International Journal of Drug Policy 34 (2016) 80–87

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research paper

The United States' Federal Parity Act and treatment of substance use disorders: Administrators' familiarity and perceptions of impact

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ARTICLE INFO

Article history:
Received 13 July 2015
Received in revised form 17 November 2015
Accepted 25 May 2016

Keywords:
Parity legislation
SUD treatment
Private insurance

ABSTRACT

Background: The 2008 Wellstone and Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) aims to secure parity in private insurance coverage between behavioral and other medical disorders in the United States (U.S.). This legislation represents an important change in the operating field of substance use disorder treatment, but to date, its impact on treatment centers has not been widely examined. The current study measured the extent of center leaders' familiarity with the MHPAEA and their perceptions of its overall impact on their centers.
Methods: Using a nationally representative sample of treatment centers in the U.S., we examined the extent of MHPAEA familiarity and its perceived impact as reported by treatment center leaders. We further employed logistic and ordered logistic regressions to determine personal and organizational characteristics associated with their reported familiarity and experienced impacts, including changes in the number of privately-insured clients seeking treatment and in the treatment coverage of those clients.
Results: We found that dissemination of parity information was low. Only 36% of administrators reported high levels of familiarity and 16% used professional sources of information. The majority of administrators (71%) reported no impact of the legislation on their organization, but those that reported any impact were more likely to state positive impact. Greater parity knowledge and perceived positive impacts were associated with administrator and organizational characteristics indicative of greater access to industry-specific knowledge, a medical model orientation, and reliance on private insurance revenue.
Conclusion: This study demonstrates that dissemination of parity information is lacking and that the majority of leaders have yet to experience an impact of the MHPAEA. Leaders of centers with more sophisticated structures are most likely to be familiar with the legislation and perceive a positive impact. Research concerning the effective management of treatment centers, including environmental scanning techniques, continues to be needed.

Introduction

In the United States (U.S.), public policy has held an historic influence in the provision of substance use disorder (SUD) treatment services. Over the past several decades, multiple federal acts have shifted the societal management of SUD from the criminal justice system to medicalized care and control (Beauchamp, 1980; Finn, 1985). Further, agencies within the National Institutes of Health have been mandated to conduct research on SUD and provide policy leadership for treatment providers (Metlay, 2013; Roman, 2014). Most recently, the 2010 Patient Protection and Affordable Care Act (ACA), which is arguably the most extensive U.S. public policy concerning healthcare ever to be established, expressly seeks to enhance Americans' access to SUD treatment.

Much of U.S. policy regarding SUD treatment has been heavily influenced by activists committed to treating SUD "as a disease like any other" (Beauchamp, 1980). These activists have stressed disparities between U.S. healthcare systems' response to mental health disorders, including SUD, and other physical illnesses in

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http://dx.doi.org/10.1016/j.drugpo.2016.05.011
0955-3959/

terms of treatment accessibility, quality, and insurance coverage. These concerns are at the heart of the 2008 Wellstone and Domenici Mental Health Parity and Addiction Equity Act (MHPAEA). This Act is intended to create national parity between third-party health insurance reimbursement for the treatment of SUD and comparable reimbursements for treatment of other medical disorders, and has served as the foundation for the ACA's approach to SUD as well. The current study's aim is to examine the extent to which SUD treatment center leaders are informed about this legislation and their initial perceptions about its impact, using a nationally representative sample of U.S. SUD treatment centers.

U.S. healthcare financing and SUD treatment

The U.S. healthcare system is costly and complex. For example, healthcare spending in the U.S. is far greater than in other industrialized nations (Lorenzoni, Belloni, & Sassi, 2014), and its healthcare financing is composed of an intricate and globally unique amalgam of private and public insurance providers (World Health Organization, 2015). While variation in healthcare financing is evident, the U.S. relies more heavily on private insurance providers than any other comparable country (Anderson, Frogner, Johns, & Reinhardt, 2006; McGuire, 2011). Despite this, SUD treatment coverage has traditionally been a supplement to insurance plans, and as such, provisions have been variable, inconsistent, and often limited (Barry, Huskamp, & Goldman, 2010). SUD coverage has also varied state-by-state, meaning that there has been little uniformity in national treatment access. Beginning in the 1970s, some states began passing legislation aimed at improving private insurance coverage of SUD and other mental health disorders (Robinson, Connolly, Whitter, & Magaña, 2006). Nonetheless, these regulations were of varied scope, often including benefits for some behavioral health conditions but not full parity between SUD and physical health concerns. Before the MHPAEA took effect, only four states had enacted comprehensive parity reform (National Alliance on Mental Illness [NAMI], 2009).

