Mental Health Parity and Mandated Coverage of Mental Health and Substance Use Disorder Services After the ACA

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Summary

Two important components of access to mental health and substance use disorder services are their insurance coverage and the terms under which they are covered. Federal mental health parity law addresses the terms under which mental health and substance use disorder services are covered in comparison with medical and surgical services in those plans that choose to offer coverage of these services. Federal law requires parity in annual and aggregate lifetime limits, treatment limitations, financial requirements, and in- and out-of-network covered benefits. However, federal parity law does not mandate the coverage of mental health and substance use disorder services.

The Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148), as amended, contains provisions that address both the coverage of mental health and substance use disorder services and the terms under which these services are covered. Specifically, the ACA includes provisions that require (1) compliance with federal parity law by certain plans and (2) the coverage of mental health and substance use disorder services by certain plans.

The ACA does not change the federal mental health requirements at all. However, it extends applicability of these requirements to three new plan types: (1) Qualified Health Plans (QHPs, offered through the state Exchanges); (2) plans offered through the individual market; and (3) Medicaid benchmark and benchmark equivalent plans that are not managed care plans.

The ACA also requires certain plans to offer coverage of mental health and substance use disorder services, by requiring these plan types to cover the Essential Health Benefits (EHB), which are defined to include mental health and substance use disorder services. The ACA requires coverage of the EHB, and therefore at least some mental health and substance use disorder services, by the following plan types: (1) QHPs; (2) new plans offered through the individual or small group market; and (3) Medicaid benchmark and benchmark-equivalent plans.

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Access to mental health and substance use disorder services is determined in part by the insurance coverage of these services and by the terms under which the services are covered. Federal parity law[1] and the health reform law[2] affect both the coverage of mental health and substance use disorder services, as well as the terms under which they are covered. Federal law requires parity in annual and aggregate lifetime limits, treatment limitations, financial requirements, and in- and out-of-network covered benefits. However, federal parity law does not mandate the coverage of mental health and substance use disorder services. The health reform law builds on federal parity law and also contains provisions that mandate coverage of mental health and substance use disorder services.

This report begins with a brief summary of federal parity law and by discussing the provisions in the health reform law that build on federal parity law. It then goes on to discuss those health reform provisions that mandate coverage of mental health and substance use disorder services.

Federal Parity Law

The goal of federal parity law is to make coverage terms for mental health and substance use disorder services, when those services are offered, no more restrictive than those terms for medical and surgical services.

Federal Mental Health Parity Requirements

Federal law requires certain insurers, when the insurer chooses to cover mental health and substance use disorder services, to offer coverage of those services at parity with medical and surgical services, specifically in the following four areas:

(1) Annual and Aggregate Lifetime Limits

(2) Treatment Limitations

(3) Financial Requirements

(4) In- and Out-of-Network Covered Benefits

Federal parity law consists of two laws: (1) the Mental Health Parity Act of 1996 (MHPA, P.L. 104-204) and (2) the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, P.L. 110-343). Together, these laws identify a group of coverage terms that must be on par between mental health and substance use disorder services and medical and surgical services (hereafter referred to as the "federal mental health parity requirements," see text box). These coverage terms include (1) annual and aggregate lifetime limits, (2) treatment limitations, (3) financial requirements, and (4) in- and out-of-network covered benefits.[3] The health reform law (the Patient Protection and Affordable Care Act of 2010 [P.L. 111-148, ACA]) did not modify or expand the federal mental health parity requirements themselves; that is, it did not modify the specific coverage terms which must be on par between mental health and substance use disorder services and medical and surgical services.

Federal parity law applies only to insurers who choose to cover mental health and substance use disorder services, and then it only applies to certain plan types. Federal parity law, prior to the

[1] Federal parity law includes the Mental Health Parity Act of 1996 (MHPA, P.L. 104-204) and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, P.L. 110-343).

[2] The Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148), as amended.

[3] For a description of these terms, see CRS Report R41249, *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010*, by Amanda K. Sarata. Meeting the federal mental health parity requirements is not simply a matter of making all coverage terms "equal." The interim final rule implementing the MHPAEA was published on February 2, 2010 (75 FED. REG. 5410), and explains how plans can comply with the parity requirements.

passage of the ACA, applied to both large fully insured and large self-insured plans.[4] In addition, it applied to Medicaid managed care plans and to Children's Health Insurance Program (CHIP) plans. The ACA builds on federal parity law by expanding its applicability to a number of additional plan types.

