Mental Health and Substance Use Disorder Parity Enforcement

What will it take for patients to receive the benefits of their premium dollars?

Introduction

Fifteen years after passage of The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), access to mental health and substance use-related health care remains out of reach for many Americans. Insufficient coverage, high out-of-pocket costs, and inadequate networks of mental health and substance use disorder (MH/SUD) physicians prevent many with health insurance from receiving timely, affordable care. In addition to health plans' continued and often flagrant non-compliance, uneven state oversight and enforcement also has led to patients not being able to access timely, affordable care. Delayed and denied care are contributing factors to the ongoing mental health and overdose epidemic that continues to kill more than 100,000 Americans every year.

> "**[P]lans and issuers continue to fall short of MHPAEA's central mandate** to ensure that participants, beneficiaries, and enrollees do not face greater barriers and restrictions to accessing benefits…"
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> **- IRS, DOL, HHS Proposed Rule (Aug. 2023)**

This is the first of three publications the American Medical Association (AMA) is preparing to highlight the need for stronger enforcement of MH/SUD parity laws to expand access to evidence-based, timely and affordable care:

- This first policy brief documents the ***ongoing problem*** of disparities in access to MH/SUD services;
- The second brief will focus on ***state parity enforcement***, highlighting successful efforts and identifying enforcement gaps and opportunities; and
- The final publication will be an ***advocacy toolkit***, providing strategies and resources that physicians, policymakers and other stakeholders can use to push for stronger parity enforcement in every state.

Mental Health and Substance Use Disorder Parity Laws

Meaning of the Federal Parity Laws

The overarching goal of mental health and substance use disorder parity laws is for health plans to cover MH/SUD treatment in a comparable way to how they cover medical and surgical health treatments. MHPAEA, as the federal parity law is known, requires, in part, that health plans must ensure that the financial requirements and treatment limitations applicable to MH/SUD services are no more restrictive than those applicable to medical/surgical health services, as written and as applied in practice. The rules apply to the full range of treatment, including inpatient and outpatient services, in-network and out-of-network services, emergency care, and pharmacy coverage.

MHPAEA's regulations explain that parity applies to three aspects of a health plan's benefits: (1) financial requirements, e.g., deductibles and cost sharing; (2) quantitative treatment limitations (QTLs), e.g., day or visit

limitations, and (3) nonquantitative treatment limitations (NQTLs), e.g., prior authorization requirements, standards for admission to participate in networks, and methods used to determine reimbursement rates.

NQTLs are common in MH/SUD benefits and, as detailed below, can substantially limit patients' access to needed health care. While financial and other QTLs are more commonly observed in health plan summary documents, NQTLs are often hidden from observers, even though patients, physicians, and other health care professionals confront NQTLs every day. As disparities in financial and other QTLs have become less common, stakeholders and regulators are focusing more on NQTLs.

Agencies Enforcing the Federal Parity Rules

As will be discussed in detail in the AMA's next issue brief, there is a matrix of state and federal agencies that oversee and enforce compliance with MHPAEA.[1] Most notably, the Employee Benefits Security Administration within the Department of Labor (DOL) oversees compliance by large group plans and submits an annual report to Congress.[2] States enforce insurance carriers' and Medicaid managed care plans' compliance and CMS enforces MHPAEA against public-employee health plans and in three states where state insurance departments do not.[3]

Information Regulators Can Use to Assess Parity

Since passage of the Consolidated Appropriations Act of 2021, health plans imposing NQTLs on MH/SUD benefits must prepare "comparative analyses" documenting the design and application of NQTLs to MH/SUD and medical/surgical benefits.[4] The comparative analyses require health plans to document the factors they use to determine when each NQTL applies to MH/SUD and medical/surgical benefits, the evidentiary standards these factors rely on, and how the standards and factors are comparable across MH/SUD and medical/surgical benefits.[5] In 2023, the federal government proposed new regulations implementing the 2021 law and strengthening the requirements for NQTLs, which are expected to be finalized in 2024.[6]

