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The Mental Health Parity and Addiction Equity Act (MHPAEA) evaluation study: Did parity differentially affect substance use disorder and mental health benefits offered by behavioral healthcare carve-out and carve-in plans?

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ABSTRACT

Background: To assess whether implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) was associated with: 1. Reduced differences in financial requirements (i.e., copayments and coinsurance) for substance use disorder (SUD) versus specialty mental health (MH) care and 2. Reductions in the level of cost-sharing for SUD-specific services.

Methods: MH and SUD copayments and coinsurance, 2008–2013, were obtained from benefits databases for carve-in and carve-out plans from Optum®. Linear regression was used to estimate the association of MHPAEA with differences between MH and SUD care financial requirements among carve-in and carve-out plans. A two-part regression model investigated whether MHPAEA was associated with changes in the use or level of financial requirements for SUD-specific services among carve-out plans.

Results: MHPAEA was not associated with significant changes in the difference between SUD and MH copayments or coinsurance levels among either carve-in or carve-out plans. MHPAEA was associated with decreases in the levels of inpatient (in-network: −$51.17; out-of-network: −$34.39) and outpatient (in-network: −$10.26) detox copayments, but increases in the levels of in-network outpatient detox coinsurance (6 percentage points) among all carve-out plans.

Conclusion: Even if SUD benefits had been historically less generous than MH benefits, SUD financial requirements were already at parity with MH financial requirements by the time MHPAEA was passed, among Optum® plans. MHPAEA's SUD parity mandate reduced cost-sharing for detox services via copayments, but, for outpatient detox, the law simultaneously increased cost-sharing via coinsurance.

1. Introduction

In addition to addressing historical inequities between medical/surgical and specialty mental health (MH) benefits, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) was the first national parity law to require parity for substance use disorder (SUD) benefits (Ettner et al., 2016). This landmark piece of legislation required commercial large-group insurance plans covering behavioral health (BH, i.e., MH and/or SUD) to do so on the same terms as medical/surgical coverage. The law applied its parity mandate not only to SUD financial requirements (e.g., copayments, coinsurance, deductibles, etc.) but also to SUD quantitative treatment limits (QTLs, e.g., annual number of inpatient days or outpatient visits covered by the plan). Additionally, MHPAEA's Interim Final Rule (IFR), published in 2010, required parity for SUD non-quantitative treatment limits (NQTLs, e.g., utilization review, etc.) (Department of Health and Human Services, 2010).

Treatment for SUD patients often involves ongoing treatment for

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drug and/or alcohol addiction as well as any comorbid mental health conditions. This can be costly for patients over time (French et al., 2008). Prior work documents that expenditures are substantially higher among privately-insured, non-elderly adults with SUD diagnoses compared to the same population as a whole (Harwood et al., 2017; Friedman et al., 2017). Since sufficiently generous financial requirements, commonly used insurance benefit design features, can reduce patients' out-of-pocket expenditures for these services, they are a key determinant of access to SUD treatment. The high burden of SUD in the U.S. (in 2013, 21.5 million people had at least one SUD) made adequate insurance coverage and generosity for these conditions a policy priority (Center for Behavioral Health Statistics and Quality, 2015).

Additionally, researchers who investigated the legislative process leading up to MHPAEA's passage report that some legislators who championed MHPAEA had personal experiences with addiction (as well as MH conditions). For example, Senator Kennedy reported that his SUD conditions were treated as second-class illnesses. In several cases, these personal experiences prompted legislators to promote inclusion of SUD in the parity law in the hopes of improving equity for SUD insurance coverage (Barry et al., 2010).

SUD benefits are of particular interest as outcomes in light of perceived differences between SUD benefits and MH benefits prior to MHPAEA implementation and the expectation that MHPAEA resulted in parity between SUD and MH benefits. Frank et al. note that prior to MHPAEA, exclusion of SUD treatment was more common than exclusion of MH treatment among benefits for commercially insured individuals (2014). Additionally, many states' passage of MH parity laws that excluded SUD benefits fed the perception that SUD benefits lagged in generosity behind MH benefits and medical/surgical benefits.

To date, several studies have investigated whether BH benefits subject to MHPAEA changed post-parity. One study used plan benefit data to examine the effects of MHPAEA on specialty MH financial requirements (Friedman et al., 2016). Another study surveyed plans to examine the effects of MHPAEA on measures of BH financial requirements but did not distinguish between benefits for specialty MH and SUD (Horgan et al., 2016). A third study examined the effects of MHPAEA on use of limits for specialty MH as well as SUD care (Thalmayer et al., 2016). However, despite the unique inclusion of SUD benefits in MHPAEA, and despite the key role of financial requirements in access to SUD care, no studies have used benefit data to examine the effect of MHPAEA on SUD financial requirements.