How Did the ACA Build on Federal Parity Law?

The ACA builds on federal parity law by expanding the requirement for compliance with the law to three types of plans. These include (1) Qualified Health Plans (QHPs), the plans that will be offered through the Exchanges;[5] (2) plans offered through the individual market; and (3) Medicaid benchmark and benchmark-equivalent plans (that are *not* managed care plans).

The ACA requires the establishment of Exchanges, health insurance marketplaces where individuals and employers may purchase health insurance. Plans offered in the Exchanges, the QHPs, must meet a number of requirements, including compliance with federal parity law. The ACA requires all QHPs to comply with federal parity law in the same manner, and to the same extent, that health insurance issuers and group health plans must comply with these requirements. QHPs will be provided through both the small group and individual markets and may also be offered outside of an Exchange.[6] In addition, the ACA requires plans offered through the individual market to comply with federal parity law.[7]

Medicaid may be offered either in the form of traditional state plan benefits or by enrolling state-specified groups in benchmark or benchmark-equivalent coverage. Either of these options may be provided through managed care plans ("Medicaid managed care plans"). The ACA requires Medicaid benchmark and benchmark-equivalent plans (which are not Medicaid managed care plans) to *partially* comply with federal parity law.[8] Specifically, these Medicaid plans are only required to ensure that treatment limitations and financial requirements are on par for mental health and substance use disorder services and medical and surgical services. This may be in part

[4] A common distinction made between types of health insurance products is whether they are fully insured or self-insured. A fully insured health plan is one in which the plan sponsor purchases health coverage from a state-licensed insurance carrier. The insurer assumes the risk of providing health benefits to the sponsor's enrolled members. In contrast, organizations who self-insure (or self-fund) do *not* purchase health coverage from state-licensed insurers. Self-insured plans refer to health coverage that is provided directly by the organization seeking coverage for its members (e.g., a firm providing health benefits to its employees). Such organizations set aside funds and pay for health benefits directly. Under self insurance, the organization bears the risk for covering medical expenses, and such benefit plans are not subject to state insurance regulations. Firms that self fund typically contract with third-party administrators (TPAs) to handle administrative duties such as member services, premium collection, and utilization review. For more information, see CRS Report RL32237, *Health Insurance: A Primer*, by Bernadette Fernandez.

[5] The ACA enables and supports states' creation by 2014 of "American Health Benefit Exchanges." Exchanges will not be insurers, but will provide qualified individuals and small businesses with access to insurers' QHPs. Exchanges will be state-established government or nonprofit entities that will have additional responsibilities as well, such as certifying plans and identifying individuals eligible for Medicaid, CHIP, and premium and cost-sharing credits.

[6] ACA §1311(j).

[7] ACA §1563, amending PHSA §2726 as redesignated by ACA §1001(2).

[8] ACA §2001. For more information on Medicaid benchmark and benchmark-equivalent plans and the ACA, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline*, by Evelyne P. Baumrucker et al.

related to the fact that these are likely the more relevant of the four requirements in a non-managed care setting.[9]

Are Any Plans Exempt from Compliance with Federal Parity Law?

Fully insured and self-insured small plans appear to be exempt from compliance with federal parity law. In addition, federal parity law does not apply to traditional fee-for-service Medicaid or to traditional fee-for-service Medicare. **Table 1** summarizes the applicability of federal parity law to various private and public coverage arrangements.

Federal parity law contains an exemption for any group health plan (either fully insured or self-insured) of a small employer (employers with between 2 and 50 employees). In cases where states consider "groups of one" to be small employers, the exemption extends to those groups of one as well. The ACA did not amend the small employer exemption, and therefore it appears to remain in effect.[10]

Federal parity law also does not appear to apply to traditional fee-for-service Medicaid. This might be due to the structure of such coverage, which may result in certain of the parity requirements (e.g., parity in in- and out-of-network benefits) not being reasonably applicable.

Finally, federal parity law does not apply to traditional fee-for-service Medicare. Although federal parity law does not apply to Medicare, federal law does require that copayments for covered Medicare Part B outpatient mental health services and other medical services both be 20% of the Medicare-approved amount by 2014.[11]

Table 1. Applicability of Federal Parity Law, by Coverage Arrangement

Coverage Arrangement	Required to Comply with Federal Parity Law	Requirement Established by ACA
Private Plans		
Large Fully Insured[a]	√	
Large Self-Insured[b]	√	
Small Fully Insured		
Small Self-Insured		
Individual Plans	√	√
Qualified Health Plans	√	√
Public Coverage		
Traditional Medicaid (FFS)[c]		
Traditional Medicaid (MC)[d]	√	

[9] Medicaid managed care plans are required to comply with all of the federal mental health parity requirements.

