

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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MEMORANDUM

September 7, 2016

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on “An Examination of Federal Mental Health Parity Laws and Regulations”

On **Friday, September 9th, at 9:00 a.m., in Room 2322 of the Rayburn House Office Building**, the Subcommittee on Health will hold a hearing titled “An Examination of Federal Mental Health Parity Laws and Regulations.”

I. BACKGROUND

Historically, individuals seeking mental health and substance use care have faced much higher costs and limited access to treatments compared to those seeking care for physical conditions. Congress and the states have worked over the past decade to implement parity laws to end this inequity. Current parity laws allow nearly all insured Americans to receive coverage for mental health and substance use disorder benefits at the same level as coverage for other medical benefits. However, evidence shows that more can be done to improve and enforce parity laws for mental health and substance use disorders.

II. MENTAL HEALTH PARITY ACT OF 1996

In 1996, Congress passed the Mental Health Parity Act (MHPA) which prohibited employer sponsored group health plans with more than 50 employees from setting higher annual or lifetime dollar limits on mental health benefits than those for medical or surgical benefits.¹ The law contained a provision that exempted qualifying group health plans from some of the

¹ Sarah Goodell, *Enforcing Mental Health Parity*, Health Affairs (Nov. 9, 2015) (www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=112).

law's requirements, provided the plan could show that their costs increased by at least one percent due to compliance. The MHPA did not require plans to cover specific mental health treatments. It also did not address other critical issues such as differences in cost sharing or treatment limitations. Therefore, a plan could still, for example, set a limit on the number of visits an individual could receive for a certain mental illness or charge a higher copay for a mental health treatment than for another type of treatment.

The Balanced Budget Act of 1997 (BBA) generally applied certain aspects of MHPA provisions, including the parity requirement in aggregate lifetime and annual dollar limits, to Medicaid Managed Care Organizations and Children's Health Insurance Program (CHIP) benefits.² Furthermore, mental health parity was expanded to the Federal Employees Health Benefits (FEHB) program in 1999. Unlike plans subject to MHPA, FEHB plans also expanded parity to substance use disorders. FEHB program research has shown that the implementation of parity can improve consumer protections without increasing mental health spending.³

III. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) builds on the Mental Health Parity Act of 1996, and provides important protections regarding equivalency of coverage for medical, surgical, and mental health and substance use disorder services.

Essentially, MHPAEA requires that financial requirements (such as deductibles and co-payments) and treatment limitations (such as number of visits) for mental health and substance use disorder services be "no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits."⁴

With respect to vulnerable children, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. However, provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) clarified that states operating CHIP plans separately (i.e. not as an extension of their Medicaid programs), are required to comply with key parity provisions of MHPAEA in the same way as group health plans. In addition, there can be no separate cost-sharing

² Centers for Medicare and Medicaid Services (CMS), *Medicaid Fact Sheet: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP* (Mar. 29, 2016) (www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/fact-sheet-cms-2333-f.pdf).

³ Howard H. Goldman, et al., Behavioral Health Insurance Parity for Federal Employees, *New England Journal of Medicine* (Mar. 30, 2006) (www.nejm.org/doi/pdf/10.1056/NEJMsa053737).

⁴ CMS, *The Mental Health Parity and Addiction Equity Act* (cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html).

requirements or treatment limitations applicable only to mental health or substance use disorder benefits. State CHIP plans that include coverage of Early and Periodic Screening and Diagnostic Treatment (EPSDT) services (as defined in Medicaid statute) are deemed to satisfy this mental health parity requirement.⁵

IV. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008, AS AMENDED BY THE AFFORDABLE CARE ACT (ACA)

