Recommendation for Mental Health Benefits Legislation

Community Preventive Services Task Force

Task Force Finding

The Community Preventive Services Task Force recommends mental health benefits legislation, particularly comprehensive parity legislation, based on sufficient evidence of effectiveness in improving financial protection and increasing appropriate utilization of mental health services for people with mental health conditions. There is also evidence that mental health benefits legislation is associated with increased access to care, increased diagnosis of mental health conditions, reduced prevalence of poor mental health, and reduced suicide rates.

Evidence from a concurrent economic review indicated that legislated expansion of mental health benefits did not lead to any substantial increase in cost to health insurance plans, measured as a percentage of premiums.

A summary of the Task Force finding and rationale is available at www.thecommunityguide.org/mentalhealth/RRbenefitslegis.html.

Definition

Mental health benefits legislation involves changing regulations for mental health insurance coverage to improve financial protection (i.e., decrease financial burden for the insured) and to increase access to, and use of, mental health services including substance abuse services. Such legislation can be enacted at the federal or state level:

- Parity laws cover a continuum of benefits.
  - Limited parity may cover specific mental health conditions, including substance abuse, or allow more restrictions in benefits compared to physical health (e.g., visit limits, copayments, deductibles, annual and lifetime limits).
  - Comprehensive parity covers a broad range of mental health conditions, including substance abuse, with few or no restrictions.
- Mandate laws may or may not be parity laws. These laws require insurers or health insurance plans to do at least one of the following:
  - provide some specified level of mental health coverage, or in cases when mental health insurance was already being provided, meet a minimum benefits level; and/or
  - offer the option of mental health coverage.

Basis of Finding

Despite the high prevalence of mental illness in the U.S.,[1] many affected people do not receive adequate mental health care.[2] Several IOM reports have examined the impact of financial burden on healthcare utilization[2–5] and determined that the cost of care is a major factor limiting access to care.[2] More than 50% of American families reported restricting their medical care in 2009 because of cost concerns, and nearly 20% reported serious financial problems because of medical bills, in some cases resulting in an inability to pay for food, heat, or housing.[2] Medical bills also contributed to half of all personal bankruptcy filings.[3,4] There is a strong association between health insurance plans that offer coverage for preventive and screening services, prescription drugs, and mental health care and patient or client receipt of appropriate care.[5]

The review[6] on which this finding is based found evidence that mental health benefits legislation is associated with improved financial protection and increased appropriate utilization of mental health services among people with mental health conditions. Appropriate utilization (i.e., receiving the proper amount and quality of services when needed) includes, but is not limited to, mental health visits for people identified with a mental health need, visits rendered by mental health specialists, or care visits that follow evidence-based guidelines for mental health care. The review also found evidence associating mental health benefits legislation with increased access to care, increased diagnosis of mental health conditions, reduced prevalence of poor mental health, and reduced suicide rates.

The Task Force finding is based on evidence from a systematic review[6] of 30 studies reported in 37 papers (search period, 1965–March 2011). Of these, 28 studies

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examined the effects of state or federal mental health parity legislation or policies, and two studies examined the effects of state-mandated coverage for mental health and substance abuse care; these studies generally found favorable effects. Six studies that examined the effects of comprehensive parity legislation or policies generally found stronger effects on mental health outcomes for comprehensive parity legislation or policies than for less comprehensive legislation/policies. The Task Force found the evidence to be sufficient rather than strong because of the limited number of studies on health outcomes and because of difficulties disentangling the effects of mental health benefits legislation and managed care, as both became more prevalent in the U.S. during the same time period.

Applicability

The results indicate that financial protection effects are comparable for children and adults. Similarly, there are no differences in access to care for subgroups by region or employer size. Although no studies reported outcomes by racial or ethnic minority groups, the body of evidence is from studies conducted in the U.S. and includes national samples that should be representative of various racial and ethnic groups. However, these findings are applicable to people with private and public health insurance and not the uninsured population.

For the appropriate utilization outcome, there were some findings for Medicare enrollees and certain low-income groups. One study found that among Medicare enrollees aged 65 years and older, mental health benefits changes were most effective for people in the lowest income and education groups. Another study found that state parity mandates were most effective for people in the lowest income group who work for small employers (<100 employees), but also found that employees with mental health needs working for small employers were more likely to use mental health services after implementation of state parity mandates regardless of income.

