One parity goal reached, yet others remain
Four more doors must be opened in order to ensure fair, effective care for behavioral health
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On Tuesday, Feb. 2, the U.S. Departments of HHS, Labor, and Treasury published the long-awaited “Interim Final Regulations” for parity of mental health and substance use insurance and care benefits. These regulations were triggered by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The regulations become effective on April 5 for annual health plans that commence on July 1, 2010, and later. Comments on the interim regulations are due no later than May 3. The regulations can be viewed at: http://www.federalregister.gov/OFRUpload/OFRData/2010-02167_PI.pdf.

These regulations represent an essential plateau for the mental health and substance use care fields. Together, the Wellstone-Domenici Act and the associated regulations are intended to make it precisely clear that these fields are to be treated no differently than medical/surgical care. For both quantitative factors, e.g., number of visits, and qualitative factors, e.g., management of benefits, health plans are required to offer benefits for these fields that are no different than those offered for medical/surgical care. Clearly, this represents a monumental step forward, for which we all are grateful.

We owe a tremendous debt to Rep. Patrick Kennedy of Rhode Island and former Rep. Jim Ramstad of Minnesota, who authored the legislation, and 274 of their House colleagues who cosponsored this legislation. The quest toward parity legislation has extended more than a decade and has involved many legislators and field advocates. The rapid growth of State parity laws also heralded the federal effort.

The new law and regulations apply to private employment-based group health plans that offer mental health and substance use care benefits and that cover 50 or more persons. By extension, they also apply to State Medicaid Programs that are managed by private sector organizations (regulations governing the latter will be released later.). The regulations specify that, when requested, health plans are required to disclose their medical necessity criteria, and they are required to disclose the reasons for care denial. The law and the regulations do not require that plans offer mental health and substance use care benefits, nor do they apply to public insurance plans, such as Medicare, or self-insurance plans operated by State, County, and Local Governments. Neither do they apply to individual or small-group plans that cover fewer than 50 persons. Covered entities can opt out for one year if added costs in the first plan year are at least two percent higher than those in the year preceding implementation.

Beyond this essential plateau, I want to assert that we still have many miles to climb up the parity mountain. To help understand this, I have conceptualized parity in terms of a series of doors (or plateaus) one must reach to receive care that is effective. These doors are:

Door 1, Insurance Benefits: The parity legislation and regulations do address equality of insurance benefits for private sector group health plans that cover 50 or more persons. However, they do not address public health insurance plans, private individual or small group health plans that cover less than 50 persons, or health insurance coverage for the 46 million Americans who are uninsured. These remain gaping holes in the social safety net.

Door 2, Care Access: Because they address qualitative factors such as management of benefits, the law and regulations are designed to improve equality of access between medical/surgical care and mental health or substance use care. However, since they do not specify common standards of medical necessity, the degree of access is very likely to continue to vary dramatically across health insurance plans. This means that two people in two different health plans with the same problem and same severity will very likely not have the same degree of access to care.

Door 3, Care Quality: The regulations do not address scope or quality of services. Clearly, scope of services is important, since failure to receive a needed service can result in a less desirable outcome. Similarly, receiving a needed service in a low quality manner can also lead to a less desirable outcome. As we continue to move ahead, it will be extremely important to address both of these factors. It is not unreasonable to ask that scope and quality of care be at parity with medical/surgical services.

Door 4, Care Outcome: The penultimate goal is to receive effective care that makes a difference in one’s life. Hence, why should we be willing to accept any lesser outcomes for behavioral healthcare than for primary care? Future work

on parity must address this very important issue.

Good, effective care requires that we successfully negotiate all four of these doors. You and I both know that this frequently does not happen in behavioral healthcare.

The Wellstone-Domenici legislation and regulations have allowed us to climb to a very important plateau on the parity mountain. This new vantage point allows us to see that there are still essential, higher plateaus to be scaled in the quest for equity and quality of mental health and substance use care.