This study used data from the BH division of Optum® (hereafter called Optum Behavioral), a subsidiary of UnitedHealth Group, to investigate changes in copayments and coinsurance for SUD services before and after MHPAEA implementation. The data allowed for investigation of both carve-in plans (which administer both medical/surgical benefits together with behavioral health benefits) and carve-out plans (which only administer behavioral health benefits), improving the generalizability of the results. The analysis was done, in part, by comparing specialty MH cost-sharing to SUD cost-sharing to see if parity implementation resulted in equal levels of copayment and coinsurance (i.e., reduced differences between SUD and specialty MH cost-sharing) for the two types of care (1) among carve-in plans and (2) among carve-out plans. The analysis also investigated how benefits for SUD-specific services, required only among carve-out plans, changed following MHPAEA implementation. This component of the analysis asked: (3) did the likelihood of any use of cost-sharing for SUD-specific services decrease post-parity, (4) did the level of cost-sharing for SUD-specific services decrease post-parity among plans that required cost-sharing for these services, and (5) did the level of cost-sharing for SUD-specific services decrease post-parity among all carve-out plans, including those that did and those that did not require cost-sharing for these services?

2. Study data and methods

This study uses 2008–2013 administrative benefit data from Optum Behavioral drawn from proprietary insurance databases. The data include information from both carve-in and carve-out plans. These databases determine payments for claims and calculate patient out-of-pocket costs. The benefits data include specialty MH and SUD copayment dollar amounts and patient coinsurance rates. Additional information on employer characteristics (size, industry, region) and plan type were also provided by Optum Behavioral. The unit of analysis is the plan-year. This study compares benefits across three time-periods: (1) pre-parity, 2008–2009, (2) transition, 2010, when good-faith efforts at financial requirement and QTL parity compliance were required for plans renewing on a calendar-year basis, and (3) post-parity, 2011–2013, when publication of MHPAEA's IFR required legal compliance with financial requirement and QTL provisions as well as for NQTLs.[1]

The initial sampling process was done at the employer level. The initial carve-in sample of 661 employers contained all plans offered by contracted employers at least one year pre- and one year post-parity (based on 2008–2012) or during 2009. The initial carve-out sample contained 175 employers with carve-out contracts in any year during the study period. Both the carve-in and carve-out study samples include plans of large employers in the 50 U.S. states, which are subject to parity and renewed on the calendar year. The carve-in sample includes only self-insured plans, for which the employer is at risk for the costs of care, a common feature of insurance plans among large employers. The sample excludes fully-insured plans, for which the insurer is at risk for the costs of care, because this type of plan is rare in the initial sample. The final carve-in sample contains 385 employers, 3822 plans, and 12,163 plan-years; the final carve-out sample contains 40 employers, 1527 plans, 2257 plan-years. The carve-in plans represent approximately 8.5 million unique enrollees, while the carve-out plans represent approximately 3.1 million enrollees.

Some carve-in plans cover only in-network care (INN-only plans), while others cover both in- and out-of-network care (INN/OON plans). Therefore, analyses of carve-in plans are stratified into an INN-only sample (3609 INN-only plan-years) and an INN/OON sample (8554 INN/OON plan-years). Carve-out plans do not make this distinction and are analyzed as a single sample.

The carve-in and carve-out samples use different sets of outcome measures corresponding to the different types of care for which benefits are defined for the two kinds of plans. For the carve-in sample, outcome measures include INN inpatient, intermediate, and office-based professional care copayments (per visit or per-admission for inpatient care) as well as inpatient, intermediate, and outpatient office-based professional care patient coinsurance. The intermediate category includes a variety of settings— some are unique to SUD treatment, such as partial hospitalization, day treatment, intensive outpatient treatment, sober living, and transitional living arrangements. Separate variables measure benefits for specialty MH and for SUD care; however, the analyses use the difference of these variables (SUD copayment or coinsurance rate—specialty MH copayment or coinsurance rate).

For the carve-out sample, outcome measures include both INN and OON copayments and patient coinsurance rates for 8 types of care that are used to treat either specialty MH or SUD conditions: inpatient hospitalization, inpatient emergency room, inpatient professional, inpatient emergency room professional, residential treatment, intensive outpatient, outpatient psychotherapy, and outpatient medication management. As with the carve-in variables, separate variables measure specialty MH and SUD benefits, but the analyses use the difference

[1] It is worthwhile to note that although the Final Rule (FR) took effect after the study period, the FR confirmed the IFR provisions and clarified interactions with the ACA.