Lack of Access to Mental Health and Substance Use Disorder Care

The continuing mental health crisis and overdose epidemic in the U.S. underscore an urgent need for improved parity compliance and enforcement. Recent data from the Substance Abuse and Mental Health Services Administration (SAMHSA) sheds light on the depth of the problem: Almost 50 million Americans 12 or older had an SUD in the last year, and more than 15 million adults had a serious mental illness.[7] Yet, among the nearly 60 million adults with mental illness, only half received treatment in the past year. Even among the 15 million adults with serious mental illness, only two-thirds received treatment in the past year.[8] The SAMHSA report also reveals that insurance coverage is a primary barrier to accessing care with about 40% of those surveyed citing insurance coverage as a reason for not getting SUD treatment and 13% citing insurance coverage as the primary barrier to receiving mental health treatment.[9]

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[1] Kaye Pestaina, *Mental Health Parity at a Crossroads*, Table 2: MHPAEA Enforcement (Aug 18, 2022), https://www.kff.org/mental-health/issue-brief/mental-health-parity-at-a-crossroads/
[2] MHPAEA Comparative Analysis Report to Congress. U.S. Department of the Treasury. U.S. Department of Labor. U.S. Department of Health and Human Services. July 2023. https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis.pdf
[3] MHPAEA does not apply to Medicare and Medicare Advantage.
[4] Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, § 203 (2020).
[5] 42 U.S.C. § 300gg-26(a)(8)(A).
[6] Internal Revenue Service et al., Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51552 (Aug. 3, 2023), https://www.federalregister.gov/documents/2023/08/03/2023-15945/requirements-related-to-the-mental-health-parity-and-addiction-equity-act.
[7] Substance Abuse and Mental Health Services Administration (SAMHSA), *Results from the 2022 National Survey on Drug Use and Health* (Nov. 2023), https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-nnr.pdf
[8] Id.
[9] Id. at A30-A33.

Evidence of Ongoing Disparities in Coverage of Mental Health and Substance Use Disorder Treatment

There is substantial evidence that health plans remain out of compliance with MHPAEA. In addition to the issues that have historically raised compliance concerns, including higher co-payments[10] and numerical limits on mental health and substance use disorder benefits, health plans' NQTLs continue to attract scrutiny. Among the most concerning are NQTLs related to treatment exclusions, prior authorization and concurrent review, network admission criteria, out-of-network reimbursement rates, network adequacy, and medical necessity criteria.

Treatment Exclusion

The federal parity law addresses the basic question of whether health plans manage mental health and SUD treatment in a similar way to physical health services. It is not that health plans must cover particular MH/SUD services, but they cannot *exclude* particular types of MH/SUD treatment from coverage in a way that is more restrictive than medical/surgical treatments. In its latest Report to Congress,[11] DOL found that nine of twenty-six determinations of non-compliance were due to health plans excluding certain MH/SUD treatments from coverage.

DOL provides examples of improper exclusion of MH/SUD treatment, including a health plan that did not cover treatment received at MH/SUD residential treatment facilities, while allowing coverage for similar services at skilled nursing or other medical/surgical residential facilities.[12] In another case, a plan excluded MH/SUD benefits provided via telehealth, but did not similarly restrict coverage for medical telehealth services.[13] In the pharmaceutical space, DOL reported that a plan excluded coverage of methadone for opioid use disorder, but covered methadone for medical/surgical conditions. In each case, DOL issued a notice of non-compliance and the health plan eliminated the coverage exclusion.

Prior Authorization and Concurrent Care Review

Health plans routinely condition coverage for services based upon their prior approval of coverage (prior authorization) or their approval of ongoing services (concurrent review). To comply with MHPAEA, health plans' policies and practices related to prior authorization and concurrent review must be applied comparatively, and no more stringently, for MH/SUD treatment than medical/surgical treatments.[14]

The 2023 DOL report cites a troubling example involving an issuer and third-party administrator. The plan required prior authorization for several outpatient services, including certain "intensive" MH/SUD treatments, which it categorized as outpatient, even though equivalent treatment-levels for medical/surgical care (like partial hospitalization) were not considered outpatient, so no prior authorization was required. After notice from DOL, the plan re-categorized the intensive outpatient MH/SUD benefits, removing the prior authorization requirement.

