U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

CHANGES IN INDIVIDUAL AND SMALL GROUP BEHAVIORAL HEALTH COVERAGE FOLLOWING THE ENACTMENT OF PARITY REQUIREMENTS:

FINAL REPORT

January 2017

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This report was prepared under contract #HHSP23320095651WC between HHS's ASPE/DALTCP and the Research Triangle Institute. For additional information about this subject, you can visit the DALTCP home page at https://aspe.hhs.gov/office-disability-aging-and-long-term-care-policy-daltcp or contact the ASPE Project Officers, Laurel Fuller and D.E.B. Potter, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201; Laurel.Fuller@hhs.gov, D.E.B.Potter@hhs.gov.

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Final Report

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ABSTRACT

Summary: In 2014, parity protections were extended to individual and small group plans that offer coverage for behavioral health treatment to have terms of coverage that are no more restrictive than for medical/surgical treatment. For this report, we assessed the degree to which behavioral health coverage and medical/surgical coverage in individual and small group plans changed after federal parity requirements in coverage took effect in 2014. The results focus on changes in scope of coverage (what conditions and services are covered) and level of coverage (quantitative restrictions, such as the co-payment and limits on visits). The findings suggest that parity legislation may have had the intended effect.

Major Findings: The current study suggestions that, on the whole, there was little evidence of differential quantitative restrictions in the 2014 plans. The findings show that there were some differences in scope and level of coverage between behavioral health and medical/surgical coverage in 2013, but these were not apparent in 2014. For example, in 2013, 86 percent of plans covered office visits for behavioral health reasons, but 88 percent covered office visits for medical/surgical reasons. In 2014, the two proportions were equal: 86 percent of plans covered office visits for behavioral health, and the same proportion covered office visits for medical/surgical care. Our findings suggest at least two areas where further understanding is needed on parity in the individual and small group market. First, the results suggest focusing on aspects of coverage other than quantitative restrictions, such as non-quantitative treatment limitations (NQTLs). A second area requiring further scrutiny is whether plans' provider networks sufficiently ensure consumer access to services.

Purpose: The findings in the current study should contribute to the current policy discussions regarding parity in behavioral health care in practice, both in terms of quantitative restrictions and NQTLs.

Method: We created a purposive sample of states and then a sample of individual and small group plans within those states. We obtained documents for 166 plans and then used those documents to compare changes in coverage from 2013 (before the parity requirements took effect) to 2014 (after they took effect). We also convened discussions with key informants to provide context and insight into aspects of coverage -- such as network adequacy -- that were not captured by reviewing plan data.

ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

ADHD	Attention Deficit/Hyperactivity Disorder
AHRQ	HHS Agency for Healthcare Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
BCBS	Blue Cross Blue Shield
CCIIO	Center for Consumer Information and Insurance Oversight
CFR	Code of Federal Regulations
CMS	HHS Centers for Medicare & Medicaid Services
EHB	Essential Health Benefits
FFM	Federally Facilitated Marketplace
HCl	Hydrochloride
HIV	Human Immunodeficiency Virus
HHS	U.S. Department of Health and Human Services
HPSA	Health Professional Shortage Area
HRSA	HHS Health Resources and Services Administration
IOT	Intensive Outpatient Treatment
MAT	Medication Assisted Treatment
MHPAEA	Mental Health Parity and Addiction Equity Act
MLR	Medical Loss Ratio
NAIC	National Association of Insurance Commissioners
NAMHC	National Advisory Mental Health Council
NQTL	Non-Quantitative Treatment Limitation
PUF	Public Use File
QHP	Qualified Health Plan
RBIS	CCIIO Rate and Benefit Information System
RF	Rate Filings
RTI	Research Triangle Institute
SAMHSA	HHS Substance Abuse and Mental Health Services Administration
SERFF	System for Electronic Rate and Form Filing
SHOP	Small Business Health Options Program

EXECUTIVE SUMMARY

Historically, behavioral health coverage has often been more restricted in individual and small group private plans than in large employer plans. In 2014, parity protections were extended to individual and small group plans, requiring plans that cover behavioral health treatments to have terms of coverage that are no more restrictive than coverage for medical/surgical services. These requirements represent an expansion of parity protections established in prior federal legislation in 2008 and 1996, as well as numerous state legislative actions over at least three decades.

For this report, we assessed the degree to which behavioral health coverage and medical/surgical coverage in individual and small group plans changed after federal parity requirements in coverage took effect. The results focus on changes in scope of coverage (what conditions and services are covered) and level of coverage (quantitative restrictions, such as the co-payment and limits on visits).

We created a purposive sample of states and then a sample of individual and small group plans within those states. We obtained documents for 166 of the 217 plans included in the sample and then used those documents to compare changes in coverage from 2013 (before the parity requirements took effect) to 2014 (after they took effect). We also convened discussions with key informants to provide context and insight into aspects of coverage -- such as network adequacy -- that were not captured by reviewing plan data.

The current study suggestions that, on the whole, there was little evidence of differential quantitative restrictions in the 2014 plans. However, findings suggest that parity legislation may have had some effect. The purpose of parity legislation was to remove differences between behavioral health and medical/surgical coverage in terms of quantitative restrictions. The findings show that there were some differences in scope and level of coverage between behavioral health and medical/surgical coverage in 2013, but these were not apparent in 2014. For example, in 2013, 86 percent of plans covered office visits for behavioral health reasons, but 88 percent covered office visits for medical/surgical reasons. In 2014, the two proportions were equal: 86 percent of plans covered office visits for behavioral health, and the same proportion covered office visits for medical/surgical care. The findings also indicated similar convergence in the level of coverage -- such as co-insurance -- from 2013 to 2014.

Our findings suggest at least two areas where further understanding is needed, and thus where further investigation on parity may be most productively focused. First, the results support the developing guidance for enforcing parity requirements in the individual and small group market toward aspects of coverage other than quantitative restrictions, such as non-quantitative treatment limitations (NQTLs). NQTLs are used by insurers to manage utilization, such as through prior authorization, which typically requires plan administrators or qualified providers to approve reimbursement for a service for a specific patient before it is provided. The data in the current study allowed only a limited assessment of parity in NQTLs between behavioral health and medical/surgical coverage. Thus, although the current study did not find differences in NQTLs with regard to behavioral health and medical/surgical coverage, further study is warranted.

A second area requiring further scrutiny is whether plans' provider networks sufficiently ensure consumer access to services. The data clearly show that, relative to 2013, plans in 2014 had increased incentives for consumers to use care from providers in the plan

network. In 2014, for example, only half of the plans covered out-of-network outpatient care. For in-network coverage to help ensure access to services, the provider network must be adequate and the appropriate services must be available in a timely fashion. Even though the current study does not show coverage differences between behavioral health and medical/surgical services, research is needed on the adequacy of networks and the impact of ongoing shortages in specialty behavioral health care providers.

Until the current study, no study to our knowledge used a wide selection of plan data from the individual and small group markets to determine how behavioral health coverage may have improved over time. The findings in the current study should contribute to the current policy discussions regarding behavioral health coverage, both in terms of quantitative restrictions and NQTLs. The results presented here will inform future directions for improving parity in behavioral health coverage specifically and further research on policies to help people with behavioral health needs access treatment and services.