[10] For more information about the small employer exemption and its potential interaction with other ACA provisions, see CRS Report R41249, *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010*, by Amanda K. Sarata.

[11] Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), §102; SSA §1833(c).

Coverage Arrangement	Required to Comply with Federal Parity Law	Requirement Established by ACA
Medicaid Benchmark/ Benchmark Equivalent Coverage (FFS)	√	√
Medicaid Benchmark/ Benchmark Equivalent Coverage (MC)	√	
Medicare (FFS)		
Children's Health Insurance Program	√	

Source: CRS analysis.

a. A fully insured health plan is one in which the plan sponsor purchases health coverage from a state-licensed insurance carrier. The insurer assumes the risk of providing health benefits to the sponsor's enrolled members.

b. Self-insured plans refer to health coverage that is provided directly by the organization seeking coverage for its members (e.g., a firm providing health benefits to its employees). Under self insurance, the organization bears the risk for covering medical expenses, and such benefit plans are not subject to state insurance regulations.

c. FFS: Fee-for-Service.

d. MC: Managed Care.

Coverage of Mental Health and Substance Use Disorder Services

Traditionally, there has been a disparity not only in the coverage terms under which mental health and substance use disorder services were offered, but also in whether they were offered at all.[12] Federal parity law aims to mitigate disparities in coverage terms between mental health and substance use disorder services and medical and surgical services. However, as mentioned previously, federal parity law does not require the coverage of mental health and substance use disorder services. This approach, where the coverage of mental health and substance use disorder services is not required, but where parity with medical and surgical services is required if mental health and substance use disorder services are covered, is termed a *mandated offering parity* approach. This fundamental approach to federal parity law was not changed by the ACA, as noted above.

The ACA did, however, include broader changes which create requirements for the coverage of mental health and substance use disorder services, among other types of services. The impact of these changes on the coverage of mental health and substance use disorder services is discussed in more detail below.

[12] See, for example, Barry CL *et. al.*, "A Political History of Federal Mental Health and Addiction Insurance Parity." *Milbank Quarterly*: 88(3): 404-433; September 2010.

The Essential Health Benefits Create a Coverage Mandate for Mental Health and Substance Use Disorder Services

As mentioned above, the ACA requires the establishment of Exchanges, health insurance marketplaces where individuals and employers may purchase health insurance. Plans offered in the Exchanges, the QHPs, must meet a number of requirements, one of which is the offering of a minimum set of benefits. This set of benefits is referred to as the Essential Health Benefits Package (EHBP), and is defined to include the Essential Health Benefits (EHB), certain cost-sharing arrangements, and specified tiers of coverage.[13]

The ACA requires the Secretary of Health and Human Services (HHS) to define the items and services that will be included in the EHB, and lists 10 categories of services and/or items which must, at a minimum, be included as a part of the EHB. This list includes a category for mental health and substance use disorder services (see text box). In addition, the benefits included in the EHB are required to be of "equal scope" to those benefits offered under a "typical employer plan."[14] To determine the benefits covered under a typical employer plan, the ACA required the Department of Labor (DOL) to carry out a survey of employer-sponsored coverage and to report its results to the HHS Secretary. On April 15, 2011, DOL released a report to fulfill this statutory requirement: "Selected Medical Benefits: A Report for the Department of Labor to the Department of Health and Human Services."[15] This report found that the majority of health plans surveyed offer both inpatient and outpatient mental health and substance use disorder treatment.

The ACA does not require that *specific* mental health and substance use disorder services be included as part of the EHB. The specific services and items that will be a part of the EHB, and thus of the EHBP, will be determined through the rulemaking process. Although the statute specifically lists 10 categories of services that must, at a minimum, be included, the HHS Secretary has the discretion to include benefits, items, or services in addition to those that may fall into these 10 categories. In December of 2011, HHS released an informational bulletin regarding the upcoming EHB rulemaking process. The bulletin describes "a comprehensive, affordable and flexible proposal and informs the public about the approach that HHS intends to pursue in rulemaking to define essential health benefits."[16] In the bulletin, HHS outlines a proposal that would allow states to define the EHB for their state using benchmark health insurance plans. Under the HHS proposal, states would choose a specified benchmark health insurance plan from among four possible options: (1) the largest HMO in the state; (2) one of the

[13] ACA §1302(a) defines the Essential Health Benefits Package as coverage that "(1) provides for the essential health benefits defined by the Secretary under subsection (b); (2) limits cost-sharing for such coverage in accordance with subsection (c); and (3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d)."

