HB 889/SB 80: Mental health parity

Executive Summary

Historically, health insurance plans have classified mental or behavioral health benefits, such as substance abuse counseling or access to antidepressant medication, separately from other medical or surgical benefits, such as routine physician visits or access to antibiotics. In 2008, the U.S. Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA), prohibiting large private and public sector employers from offering insurance plans that place stricter limits, such as the number of provider visits, on mental health benefits than on traditional medical or surgical benefits. The Patient Protection and Affordable Care Act, passed in 2010, extended these parity requirements to individual and small employer plans, and required insurance plans to include mental health benefits. In order to define these mental health benefits, specify parity protections, and provide avenues for state-level enforcement of these standards, state legislatures have passed their own mental health coverage and parity laws. HB 889 and SB 80 would prohibit health insurance plans in the state, with some exceptions such as supplemental or short-term major medical policies, from applying stricter limits on mental health benefits than to medical or surgical benefits.

Highlights

- As of 2015, **26 states, including Arkansas and Illinois, have enacted mental health parity laws**.
- Two federal laws mandating mental health parity, the MHPAEA and PPACA, and state-level parity laws have been shown to **increase mental healthcare access and utilization, particularly in youth, low-income, and low-education populations**.
- Mental health parity laws also **increase the treatment rate for substance use disorders, decrease the suicide rate, and reduce traffic fatalities involving intoxicated drivers**.

Limitations

- State-to-state outcomes may vary after enacting mental health parity laws based on the level of mental healthcare use prior to their enactment, and demographic factors such as age, education, and income.

Research Background

Mental health parity and minimum coverage requirements

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 prohibited plans offered to individuals and by large employers (more than 50 employees) from imposing stricter quantitative limits on mental health benefits than on other medical benefits. Prior to its passage,

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benefit plans could place restrictions on things such as the number of provider visits and dollar limits on treatment costs, co-pays, and deductibles, as a cost-saving strategy.[1]

This law also prohibited plans from applying stricter "non-quantitative" standards to mental health benefits than to traditional benefits. Some examples of such restrictions are determinations of medical necessity, approvals for prescription drugs, standards for including providers in the coverage network, and reimbursement rates for services.

Although the MHPAEA established parity for insurance plans that already provided mental health and substance use benefits, not all plans were required to provide mental health benefits until the passage of the Patient Protection and Affordable Care Act (PPACA) in 2010. The PPACA also extended mental health parity to all plans listed on state health insurance marketplaces, small employer plans, and to plans provided to newly eligible Medicaid recipients after state Medicaid expansions. As of 2016, the U.S. Department of Health and Human Services estimated that over 80 million individuals had mental health parity protections as a result of these laws.[1]

Though these laws impose mental health parity protections, uniform enforcement of these standards can be difficult due to the complexity of coverage requirements, lack of oversight of benefit plans, and differences in state-level requirements. For example, the PPACA delegated definition of the essential benefit package for mental health and substance abuse to the states. To address these issues, state legislatures have passed their own requirements that specify the conditions, treatments, and standards for mental health benefits and parity requirements. In Missouri, group and individual plans must offer coverage for mental health conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, including substance use disorders. Legislation passed in 2019 also mandates that all insurance policies cover medication-assisted treatment for substance use disorders.(§ 376.811 RSMo 2020) HB 889 and SB 80 would codify specific non-quantitative standards, including those listed above, that must be applied consistently to mental health and medical benefits. As of 2015, 26 states, including Arkansas and Illinois, had passed similar mental health parity legislation.

Effects of mental health parity on healthcare use

Prior to the MHPAEA and PPACA, some states enacted laws mandating minimum mental health benefits. Without broad parity requirements and enforcement, however, these laws were found to have no effect on mental healthcare use or suicide rates.[2] States that enacted parity requirements, however, observed a 5% decrease in suicide rates.[3]

After passage of the MHPAEA and PPACA, several studies show positive effects of parity on mental healthcare use and outcomes. One study finds that children in families making less than 400% of the federal poverty line in states that did not previously have parity laws increased their use of mental healthcare services, such as provider visits, by about 3% after passage of these federal laws. Diagnoses of anxiety also increased in this population, suggesting that increased use of mental healthcare services resulted in increased identification of mental health conditions that would have otherwise gone unscreened.[4] Extension of parity to Medicare recipients also

increased follow-up rates after a psychiatric hospitalization by 11%, and was concentrated among low-income and low-education enrollees.[5]

State-level parity laws can also improve mental healthcare use and outcomes. One study shows that in 24 states that enacted explicit parity standards, outpatient mental health visits increased by 8.5% after 2 years of implementation, while emergency room visits and hospitalizations for mental health conditions did not increase.[6] Additionally, state-level mental health parity laws are associated with an increase in the treatment rate for substance use disorders of 13%.[7,8] Beyond increased use of healthcare services, states that enact parity laws also have reduced traffic fatalities involving intoxicated drivers by 7%, and alcohol and psychoactive drug-related overdose fatalities by 5%.[9]

Finally, parity laws are also associated with 3.5% increases in mental healthcare provider wages, as increased use and reimbursement for services provide more revenue for mental healthcare facilities.[10] However, a meta-analysis did not find parity laws to substantially increase insurance premiums,[11] and benefit providers in Missouri are eligible to apply for parity waivers if premiums increase by more than 2% in 2 years due to these requirements. One limitation to these findings is that mental health parity laws are more likely to be passed in states with low mental healthcare utilization, so the effects observed above may vary state-by-state depending on things such as unmet need for mental healthcare, and mental healthcare provider availability.[2]

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