EXECUTIVE SUMMARY

The passage of comprehensive mental health parity appears to have done little to increase access for patients with mental health conditions. Completing a national analysis using commercial claims data from the Health Care Cost Institute database, our findings reveal that the Mental Health Parity and Addiction Equity Act had little to no effect on access and utilization of mental health services for patients with depression, bipolar, or schizophrenia. These findings have several policy implications all of which aim to better address the unmet mental health need throughout our states:

1. Strengthen enforcement of mental health parity across the country;
2. Consider alternate access points for mental health beyond mental health settings (e.g. primary care); and,
3. Assess the adequacy of the mental health workforce to ensure there are enough providers in the right place to address community need.

Historically, mental health care in the United States has been separate from physical health care – mental health has distinct providers and systems, and, importantly, discrete treatment by insurance plans. In response, some states passed laws requiring health insurers to reduce the inequality between mental and physical health care coverage. These laws were designed to increase access to mental health services by requiring parity between physical and mental health insurance coverage. However, in some states, the state laws had limitations. For example, some state laws did not affect self-insured employer plans covered by the Employee Retirement Income Security Act of 1974 (ERISA).

The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which amended the original Mental Health Parity Act of 1996, increased parity in all 50 states. The Act requires plans that choose to offer both medical benefits and mental health or substance use disorder benefits to offer such benefits in parity. As outlined in the Act, plans must ensure that the financial requirements and treatment limitations applied to mental health and substance use disorders are not more restrictive than those applied to medical surgical benefits.

The MHPAEA implemented standardized requirements for medical and mental health insurance coverage. Specifically, the law requires that if a group health plan or

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Insurance coverage includes medical and mental health benefits, financial requirements and treatment limitations for mental health may not be more restrictive than the predominant financial requirements or treatment limitations that apply to medical/surgical benefits.

Mental health parity was further advanced by the passage of the 2010 Affordable Care Act (ACA). The ACA strengthened MHPAEA by applying parity to individual health insurance coverage and the plans sold through the health insurance exchanges.6

Research indicates that state level parity laws were somewhat effective. A study by Cunningham determined that compared to primary care providers in states with no mental health parity laws, those in states with mandatory parity were eight percentage points less likely to report access problems due to health plan barriers and about five percentage points less likely to report problems stemming from lack of or inadequate coverage.7 However, parity laws may exacerbate problems with provider shortages because of increased demand for mental health services. Cunningham also found that primary care providers in states with parity laws were more likely than those in states with no parity laws to report problems due to a shortage of providers, although the results were not statistically significant (p = 0.12).7

As more states pay attention to mental health and the need to better address the historically unmet need, the question remains, how does the federal mental health parity law affect health plan beneficiaries and their ability to access mental health services? Specifically, does legislation requiring health insurance parity increase access to — and thus, utilization of mental health services?

We sought to answer this question by comparing the effect of parity laws on individuals who had one of three mental health conditions and who reside in states that had weaker parity laws compared to states with stronger parity laws than required through MHPAE. Since MHPAE set a standard for minimal parity requirements, states that had adequate parity laws did not have to change post MHPAEA. Federal Parity establishes at a minimum a floor for health benefits but allows states to enforce any parity requirement stronger than the federal law. A key point, however, is that the state law cannot compromise the federal law. Plans that are not subject to state laws (e.g. ERISA), stipulates that federal law sets both the floor and the ceiling. This new “floor” for mental health benefits means states who were below the “floor” had to bring up their benefits to accommodate the new law.

To study the impact of parity laws, our team picked three conditions that are often seen in mental health settings: depression, schizophrenia and bipolar disorder. A preliminary difference-in-difference analysis was conducted to examine changes in healthcare utilization patterns before and after the implementation of the MHPAEA on July 1, 2010. The analysis compared the utilization patterns of beneficiaries in states with minimal parity prior to MHPAEA (DC, TX, FL, DE, CO, OH, MO, NJ) to utilization patterns of beneficiaries in states with comprehensive parity (OR, MN, VT, CT, MD) prior to MHPAEA legislation. Individuals were identified as having one of the three mental health conditions if they had either two outpatient claims or one inpatient claim with the diagnosis codes for any of these conditions. To compare the
differences in utilization patterns for the same individuals before and after implementation of the MHPAEA, inclusion in the analysis required an individual to have been enrolled in the same plan and living in the same state from July 1, 2009 – December 31, 2011.

The analysis examined three measures of mental healthcare utilization: the number of visits in a twelve month period to a psychiatrist, visits to a psychologist, and visits to other mental health providers. For each individual, the outcome measure equals the raw number of visits s/he had in the “pre” time period and the “post” time period. The “pre” time period was the 12 months before the MHPAEA went into effect (July 1, 2009 – June 30, 2010). The “post” period was January 1, 2011 - December 31, 2011.