MHPAEA was further strengthened by the Affordable Care Act (ACA) in 2010. Under the ACA, all new individual and small group insurance plans are mandated to cover mental health and substance use disorder services as one of ten Essential Health Benefits. Furthermore, the ACA expanded the application of MHPAEA to benefits in Medicaid non-managed care benchmark and benchmark-equivalent state plan benefits pursuant to section 1937 of the Act.⁶ The ACA also required parity to apply to individual health insurance coverage. MHPAEA does not apply directly to small group health plans, although its requirements are applied indirectly in connection with the ACA's essential health benefit (EHB) requirements. The EHB requirements also apply to Medicaid alternative benefit packages.⁷ The passage of the ACA marked an important step toward mental health and substance use disorder parity by mandating coverage rather than requiring parity only if coverage is provided. To comply with the EHB requirements, insurers must comply with MHPAEA.

The law includes a one-year exception for plans that experience at least a one percent increase in costs as a result of compliance with the law.⁸ MHPAEA does not preempt state laws with stricter parity standards for mental health and substance use disorders.

The final rule implementing MHPAEA for individual issuers and employer group health plans went into effect on January 13, 2014, and generally applies to plan or policy years

⁵ See www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf ((for the State Health Official letter regarding application of requirements of MHPAEA to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans)).

⁶ In the Medicaid program, states have the option to provide benefits specifically tailored to meet the needs of certain Medicaid population groups, target residents in certain areas of the state, or provide services through specific delivery systems. These benefit packages are referred to as "benchmark coverage" or "benchmark-equivalent coverage."

⁷ Under the Affordable Care Act, states that expand Medicaid are required to design their own set of benefits for those who are newly eligible for Medicaid. These sets of benefits are called Alternative Benefit Plans. Federal guidelines specify what these plans must include, but each state has considerable flexibility in plan design.

⁸ Sarah Goodell, *Enforcing Mental Health Parity*, Health Affairs (Nov. 9, 2015) (www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=112).

beginning on or after July 1, 2014.⁹ The rule did not fully implement MHPAEA in the Medicaid program; that regulation was issued separately by the Medicaid program and was finalized in March 2016. Instead, the regulation applies to health insurance coverage in the individual health insurance market, large employers' insurance plans (non-Federal governmental plans with more than 100 employees), and to group health plans of private employers with more than 50 employees.

On March 30, 2016 the Centers for Medicare and Medicaid Services (CMS) published a final rule to fully implement MHPAEA and the ACA in the Medicaid and CHIP programs.¹⁰ Generally, the regulation requires that Medicaid beneficiaries receiving coverage through Medicaid Managed Care Organizations, CHIP, and Alternative Benefit Plans receive access to mental health and substance use benefits at parity with other benefits, regardless of whether the services are provided through the managed care organization or another service delivery system. The final rule also extends parity protections to long term care services for mental health and substance use disorders.¹¹ These regulations are effective beginning May 31, 2016. Proper enforcement of MHPAEA and the ACA in the Medicaid program is critical as Medicaid is the single largest payer for mental health services in the United States.¹²

The ACA's expansion of coverage and parity protections through Medicare, Medicaid, and the health insurance Marketplaces stands to greatly benefit people with mental health and substance use conditions by making early treatment and prevention services more accessible, which will help avert crisis situations from arising in the first place.¹³

V. ENFORCEMENT OF MENTAL HEALTH PARITY LAWS

Enforcement of the parity laws differs based on an individual's source of health insurance coverage and the state in which he or she lives. Enforcement responsibility is divided between the states and the federal government ((including the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Treasury Department)). Individuals who

⁹ U.S. Department of the Treasury, U.S. Department of Labor, and U.S. Department of Health and Human Services, *Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program*; 78 Fed. Reg. 219 (Nov. 13, 2013) (final rule).

¹⁰ CMS, *Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans*, 81 Fed. Reg. 18389 (Mar. 30 2016) (final rule).

¹¹ CMS, *Medicaid Fact Sheet: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP*, (Mar. 29, 2016) (www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/fact-sheet-cms-2333-f.pdf).

¹² CMS, *Behavioral Health Services* (www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html).