[14] ACA §1302(b)(2).

[15] Department of Labor. "Selected Medical Benefits: A Report for the Department of Labor to the Department of Health and Human Services." April 15, 2011. See http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf.

[16] "Essential Health Benefits: HHS Informational Bulletin." See http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html. This bulletin is not legally binding nor does it formally constitute part of the rulemaking process. However, the information it provides allows states to determine their budget prior to the close of their legislative sessions. This is relevant because, in addition to the fact that most states are required by law to maintain balanced budgets, the ACA requires that states, where they choose to include a state mandated benefit in the EHBP, cover the cost associated with the provision of that benefit. Therefore, state budgets could be significantly impacted based on decisions about inclusion of state mandated benefits in the EHBP and these decisions needed to be made prior to determining the states' budgets.

three largest federal employee health plan options by enrollment in the state; (3) one of the three largest state employee health plans by enrollment; or (4) one of the three largest small group plans by enrollment in the state. Any of these designated plans would have a scope of services comparable to those of a "typical employer plan" (see discussion in previous paragraph), and the benefits covered by the designated benchmark plan would be the EHBP for the state.

In addition, to inform her definition of the EHB, the HHS Secretary requested the Institute of Medicine (IOM) to carry out a consensus study on the determination of the EHB. The IOM was specifically tasked with "mak(ing) recommendations on the criteria and methods for determining and updating the essential health benefits package."[17] The IOM released its report, "Essential Health Benefits: Balancing Coverage and Cost" on October 7, 2011. The report does *not* recommend specific services and items for inclusion in the EHB.

Essential Health Benefits: Required Service Categories

ACA Section 1302(b) requires the essential health benefits to include, at a minimum, services and items in the following 10 categories:

(1) Ambulatory patient services.

(2) Emergency services.

(3) Hospitalization.

(4) Maternity and newborn care.

(5) Mental health and substance use disorder services, including behavioral health treatment.

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

(9) Preventive and wellness services and chronic disease management.

(10) Pediatric services, including oral and vision care.

By requiring plans to offer either the EHBP or the EHB, the ACA creates a coverage mandate for mental health and substance use disorder services, among other services. The ACA requires not only the QHPs, but other plans as well, to offer either the EHBP or EHB. This is discussed in more detail below.

Are All Plans Required to Cover the EHB or the EHBP?

The ACA does not require all plans to offer the EHB or the EHBP (see **Table 2** for more information). It specifically requires four types of plans to offer *either* the EHB or EHBP: (1) new plans offered through the individual market; (2) new plans offered through the small group market; (3) QHPs; and (4) Medicaid benchmark and benchmark equivalent plans.

The ACA requires QHPs and new plans offered in the small and individual market to include coverage of the EHBP. The ACA requires Medicaid benchmark and benchmark equivalent plans to cover the EHB (therefore excluding a requirement for certain cost-sharing arrangements and tiers of coverage, as are a part of the EHBP). All of these requirements must be in effect no later than January 1, 2014.

[17] For more information on the IOM consensus study, see http://www.iom.edu/Activities/HealthServices/EssentialHealthBenefits.aspx.

Grandfathered plans, and large group plans offered outside of the Exchanges, are not required to offer the EHBP.[18]

Table 2. Coverage Arrangements Required to Offer at Least the EHB or the EHBP Under the ACA

Coverage Arrangement	Required to Offer the EHB or the EHBP
Private Plans	
Large Fully Insured	
Large Self-Insured	
Small Self-Insured	√[a]
Small Fully-Insured	√[b]
Individual Plans	√[c]
Qualified Health Plans	√
Public Plans	
Medicare	
Traditional Medicaid	
Medicaid Benchmark and Benchmark Equivalent Coverage	√[d]

Source: CRS analysis.

Note: All requirements are effective as of January 1, 2014.

a. Only *new* small self-insured plans; required to offer the EHBP at a minimum.

b. Only *new* small fully-insured plans; required to offer the EHBP at a minimum.

c. Only *new* individual plans; required to offer EHBP at a minimum.

d. Only required to offer the EHB, at a minimum.