If the MHPAEA increased access to mental health services one would expect to see utilization of these services to increase over time in the states with minimal parity laws compared to states with comprehensive parity laws after accounting for common time trends across all states. A linear regression framework isolated the changes in utilization of mental health services in states with minimal parity laws before July 2010 assuming common time trends in utilization across all states.

The results from our linear regression difference-in-difference analysis suggests that MHPAEA had little to no effect on access and utilization of mental health services for patients with depression, bipolar, or schizophrenia. When examining a pre-/post-comparison of these three mental health utilization measures in states with minimal parity laws prior to implementation of MHPAEA, the number of visits to all three types of providers did not increase as would be expected if parity increased access to care.

These results confirm findings from previous studies that the MHPAEA actually reduced utilization of psychiatric services and had no significant effect on psychologist and other mental health services. This trend was seen among states that already had significantly lower utilization of psychiatric and other mental health services. Interestingly there was also a significant decrease in number of visits to a psychiatrist and visits to other mental health providers between the two time points for people living in states with comprehensive parity before the MHPAEA.

These data have policy implications because they show that mental health parity laws may not have had the intended effect of increasing access and utilization of mental health services. While our analysis did not address the drivers underlying the trends in the opposite direction of the intended effects of parity laws, others have hypothesized that two key factors could explain these findings:

1. Enforcement: Enforcing mental health parity remains a challenging and elusive activity for state insurance regulators. It is possible that some plans in states that did not have parity laws prior to the MHPAEA are not fully implementing parity and these plans are not being penalized due to a lack of accountability and enforcement.

2. Shortages of mental health services: While this study was not able to look at other non-commercial claims, there may have been a significant uptick in the utilization of services from individuals covered under Medicare and Medicaid who made greater use of mental health services limiting the number of visits that could have been made by privately insured individuals with prior mental health needs. In addition, the implementation of parity may also have significantly increased the number of individuals diagnosed with mental health conditions and these newly diagnosed individuals made greater use of mental health services, which could have crowded out visits by individuals with prior mental health diagnoses.

While additional analyses are needed, these preliminary results suggest the following policy recommendations:
1. Strengthen enforcement of mental health parity: Examining whether or not states are following the parity law remains a challenge. If parity is not being fully implemented across payers and states, there may still be issues associated with access and utilization. As our analysis shows, there does not appear to be any significant changes in states post-parity for patients accessing or utilizing the mental health system.

2. Consider alternate access points for mental health: If parity has not helped to increase the ability for patients with mental health needs to access the mental health system, states may consider other delivery settings where mental health could be addressed. For example, for decades primary care has been described as the “de facto” mental health system due to the number of individuals identified and treated in this setting. Recent research has shown that by integrating mental health providers into primary care, we can increase access, improve outcomes, and decrease cost.

3. Assess the adequacy of the mental health workforce: Examine whether or not there is an adequate workforce in place to address the multitude of mental health needs in states. Workforce issues abound for mental health, and it may be possible that increases in the number of individuals now eligible for mental health services results in less utilization by each individual because the available providers were allocating a fixed capacity across more individuals rather than not accepting new patients. Further, states may consider the location of their existing mental health workforce to better position them for easier access and more timely services delivery for newly diagnosed patients as well as existing patients with mental health service needs. For example, closer integration of mental health services in primary care settings could address these workforce issues as in many cases, primary care practices remain the predominant place where individuals are identified, diagnosed, and treated for mental health conditions.

Overall MHPAE attempted to address a problem of inequity with mental health benefits amongst health plan beneficiaries. While conceptually parity made great strides to help those who benefit from mental health services, our analyses do not show any major difference in states utilization patterns post MHPAE.
TECHNICAL APPENDIX

To assess the potential effect of the MHPAEA on utilization of mental health services we implemented a linear regression specification of a difference-in-differences approach using the data described above. The linear regression specification is represented by:

\[ Y_{it} = \beta_0 + \beta_1 \cdot \text{StateLaw} + \beta_2 \cdot \text{Time} + \beta_3 \cdot \text{StateLaw} \cdot \text{Time} + \gamma' \cdot Z_{it} + \epsilon_{it} \]

where \( Y \) estimates the number of visits to a psychiatrist, psychologist, or other mental health provider in the year.

Control variables included in the regression analysis are sex, age band (18-24, 25-34, 35-44, 45-54, 55-64), and whether the individual lived in a rural area (as determined by a zip code missing from the dataset). The number of visits to a psychologist were not significantly affected by the MHPAEA (\( p = 0.250 \)). The number of visits to a psychiatrist were significantly negatively affected by the MHPAEA; the average individual had 0.339 fewer visits to a psychiatrist in the “post” MHPAEA implementation period as compared to the “pre” period (\( p = 0.017 \)). The number of visits to another type of mental health provider was not significantly affected by the MHPAEA (\( p = 0.803 \)).

REFERENCES


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