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[10] A recent report from the Robert Wood Johnson Foundation found significant differences in cost sharing between mental health and primary care services in Medicare Advantage Plans. Although MA Plans are not governed by MAHPAEA, the report raises concern about access to mental health care for seniors. *See* Katherine Hempstead, *Marketplace Pulse: Differences in Cost-Sharing Create Barriers to Mental Healthcare in Medicare Advantage* (Feb. 1, 2024), https://www.rwjf.org/en/insights/our-research/2024/02/marketplace-pulse-differences-in-cost-sharing-create-barriers-to-mental-healthcare-in-medicare-advantage.html

[11] MHPAEA Comparative Analysis Report to Congress. U.S. Department of the Treasury. U.S. Department of Labor. U.S. Department of Health and Human Services. July 2023. https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis.pdf

[12] Id. at 35 (Example 1).

[13] Id. at 37 (Example 3).

[14] MHPAEA's regulations describe the general rule for NQTLs, which include prior authorization, as follows: "A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification *are comparable to, and are applied no more stringently than*, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification." 29 C.F.R. § 2590.712(c)(4)(i) (emphasis added).

Non-Compliance with Comparative Analysis Requirements

Since February 10, 2021, the Consolidated Appropriations Act has required health plans to prepare and maintain comparative analyses, documenting the processes, strategies, evidentiary standards, and other factors used to apply NQTLs to MH/SUD benefits. Plans must make the comparative analyses available to DOL, state regulators, and plan participants upon request. DOL's MHPAEA Self-Compliance Tool explains how plans should analyze whether the NQTLs meet those requirements.

In its July 2023 Report to Congress, DOL found that "many plans and issuers" did not have a comparative analysis at all when DOL requested them. Instead, these plans "quickly created one after receiving [DOL]'s request." For the analyses that it did review, DOL noted that "[t]he common deficiencies that were listed in the January 2022 Report continue to persist." A New York state report similarly found that among the 17 Medicaid managed care organizations the state evaluated, none had fully compliant comparative analyses and for several categories of NQTLs only a few were in compliance.

Reimbursement Rates

To comply with MHPAEA, health plans must use comparable factors when setting reimbursement rates for physicians and other health care professionals that provide MH/SUD and medical/surgical treatment. There is evidence supporting what physicians and other health care professionals know intuitively: reimbursement rates are lower for behavioral health than medical/surgical treatments and health plans do not use the same factors to determine those rates.

A 2019 report[15] analyzed average in-network reimbursement rates across the country and found that rates for behavioral health office visits were lower than medical/surgical office visits as a percentage of Medicare.[16] The rate disparity increased from 2015 to 2017, with primary care reimbursements 23.8% higher than behavioral health reimbursements in 2017. Health plans argue that they reimburse MH/SUD services less because MH/SUD physicians and other professionals have less bargaining leverage than medical/surgical ones. Commentators and regulators have refuted this claim, explaining that a fair application of bargaining leverage would lead to increased reimbursement rates and more MH / SUD physicians and other professionals coming into the network, not fewer.[17]

Network Adequacy

MHPAEA requires that health plans use comparable adequacy standards for MH/SUD networks as they do for medical/surgical networks. There is overwhelming evidence that health plans do not have adequate MH/SUD networks in absolute terms and when compared to their medical/surgical networks.

A July 2023 national survey found that 57% of patients who sought mental health or SUD care did not receive it, compared to 32% of patients who sought physical health care.[18] Another 2023 survey found that only 31% of employers were satisfied with their members' access to in-network behavioral health care.[19] In a 2022 survey, 82%

[15] Steve Melek et al., Additional and mental health vs. physical health: Widening disparities in network use and provider reimbursement, at 6 (Nov. 19, 2019), https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx
[16] See also Stoddard Davenport et al., Access across America: State-by-state insights into the accessibility of care for mental health and substance use disorders, at 16 (Dec. 2023), https://www.milliman.com/-/media/milliman/pdfs/2023-articles/12-12-23_milliman-report-access-across-america.ashx
[17] *See* Henry T. Harbin & Beth Ann Middlebrook, Federal Parity Law (MHPAEA): NQTL of In-Network Reimbursement Rates: Non-Comparable Use of Factors of Provider Leverage a/k/a Bargaining Power and Workforce Shortages (June 2002), https://www.thekennedyforum.org/app/uploads/2022/06/Provider-Leverage.Bargaining-Power.Issue_.Brief_.06.07.22.pdf
[18] Jude Sky et al., Equitable Access to Mental Health and Substance Use Care: An Urgent Need (July 18, 2023), https://www.mhtari.org/Survey_Conducted_by_NORC.pdf
[19] Voice of the Purchaser Survey on Behavioral Health Support: Spring 2023 Survey Results at 3, https://higherlogicdownload.s3.amazonaws.com/NAHPC/3d988744-80e1-414b-8881-aa2c98621788/UploadedFiles/T514R490RouKpe2lnF9J_VOP%20Public%20Report_Finalized%203.pdf