Conclusion

As discussed in this report, the health reform law made a number of changes that are likely to affect access to mental health and substance use disorder services. Specifically, many plans will now be required to cover these services and more plans will be required to offer coverage for these services on par with coverage for medical and surgical services. Although there are coverage arrangements that are not required to cover mental health and substance use disorder services or to comply with federal parity law, the broader requirements may lead to plans

[18] The ACA does not explicitly mandate a large employer to offer employees acceptable health insurance, nor does it require large employers offering coverage to include the EHB. Under the ACA, large employers with at least one employee who receives a premium credit through an Exchange will be penalized. An individual may be eligible for a premium credit if a large employer (1) does not offer coverage, or (2) does not provide *minimum essential coverage* (coverage that must be "affordable" and of "minimum value," among other things). This creates an incentive to offer adequate coverage, but not a mandate. Additionally, as the statute does not define minimum essential coverage to include either the EHB or the EHBP, where coverage is offered, it is not required to include mental health and substance use disorder services. For more information, CRS Report R41159, *Summary of Potential Employer Penalties Under the Patient Protection and Affordable Care Act (PPACA)*, by Janemarie Mulvey.

voluntarily offering these services or complying with federal parity law in order to be more competitive in the private market.

Appendix. Mental Health Parity and Mandated Coverage of Mental Health and Substance Use Disorder Services Provisions in the ACA

Table A-1. ACA Provisions Mandating Coverage of Mental Health and Substance Use Disorder Services

Issue Area	Description/Purpose	ACA Section	New/Existing Authority
Definition of Essential Health Benefits	**Essential Health Benefits Requirements**. Authorizes the HHS Secretary to define the essential health benefits within certain parameters. Specifies certain categories, such as mental health and substance use disorder services, including behavioral health treatment. Effective date(s): January 1, 2014.	1302	New authority
Required Coverage of Essential Health Benefits	**Coverage of Essential Health Benefits, Nongroup and Small Market.** Requires new plans offered through the small and nongroup market to cover the essential health benefits defined at §1302(a). Essential health benefits include mental health and substance use disorder services. Effective date(s): January 1, 2014.	1201(4)	New PHSA §2707(a)
	Coverage of Essential Health Benefits, Qualified Health Plans. Requires qualified health plans to offer the essential health benefits described in 1302(a), which includes mental health and substance use disorder services. Effective date(s): January 1, 2014.	1301(a)(1)(B)	New authority
	Medicaid Benchmark Benefits Must Consist Of At Least Minimum Essential Coverage. Requires Medicaid benchmark and benchmark equivalent plans to cover at least the essential health benefits defined at §1302(b). Effective date(s): January 1, 2014.	2001(c)(2)	Amends SSA §1937(b)

Source: Congressional Research Service analysis of the ACA (as amended).

Table A-2. ACA Provisions Relating to Mental Health Parity

Issue Area	Description/Purpose	PPACA Section	New/Existing Authority
Parity and QHPs	**Applicability of Mental Health Parity to QHPs**. Applies the existing federal mental health parity requirements to qualified health plans (which may be offered both inside or outside of an Exchange). Effective date(s): January 1, 2014.	1311(j)	PHSA §2726
Parity in the Individual Market	**Applicability of Mental Health Parity in the Nongroup Market**. Applies existing mental health parity requirements to plans offered through the nongroup market. Effective date(s): Effective upon enactment (i.e., March 23, 2010).	1563	Amends PHSA §2726
Parity and Medicaid Benchmark and Benchmark Equivalent Plans	**Applicability of Mental Health Parity to Medicaid Benchmark and Benchmark Equivalent Plans**. Applies certain of the federal mental health parity requirements to Medicaid benchmark and benchmark-equivalent plans that are not managed care plans. Those plans that provide early and periodic screening, diagnostic, and treatment (EPSDT) services are deemed to satisfy the parity requirement.[a] Effective date(s): January 1, 2014.	2001(c)(3)	Amends SSA §1937(b)

Source: Congressional Research Service analysis of the ACA (as amended).

a. It is unclear what effect requiring these Medicaid plans to adhere to federal parity law, but then deeming those plans which offer EPSDT services as meeting these requirements, which they are required by law to do, will have on the actual terms of coverage for mental health and substance abuse services for Medicaid enrollees.

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