¹³ *Id.*

purchase insurance on their own (through the Marketplace or otherwise) and individuals who receive insurance through a fully insured employer have the ability to file a complaint with their state's department of insurance. HHS may enforce MHPAEA if they determine that a state is not already "substantially enforcing" the law. Five states --Alabama, Oklahoma, Missouri, Texas, and Wyoming have determined that their state insurance departments do not have the authority to enforce MHPAEA, therefore individuals in those states must file complaints with HHS. The federal government is also responsible for enforcing parity in self-insured plans through DOL (including state or local government plans that self-insure and employer based insurance in which the employer self-insures). Medicaid and CHIP enrollees must generally file complaints with their state Medicaid agency.

Some argue that the patchwork of entities involved in enforcement has led to low or disparate enforcement of the parity laws generally. To date only a few states, such as California and New York, have taken enforcement actions against plans in violation of MHPAEA. Other states have determined they do not have the authority to enforce parity laws. Additionally, in a handful of states (Illinois, California, and New York for example) patients and advocacy groups have filed lawsuits against plans they believe are in violation of the federal parity law. A Kaiser Health News study found that since 2010, only 867 of the 1.5 million health insurance inquiries made to DOL concerned parity laws, and many of the inquiries regarding parity law were not complaints.¹⁴ Overall, just 140 alleged parity law violations were determined, and in each of these cases the issuer voluntarily decided to pay for the patient's services. From September 2013 through September 2014, HHS found 196 MHPAEA violations. The federal government has worked with insurers to make voluntary changes in many of these cases, however, as of August 2015, the federal government had yet to file a lawsuit or impose a fine on an insurer for an alleged parity violation.¹⁵

Some advocates argue that insurers have found ways to avoid full compliance with the parity law. According to a survey by the National Alliance on Mental Illness (NAMI), respondents were twice as likely to be denied mental health care based on "medical necessity" compared to other forms of medical care.¹⁶ A "medical necessity" review determines whether a patient requires a treatment. In some cases it is difficult to justify that a mental health treatment is "medically necessary" for the patient. Other issues facing parity enforcement include equivalence of services between mental health and substance use benefits, efficacy of services, and access to care. Most mental health and substance use disorder treatments do not have an equivalent medical or surgical treatment, so equivalency is difficult to determine and prove. Moreover, many mental health and substance use disorder treatments lack the evidence-based standards of care and in depth research on quality and effectiveness that is often available for

¹⁴ *Congress tried to fix mental health care in 2008. Lawsuits charge it isn't working*, Kaiser Health News (Aug. 3, 2015) (www.vox.com/2015/8/3/9069643/mental-health-parity-lawsuits).

¹⁵ *Id.*

¹⁶ National Alliance on Mental Illnesses (NAMI), *A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care* (April 2015) (www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead.pdf).

medical and surgical treatments.¹⁷ Finally, in several areas of the country there is a shortage of mental health and substance use providers.¹⁸ This shortage is compounded by the fact that some psychiatrists do not accept insurance.¹⁹ MHPAEA applies parity rights to both in and out of network providers, which helps to somewhat increase access to services. However, individuals may not be able to afford the cost of a provider out of their network. Generally, it is still difficult for plans to create a robust network of mental health and substance use disorder providers.

In March 2016, President Obama created the Mental Health and Substance Use Disorder Parity Task Force to help ensure that Americans understand their parity protections and that federal agencies are focused on enforcing parity laws. The Task Force has requested for patients, families, advocates, health care providers, insurers and all other interested stakeholders to submit comments on their experiences with mental health and substance use disorder parity in order to improve understanding of the current parity landscape.

VI. H.R. 2646, HELPING FAMILIES IN MENTAL HEALTH CRISIS ACT

H.R. 2646, the Helping Families in Mental Health Crisis Act was introduced by Representative Murphy (R-PA) on June 4, 2015. The legislation passed the House by a roll call vote of 422-2 on July 6, 2016. The bill contains some provisions that address mental health parity.