of employers said that their largest health plan had enough primary care providers to provide timely access to services while only 44% said there were enough behavioral health providers to provide timely access to care.[20]

"Secret Shopper" investigations of health plans' MH/SUD directories similarly reveal inadequate networks even when compared to medical / surgical directories. A 2023 Senate Finance Committee report concluded that when calling mental health physicians and other professionals identified as in-network with Medicare Advantage plans, more than 80% were either unreachable, not accepting new patients, or not in-network.[21] A February 2023 study in Oklahoma concluded that "the majority of MH/SUD health providers listed by insurance networks appear unavailable or unreachable—many with disconnected phone lines."[22] A 2022 study of Oregon Medicaid managed care plans found 67.4 percent of network directory listings for mental health prescribers were "phantom" compared to 54.0 percent of primary care physicians and other professionals.[23] This evidence should allow regulators to closely examine whether health plans are using comparable network adequacy standards for MH/SUD and medical / surgical as MHPAEA requires.

In addition, while health plans try to excuse their failings on workforce challenges, an April 2024 study found that "provider shortages do not explain the disparities in out-of-network utilization and reimbursement."[24] The study from RTI International reviewed more than 22 million claims across all 50 states from 2019-2021 across multiple different types of health plans, including HMOs and PPOs. Findings included:

- Out-of-network use was many times higher for behavioral health treatment than medical/surgical treatment, which created a significantly greater financial burden for behavioral health patients. This was true even for telebehavioral visits as compared to telemedicine visits.
- Office visit in-network reimbursement levels were much lower for behavioral health providers than for medical/surgical providers creating disincentives for behavioral health providers to participate in-network.
- The disparities in out-of-network use have remained large over the last 9 years for office visits, where most behavioral health care is delivered.

Medical Necessity

There is growing interest in medical necessity criteria as an NQTL. DOL has highlighted that health plans must use comparable factors and processes to develop medical necessity criteria for MH/SUD treatments as they do for medical/surgical treatments and must apply those criteria in comparable ways.[25]

For example, DOL's 2023 Report to Congress notes that it identified a plan that included among its MH/SUD continued stay criteria that the patient show evidence of progress, meaning coverage would be terminated if there was no significant improvement in the patient's condition. Because the plan did not have similar criteria for assessing continued coverage for medical/surgical benefits, DOL required that the plan remove the criterion.

There are similar concerns about health plans' use of internal clinical guidelines as part of medical necessity determinations. Although not a parity case, *per se*, the plaintiffs in *Wit v. United Behavioral Health* alleged that United's use of guidelines that it developed to determine coverage for BH services did not comply with generally

[20] Gary Claxton et al., Health Benefits in 2022: Premiums Remain Steady, Many Employers Report Limited Provider Networks for Behavioral Health, 41 Health Affairs 11 (Oct. 27, 2022), https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01139
[21] Senate Committee on Finance, Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks at 3 (May 3, 2023), https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf
[22] Health Minds Policy Initiative, Accessing Behavioral Health Providers Through Private Insurance in Oklahoma (Feb. 2023), https://assets-global.website-files.com/638f97e13417b746d0eb3763/640f4b4c1061a6258f27cad9_Healthy%20Minds%20network%20adequacy%20report.pdf
[23] Jane M. Zhu et al., Phantom Networks: Discrepancies Between Reported and Realized Mental Health Care Access in Oregon Medicaid, 41 Health Affairs 7 (July 2022), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00052
[24] Mark, T. L., & Parish, W. J. (2024). Behavioral Health Parity – Pervasive Disparities In Access To In-Network Care Continue. RTI International.
[25] Self-Compliance Tool for Mental Health Parity and Addiction Equity Act (MHPAEA) at 19, https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

accepted standards of practice and were, therefore, impermissible under federal law.[26] The federal district court found in favor of the plaintiff, concluding that United's practices violated federal law. The court of appeals initially reversed the plaintiff's victory,[27] but after rehearing the case, the appeals court reinstated some of the trial court decision.[28] While the case remains pending on appeal, health plans' ongoing use of internal guidelines as a limitation on coverage remains of great concern.[29]

