Using the ACA to Ensure Mental Health Parity

Population Health Sciences

Date Posted:

Apr 02, 2015



Last week we published an article about a critical failure in U.S. mental-health insurance regulation – achieving mental health parity. The 2008 federal Mental Health Parity ("MHP") law required "parity" in coverage for mental health and medical/surgical benefits. But, it permitted insurers to opt out of providing any mental health insurance benefits at all, which some did. The bigger problem, however, is not that plans have no mental health coverage but that the coverage is weak, i.e., we do not have parity. Enforcement of MHP is delegated to states under the federal law, and our review found that state efforts in this area have been limited.

In contrast to the Mental Health Parity law, the Affordable Care Act (ACA), requires mental health coverage for all "Qualified Health Plans" (QHPs) sold through Exchanges – there is no opportunity for providers to opt-out. To date, the federal government has given states and insurers the responsibility of defining that mental health coverage. The result is sub-par mental health coverage. Our review of the standards put in place by all 50 states in response to the ACA revealed broad variability in mental health inclusions, exclusions, and limitations.

Currently, MHP and the ACA are being implemented – and enforced – in silos. We propose that the United States Health and Human Services Agency and state insurance departments enforce these laws together. Enforced together, the laws could assure true parity in mental health care coverage.

For children and young adults (which is the focus of our work here at PolicyLab at The Children's Hospital of Philadelphia), enforcing mental health parity will require payers to understand what therapies and treatments best meet their needs. Many insurance plans do not cover family therapy or parent-child treatments, such as "Parent-Children Interaction Therapy," even though research has shown many of these interventions have a stronger evidence base for children with behavioral problems than many of the psychotropics more readily prescribed to them.

Timing on this issue is critical as federal regulators have a narrow window in the next year and a half to identify a minimum mental health benefit standard for QHPs sold through Exchanges. In the meantime, states which have spent much of their time focused on enrollment and other ACA issues can turn some of that attention to the quality of QHP benefits, which, to date, has been a secondary issue. Through MHP and the ACA, states can work towards achieving true mental health coverage parity.

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