What Does Mental Health Parity Really Mean for the Care of People with Serious Mental Illness?

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KEYWORDS

- Parity • Affordable Care Act • MHPAEA Act • SMI population
- Mental health and substance abuse benefits • Essential health benefits
- Medicaid expansion • Non-quantitative treatment limitations

KEY POINTS

- Achievement of parity, equality for both what is covered and also how and when it is covered, for mental health and substance abuse benefits is a major step forward in providing more comprehensive care for individuals living with SMI and psychosis.
- However, parity is a *relative* concept and does not necessarily provide access to the full set of recovery-oriented benefits, such as supported housing and employment, required by many of the SMI population for their full recovery.
- The path to parity for mental health/substance use disorder (MH/SUD) benefits has been marked by many often seemingly minor, incremental changes, which over the past 50 years have resulted in positive quantitative and qualitative changes to the reach and scope of parity.
- The combined requirements of the 2008 Mental Health Parity and Addiction Equity Act and the 2010 Patient Protection and Affordable Care Act have greatly expanded access to parity MH/SUD benefits, but major gaps in parity coverage and major challenges to its expansion still exist.
- The path to parity in many respects parallels the civil rights movement, in that full integration of benefits, rather than separate but equal ones, should be the ultimate goal.

INTRODUCTION

Over the past six decades, one, if not the most important, policy issue in behavioral health has been the establishment of benefit and coverage parity for the prevention and treatment of mental illness and addiction. Beginning with the directives of

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President John F. Kennedy to the Civil Service Commission in the early 1960s to provide parity coverage within the Federal Employees Health Benefit Program and continuing on over the next 50 years to the recent passage of the Patient Protection and Affordable Care Act (ACA), this movement toward parity has been perhaps the most important strategic guide for policy within our field. However, as has been pointed out by Grob and Goldman in their 2006 book "*The Dilemma of Federal Mental Health Policy: Radical Reform or Incremental Change?"* the path to parity has been neither quick nor direct.[1] Instead, it has been a guiding principle for a set of many incremental, sequential improvements over a long period.

With the passage of the ACA in 2010, many in the behavioral health care field saw its commitment to behavioral health prevention and treatment as the final step to parity. However, as so often proves true, the passage of legislation is not the same as its successful implementation. The thesis of this paper is that effective implementation of parity as originally envisioned by Senator Ted Kennedy of Massachusetts and Representative Patrick Kennedy of Rhode Island would be a major step forward for improving the care and outcomes for persons with serious mental illness (SMI), especially those persons living with schizophrenia. In fact, a number of roadblocks to the full achievement of that vision have occurred during the implementation process. In this article, we describe the original vision, review the obstacles and challenges to its successful implementation to date, and finally, indicate additional steps that will be necessary to implement fully the potential of parity for the SMI population.

One needs only to look back less than a decade to view a less than optimal situation for people living with SMIs and addictions. For these adults, only 50% to 60% actually received any care at that time.[2] The remainder were either part of the homeless population, in and out of local and county jails, or were being cared for by family members.[2] At the same time, state mental health agency budgets were being cut by about $4.5 billion after 2008 as a result of the Great Recession, which made the community care situation for persons with SMI even more precarious.[3] The community mental health system was very poorly funded, offered inadequate services in many places, and simply did not extend into many rural areas. Little or nothing was done to address initial psychosis at that time, and many persons with SMI were not enrolled in Medicaid.

But how, one might ask, could such a situation exist, especially after the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008. This legislation sped through the Congress and the White House, because it was the legislative vehicle used to pass the Emergency Economic Stabilization Act of 2008 in response to the Great Recession. Moreover, the MHPAEA was landmark behavioral health legislation because it required parity with medical benefits for both mental health and substance use disorder (MH/SUD) care in all private health insurance plans that offered coverage for behavioral health conditions and insured 50 or more persons. The legislation also required parity in the management of benefits, so that behavioral health care benefits could not be managed more stringently than medical benefits.[4] However, while requiring parity for insurance plans that offered mental health and substance abuse benefits, it in no way required a plan to offer them. The reach of parity under the MHPAEA was still a limited one (**Box 1**).

However, many have seen MHPAEA as the vehicle that leveled the playing field for behavioral health care so that it could participate fully in the development and implementation of the ACA.[5] The ACA extended parity's reach by requiring that MH/SUD benefits be offered in all insurance plans offered through the state health insurance marketplaces, to all insurance plans offered through the individual and small group markets, and to all new coverage offered through the state Medicaid Expansions.