Notably in *Wit*, United was required under multiple state laws to use the American Society of Addiction Medicine Criteria[30] when making determinations of medical necessity. United, however, substituted its own, internally-created criteria that the court found inferior and not comparable to the ASAM Criteria. The AMA also expressed concerns to allowing health plans to develop their own "independent professional medical or clinical standards." Rather, the AMA highlights that several states have adopted a strong definition of "generally accepted standards of care" for MH/SUD services that rely on criteria established by non-profit, professional medical associations guided by practicing physicians in addiction medicine, psychiatry, addiction psychiatry and child and adolescent psychiatry.[31]

Conclusion

Americans desperately need better access to MH/SUD care. Health plans too often stand in the way of people getting the care that they need. Some plans do not cover certain MH/SUD treatments, and others impose onerous prior authorization or continuing review requirements, even though the plans do not use similar policies for medical/surgical treatments. Plans' use of lower reimbursement rates, inadequate networks, and improper use of medical necessity criteria create further challenges for patients. These problems can be—and should be—eliminated with strong enforcement of MHPAEA at the state and federal levels. Improving patients' access to evidence-based care for MH/SUD services, and reducing the burden of the national mental health and overdose epidemics will not happen without greater MHPAEA enforcement.

As we will detail in the next issue brief, advocates, regulators and other policymakers have made some important strides, but also recognize the need to re-double their efforts to protect patients and hold health plans accountable. After more than 15 years of plans' lack of compliance, the AMA strongly urges increased efforts to help patients receive the benefits and protections that MHPAEA is supposed to provide.

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[26] *See* Brief of Rhode Island, Colorado, Connecticut, Delaware, Illinois, Maine, Maryland, Michigan, Minnesota, Nevada, New Jersey, New York, Oregon, Vermont, Washington, and the District of Columbia as Amici Curiae in Support of Plaintiffs-Appellees and Rehearing en Banc. Available at https://riag.ri.gov/media/3916/download

[27] *Wit v. United Behav. Health*, 58 F.4th 1080, 1099 (9th Cir. 2023), opinion vacated and superseded on reh'g, 79 F.4th 1068 (9th Cir. 2023)

[28] *Wit v. United Behav. Health*, 79 F.4th 1068, 1089 (9th Cir. 2023)

[29] *See* Brief of Amici Curiae National Association for Behavioral Healthcare, American Hospital Association, American Psychological Association, American Association for the Treatment of Opioid Dependence, California Hospital Association, Federation of American Hospitals, National Association of Addiction Treatment Providers, National Council for Mental Wellbeing, and REDC Consortium in Support of Rehearing en Banc, Wit v United Behavioral Health. Available at: https://www.aha.org/system/files/media/file/2022/05/amicus-brief-aha-other-hospital-and-health-care-organizations-re-wit-v-united-behavioral-health-5-13-22.pdf; Brief of American Psychiatric Association, American Medical Association, California Medical Association, Southern California Psychiatric Society, Northern California Psychiatric Society, Central California Psychiatric Society and San Diego Psychiatric Society as Amici Curiae in Support of Appellees and Supporting Affirmance. Available athttps://searchltf.ama-assn.org/case/documentDownload?uri=%2Funstructured%2Fbinary%2Fcasebriefs%2FWit_v__United_Behavioral_Health_Ninth_Circuit_Court_of_Appeals_Brief.pdf ; Brief of the State of California as Amicus Curiae in Support of Appellees' Petition for Rehearing and Suggestion for Rehearing en Banc. Available at https://www.thekennedyforum.org/app/uploads/2022/05/2022-5-16-CA-Amicus-Brief.pdf

[30] ASAM Criteria. Available at https://www.asam.org/asam-criteria/about-the-asam-criteria

[31] *See,* for example, in Illinois law, "Generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, social work, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration." 215 ILCS 5/370c.