Economic Evidence

Evidence from a concurrent economic review indicates that legislation and policy that expanded mental health benefits did not lead to any substantial increase in cost to health insurance plans, measured as a percentage of premiums.

Considerations for Implementation

There are many challenges to effective implementation of mental health benefits legislation due to longstanding systemic issues in mental health. These include underutilization, access to services, and exemptions. Underutilization of mental health/substance abuse services for people with a mental health condition is well documented[7] and legislation alone is not sufficient to address this issue in the U.S. This is due, in part, to stigma,[8–10] which is not directly addressed in mental health benefits legislation. Although the Affordable Care Act has received a lot of attention, awareness of mental health benefits legislation is low in general, which may affect service use.[11]

Limited numbers of mental health providers[12] and inpatient beds,[13] particularly in rural areas, have long been an issue in mental health, and this will most likely not be fixed by mental health benefits legislation. Another issue concerns the lack of specification of covered services and treatments in the legislation, thus allowing individual health plans to limit benefits provided for certain conditions or illnesses.[14] This extends to investigational treatments, which are typically not covered by health insurance, thus limiting access to care.[14]

Lastly, exemptions may decrease the potential reach of mental health benefits legislation. Because of the 1974 Employee Retirement Income Security Act (ERISA),[15] larger employers often self-insure, and are therefore exempt from mental health insurance–related state mandate laws. The 1996 Mental Health Parity Act (MHPA, Title VII)[16] and the 2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA, Subtitle B)[17] both allow employers with <50 employees and group health plans that demonstrate a mental health benefit–related cost increase of 1% and 2%, respectively, to be exempt from the federal legislation.[18]

Information From Other Advisory Groups

The National Institute of Mental Health (NIMH), which funds research to assess the impact of mental health parity on access to services, service use, quality, and cost, issued a report[19] in 2000 with conclusions about parity, specifically that combining parity with managed care costs less than anticipated and has some beneficial effects. However, the impact of parity on the quality of mental health services and effects on people with mental illness remain unclear. The NIMH 2008 Strategic Plan (www.nimh.nih.gov/research-priorities/strategic-objectives/index.shtml) continues to call for improvements in research that will better serve the needs of people with mental illness. The National Alliance on Mental Illness[20] supports full parity in both private and public insurance coverage for those with mental illnesses.

The *Government Accountability Office Mental Health and Substance Use Report*,[21] a narrative literature review, evaluated the effect of health insurance coverage for mental health/substance use on enrollees' healthcare expenditures; access to, or use of, mental health/substance use services; and health status. The results of the review were mixed: 17 studies found that enhanced health insurance coverage for mental health/substance use through parity requirements had some effect on access to and use of mental health/substance use services, but 13 studies found little or no effect. The researchers also found that coverage for mental health/substance use generally led to reduced enrollee expenditures (out-of-pocket expenses), with four studies evaluating mental health parity requirements of the Federal Employee Health Benefits (FEHB) program and two studies examining the impact of state parity laws.[21]

Effectiveness Evidence Gaps

The systematic review[6] identified several evidence gaps that need to be addressed in future studies of mental health benefits legislation. There is limited research investigating the effects of mental health benefits legislation on mental health outcomes. Studies are needed to assess effects on morbidity (reduction of symptoms, relapse prevention, remission, and recovery); mortality; and quality of life. In addition, research is limited on effectiveness for those covered by public health insurance (e.g., Medicaid and Medicare) and for other population subgroups (e.g., low-SES groups, racial and ethnic minorities, and individuals diagnosed with different types of mental illness).

Most studies reporting any utilization lacked measures of appropriateness of use, such as descriptions of provider type and patient need for mental health care; reporting these measures would help inform the field. In addition, researchers often reported a utilization outcome that combined measures of inpatient and outpatient utilization. The desired direction for these types of utilization differs with various patient conditions; reporting them separately will aid in determining whether patients are receiving appropriate care. Another area for research is whether care provided is evidence-based or guideline-concordant.

Most studies were evaluations of the 1996 Mental Health Parity Act[16] and state mandates. Evaluations are needed to examine effects of the 2008 Paul Wellstone and Pete Domenici MHPAEA, Subtitle B,[17] which contains more requirements for parity than the 1996 Act, and the 2010 Affordable Care Act[22] (which has provisions to establish parity for mental health and substance abuse in many insurance plans in 2014). Evaluations of long-term effects (>3 years) of mental health benefits legislation are also needed.

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