Section 801 of the bill develops inter-agency agreements for information sharing and creates new standards for updating program compliance documents. It also requires agency officials to hold stakeholder meetings with plan issuers to improve public-private coordination and take into consideration public feedback.

Section 802 directs federal agency officials to hold a public stakeholders meeting with state governments and nationwide stakeholders, including third-party groups and patient advocates, to produce an action plan for improving mental health parity and addiction equity requirements.

¹⁷ Institute of Medicine, *Psychosocial Interventions for Mental and Substance Use Disorders: A Framework for Establishing Evidence-Based Standards* (July 2015) (www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2015/Psychosocial-Report-in-Brief.pdf).

¹⁸ Kaiser Family Foundation, *Mental Health Care Health Professional Shortage Areas (HPSAs)* (kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?activeTab=map¤tTimeframe=0&selectedDistributions=total-mental-health-care-hpsa-designations).

¹⁹ Tara F. Bishop et al., *Acceptance of insurance by psychiatrists and the implications for access to mental health care*, JAMA Psychiatry (Feb. 2014) (www.ncbi.nlm.nih.gov/pmc/articles/PMC3967759/).

Section 803 requires that one year following enactment of the legislation and annually for five years, an inter-agency analysis on any serious violations of mental health parity compliance standards would be published, summarizing the results of all closed federal investigations finalized in the 12 months preceding the report.

Section 804 requires the Comptroller General of the United States, through consultation with inter-agency leaders, to provide within three years, an independent report on treatment limitations of plan issuers – including state- and federally-funded programs – that treat patients for medical and surgical benefits as well as and mental health or substance use disorder services.

Section 807 requires the Comptroller General of the United States to submit a public report to Congress two years after enactment detailing the effectiveness of compliance guidelines and the shortfalls of meeting enforcement, education, and coordination of parity requirements.

Section 808 clarifies that plan issuers offering coverage for eating disorder benefits must do so in alignment with current mental health parity standards.

VII. H.R. 4435, COMPREHENSIVE BEHAVIORAL HEALTH AND RECOVERY ACT OF 2016

H.R. 4435, the Comprehensive Behavioral Health Reform and Recovery Act of 2016 was introduced by Rep. Green (D-TX) on February 2, 2016. H.R. 4435 contains policies that originated from H.R. 4276, the Behavioral Health Coverage Transparency Act of 2015, introduced by Rep. Kennedy (D-MA) on December 16, 2015. The parity provisions included in H.R. 4435 would further strengthen parity for both mental health and substance use disorders.

Section 801 of H.R. 4435 would strengthen parity in mental health and substance use disorder benefits by requiring greater disclosure by insurers and increasing audits and enforcement by the federal agencies responsible for implementing parity. It requires the HHS Secretary to conduct randomized audits of group health plans and plans offered in the group or individual market to determine compliance with parity. Information from such audits is required to be made available on a Consumer Parity Portal website, which will also serve as a one-stop internet portal for submitting parity-related complaints and alleged violations. Finally, it authorizes \$2,000,000 for each of fiscal years 2017 through 2021 for these purposes.

Section 802 would require CMS, in collaboration with the Assistant Secretary of Labor of the Employee Benefits Security Administration and the Secretary of the Treasury, to submit to the Congress a report identifying federal investigations conducted or completed during the previous year regarding compliance with parity in mental health and substance use disorders.

Section 803 would require GAO to submit to Congress a report describing what evidence there is regarding the extent to which private health insurance plans have non-quantitative treatment limits and medical necessity criteria to behavioral health services compared to medical or surgical services.

Section 804 would require the HHS Secretary to submit a report to Congress detailing the ways in which state governments and state insurance regulators are either empowered or required to enforce parity, and their capability to carry out these enforcement powers or requirements.

VIII. WITNESSES

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