These state acts may have increased SUD coverage for some, but on a national scale, there have been long standing discrepancies between insurers' limitations on reimbursement for treatment of behavioral disorders, including SUD, and limitations on the treatment of other disorders. For non-behavioral health problems, the average insured person has been responsible for less than 5% of the total costs for physical illness care, compared to approximately 30% of the total cost for treatment of behavioral health problems (Zuvekas, Banthin, & Selden, 1998). Further, in an analysis of employee-sponsored insurance plans, Gabel et al. (2007) found that, on average, these plans had higher cost sharing, annual limits, and lifetime limits on care for SUD treatment than for medical-surgical services. Others have noted that a widening gap in coverage has occurred since the late 1980s (Barry & Sindelar, 2007).

The MHPAEA

The MHPAEA is a national response to these common coverage limitations. It also serves as a way to achieve greater uniformity in SUD and mental health coverage as it supersedes pre-existing state legislation, which rarely achieved comprehensive parity (NAMI, 2009). While it does not require insurance plans to offer SUD benefits, if such benefits are present, they must be on par with a plan's physical health benefits. Further, if a plan does not impose a financial requirement or treatment limitation to more than one-half of its physical health benefits, it cannot impose such restrictions on its SUD benefits (United States Department of Labor, 2012).

Thus, all financial requirements, such as lifetime and annual dollar limits, deductibles, copayments, coinsurance and maximum out-of-pocket expenses must be the same for SUD and physical health benefits. Parity is also required for frequency of treatment, number of visits, and days of coverage. There are however some exemptions. Private employers of fewer than 50 employees and non-federal governmental plans with fewer than 100 employees are exempt from MHPAEA requirements. The law also allows exemptions if plans can demonstrate an increase in claim costs of 2% in the first year, followed by 1% in subsequent years. The ACA has subsequently extended parity requirements to Medicaid managed care and Medicaid benchmark plans.

The MHPAEA and SUD treatment

While state-level parity legislation has often excluded or limited SUD protections (NAMI, 2009), the MHPAEA includes SUD in its definition of mental health conditions. Thus, the MHPAEA has the potential to positively influence treatment on a national scale for a disorder that is remarkably under-treated. In 2013, the U.S. National Survey of Drug Use and Health reported that 89% of individuals with SUD did not receive treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014b). This survey noted that financial barriers, treatment cost and lack of insurance were major barriers to treatment (SAMHSA, 2014b). Compounding these impediments is the fact that SUD stigma is far from eradicated (Room, 2005; Schomerus et al., 2011), and is often cited as a barrier to treatment as well (Byrne, 2000; Grant, 1997; McFarling, D'Angelo, Drain, Gibbs, & Olmsted, 2011; Schober & Annis, 1997). The SUD stigma has likely been further supported by prescribed insurance limits. These restrictions suggest that the covered care should be adequate and that failure to respond to this limited care reflects badly on the patient.

By addressing insurance limits and SUD discrimination in healthcare financing, the MHPAEA tackles many of the key obstacles to treatment. It could encourage greater utilization of treatment services through reductions in costs for clients insured through private insurance. These clients would have previously had to pay out-of-pocket for treatment, even if they were covered for equivalent physical health procedures, but under the MHPAEA, their out-of-pocket costs should be decreased. By removing stated limits in insurance policies that may encourage stigma, another barrier for treatment could be eliminated. Finally, by putting SUD on par with other medical care, the legislation should also increase treatment admissions, the duration of individual treatment, and overall revenue through higher reimbursement rates. These changes could lead to not only increases in treatment access but quality as well.

Little is yet known about the actual impact of MHPAEA on SUD treatment utilization. Analyzing insurance claims, before and after the MHPAEA's implementation, Busch et al. (2014) found a modest increase in SUD spending occurred, but no significant increase in clients seeking treatment. Making inferences from state-level parity legislation, studies on Oregon's parity legislation show that, while private insurance expenditures increased for alcohol use disorder treatment, there was little or no evidence of expenditure increases for other SUD services (McConnell, Gast, et al., 2012; McConnell, Ridgely, & McCarty, 2012). However, Dave and Mukerjee's (2011) analysis of data from SAMHSA's Treatment Episodes Data Set revealed that states mandating comprehensive parity experienced increases in SUD treatment admissions. They also found that the likelihood of privately-insured SUD treatment was higher in states with parity laws, which ultimately lowered treatment costs for individual clients. Further, Wen, Cummings, Hockenberry, Gaydos, and Druss (2013) found that state level