requirements.

However, there is room for improvement. A minority of large employer-based plans -- one in five -- still required higher copays for in-network outpatient MH/SUD services than for comparable medical/surgical benefits in 2011.

This study also examined in less detail the use of non-quantitative treatment limits (NQTLs) as defined in the IFR implementing MHPAEA. Although fully assessing compliance with parity requirements for NQTLs was outside the scope of this study, the report did identify some areas of concern. For example, in a number of cases, plans in this study appeared to use more stringent precertification and utilization management controls for MH/SUD compared to those used for medical/surgical benefits. The methods used by health plans to set provider reimbursement rates for MH/SUD services sometimes did not appear to be consistent with the plans' methods for setting rates for medical/surgical care providers.

Requirements of MHPAEA

MHPAEA requires employer-based group health plans and group health insurance issuers to ensure that financial requirements (e.g., copayments, deductibles) and treatment limitations (e.g., visit limits) applicable to MH/SUD benefits are no more restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical/surgical benefits. This standard was added to preexisting law established in the Mental Health Parity Act of 1996 which required parity in aggregate lifetime and annual dollar limits for mental health benefits and medical and surgical benefits.

The parity statute does not mandate coverage of either mental health or substance use disorder benefits (although some plans are subject to state benefit mandate laws).

The IFR also specified that separate cumulative financial requirements like deductibles or out-of-pocket maximums or separately cumulative quantitative treatment limitations are also not permissible.

The rule points out that there are other types of treatment limits, referred to as NQTLs, to which parity requirements apply. These NQTLs are not expressed numerically but involve management and administrative practices that can limit the scope or duration of benefits. Examples include medical necessity standards, utilization management techniques, prescription formulary design, and standards for admissions to provider networks.

Financial Requirements

Inpatient -- Almost All Plans Eliminated Higher Cost-Sharing

In 2010, 90% of a nationally representative sample of large employers' behavioral health benefits had inpatient financial requirements (e.g., deductibles, copays, or coinsurance) that conformed with MHPAEA requirements. By 2011, virtually all 230 large employer-based plans in another sample had inpatient benefits that conformed to MHPAEA standards.

Outpatient -- Majority of Plans Lower Copays for MH/SUD

In 2010, about 70% of large employers' plans had copays or coinsurance rates for outpatient MH/SUD benefits that were consistent with MHPAEA. In 2011, about 80% of the 140 plans tested used outpatient in-network copays that conformed with MHPAEA standards.

Separate Deductibles -- No Longer in Use

By 2011, nearly all plans had eliminated the use of separate deductibles in which MH/SUD out-of-pocket costs did not accumulate toward a single deductible combined with their medical/surgical benefits. Even in 2010, only 3.2% of plans used separate deductibles.

Quantitative Treatment Limits

Inpatient -- Significant Decline in Use of More Restrictive Day Limits

In 2010, large employer-based plans used day limits on mental health inpatient benefits that generally conformed to MHPAEA standards, and more than 80% of these plans did the same for inpatient care for substance use disorders. Significant progress was made, and in 2011 around 92% of large employer-based plans sampled used comparable day limits for inpatient care for substance use disorders. These findings were corroborated by analysis of an additional database of plan designs from 2009, 2010, and 2011 which also indicated a dramatic decline in the proportion of plans using more restrictive inpatient day limits on MH/SUD care.

Outpatient -- Dramatic Decline in More Restrictive Visit Limits

In 2010, more than 50% of large employer-based plans used more restrictive visit limits for MH/SUD services that did not conform to MHPAEA standards. In the 2011 sample of large employer-based health plans, about 93% were using comparable visit limits. This trend was also evident in the plan design database comparing plans across 2009, 2010, and 2011. There too, substantial reductions in quantitative treatment limits for MH/SUD in large employer-based plans were seen after enactment of MHPAEA.

Non-Quantitative Treatment Limits

The study cites some examples in large employer-based plans for 2010 of NQTLs that were stricter for MH/SUD benefits than for medical/surgical benefits. Below are some of the more common types of NQTLs that appeared to be problematic:

- MH/SUD precertification requirements were more stringent than those used for medical/surgical benefits.
- Medical necessity criteria appeared to apply differently to MH/SUD services compared to medical/surgical services.
- Retrospective reviews were routinely used for MH/SUD services but not medical/surgical services.
- Reimbursement rates for MH/SUD services were based on lower percentages of usual, customary and reasonable standards than medical/surgical services.

Policy Implications

These findings indicate that most large employer-based health plans have made substantial changes to their benefit designs in response to MHPAEA and the IFR -- by eliminating stricter limits on inpatient days and outpatient visits and higher cost-sharing for MH/SUD inpatient care, as well as higher cost-sharing for outpatient visits in most plans. Although opponents of the law had claimed the new requirements in MHPAEA and the IFR were overly onerous and would cause plans to drop MH/SUD coverage or lower medical/surgical benefits, this has not occurred. This study could not fully capture the extent to which the use of NQTLs changed in response to the law. However, examples are provided in the report of how plans used utilization management techniques and set provider reimbursement rates differently for MH/SUD care compared to medical/surgical benefits and indicate a need for more clarity on how parity requirements apply to these complex areas of benefit management.

More detail on these findings and the methods used to compile and analyze the data are in the final report entitled "Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008." The report was authored by NORC at the University of Chicago and a research team that included Milliman, Inc., Aon Hewitt, Truven Health Analytics, and George Washington University. The report is available at http://aspe.hhs.gov/daltcp/reports/2012/mhpaeAct.shtml.

This Brief was prepared by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy. For additional information about this subject, visit the DALTCP home page at http://aspe.hhs.gov/office_specific/daltcp.cfm or contact the author, Kirsten Beronio, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201, Kirsten.Beronio@hhs.gov.

EVALUATION OF COMPLIANCE WITH THE WELLSTONE-DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Reports Available

Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Executive Summary	http://aspe.hhs.gov/daltcp/reports/2013/mhpaeActes.shtml
HTML	http://aspe.hhs.gov/daltcp/reports/2013/mhpaeAct.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2013/mhpaeAct.pdf

Substantial Improvements to Mental Health and Substance Use Disorder Coverage in Response to the Mental Health Parity and Addiction Equity Act of 2008: Research Brief

HTML	http://aspe.hhs.gov/daltcp/reports/2013/mhsudRB.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2013/mhsudRB.pdf

To obtain a printed copy of this report, send the full report title and your mailing information to:

U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
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Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

NOTE: All requests must be in writing.

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