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How Repealing and Replacing the ACA Could Reduce Access to Mental Health and Substance Use Disorder Treatment and Parity Protections

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In Brief

Millions of Americans gained coverage for mental health (MH) and substance use disorder (SUD) treatment through the expansion of Medicaid and private insurance coverage under the Affordable Care Act (ACA). The law also included parity protections ensuring that MH/SUD benefits were not subject to plan provisions stricter than those for medical care (e.g., higher co-payments and lower visit limits).[1] Bipartisan support for MH/SUD treatment and parity has increased since the 1990s, most recently in response to the opioid epidemic. Congress has addressed coverage parity between MH/SUD and medical benefits in piecemeal fashion, initially requiring parity in annual and lifetime dollar limits for MH and medical benefits in large employer-sponsored plans. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) expanded those parity protections to SUD benefits and required large employer-sponsored plans with MH/SUD coverage to use comparable financial requirements and treatment limitations for medical and MH/SUD benefits.

The ACA closed a significant coverage gap by extending the parity protections of the MHPAEA to the individual insurance market and to certain plans that cover low-income adults through the ACA Medicaid expansion. Unlike the MHPAEA, which does not require health plans to cover MH/SUD, the ACA required nongrandfathered individual and fully insured small group plans and Medicaid expansion benefit plans to include coverage for both MH and SUD treatment. Efforts to repeal and replace the ACA—such as the American Health Care Act (AHCA), which passed the House of Representatives on May 4, 2017—could cause millions of people to lose MH/SUD coverage and the parity protections of the MHPAEA.

Introduction

In recent years, bipartisan support for expanded MH/SUD treatment has grown along with the recognition that these health conditions should be covered like other medical conditions in health insurance programs and not subject to higher financial or treatment barriers. Congress first addressed mental health coverage restrictions in private insurance in the Mental Health Parity Act of 1996. That law required large employer-sponsored health plans to offer comparable annual and lifetime dollar limits for medical and mental health benefits when the latter were offered as part of an insurance package. The Mental Health Parity Act applied only to MH benefits, not SUD benefits, and did not require plans to cover MH benefits. It also exempted health plans from the parity requirement if the cost of compliance was at least 1 percent more than the original cost of coverage.

In 2002, President George W. Bush created the New Freedom Commission on Mental Health to identify barriers to obtaining mental health services, including the stigma surrounding mental illness and the "unfair" treatment limitations and financial requirements placed on mental health benefits in private insurance. The commission's final report stated, "Understanding that mental health is essential to overall health is fundamental for establishing a health system that treats mental illnesses with the same urgency as it treats physical illnesses."[2]

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) included the 1996 law's requirement that large group plans offer comparable annual and lifetime dollar limits for medical and mental health benefits and extended these protections to SUD treatment. The MHPAEA also significantly expanded parity protections for large-group employer-sponsored insurance (ESI) to other financial requirements, such as enrollee out-of-pocket costs, and to quantitative and nonquantitative treatment limitations for medical care and MH/SUD care. Like the 1996 law, the MHPAEA did not mandate coverage of MH/SUD benefits, but required parity if a plan included them. The MHPAEA exempted plans that would incur an increased cost of at least 2 percent to comply with the parity requirements in the first year, or at least 1 percent in any subsequent year.[3]

Also in 2008, Congress enacted the Medicare Improvements for Patients and Providers Act, which eliminated higher

co-payments for outpatient MH/SUD services in Medicare Part B. In 2009, Congress adopted the Children's Health Insurance Program Reauthorization Act (CHIPRA), which applied the MHPAEA to the Children's Health Insurance Program (CHIP).[4]

In 2009, before the ACA was adopted, an estimated 2 percent of people with ESI had no coverage for MH benefits, and 7 percent had no coverage for SUD benefits.[5] The MHPAEA provided protections to the remaining people with ESI who had coverage for these services in the large group market. However, coverage of MH/SUD services in the individual market was much more limited. Approximately one-third of people in the individual market had no coverage for SUD, and nearly 20 percent had no coverage for MH services, including outpatient therapy and inpatient crisis intervention and stabilization.[6] Those who had some MH/SUD coverage in the individual market had no parity protections for those services, and those benefits were typically very limited. According to data from 2008 to 2013 analyzed by the Government Accountability Office (GAO), approximately 17 percent of ***low-income uninsured adults*** (3 million people) had a serious mental illness, substance use condition, or both.[7]

The ACA was enacted in this coverage environment. It substantially expanded coverage to previously uninsured Americans and extended the parity protections of the MHPAEA to the individual market and to low-income adults covered through the ACA Medicaid expansion.[8] The ACA went further than earlier legislation, requiring coverage of MH/SUD benefits in nongrandfathered individual and fully insured small group plans and in Medicaid alternative benefit plans, the health plans for the Medicaid expansion population.[9] Under these types of coverage, health plans must include MH/SUD treatment as one of ten categories of essential health benefits (EHBs). These plans also are required to include prescription drug benefits, which are critical for many people with mental illness and SUDs. U.S. Department of Health and Human Services regulations on EHB requirements also applied the protections of the MHPAEA to nongrandfathered plans in the small group market.[10]

The EHB requirement ***combined*** with the extension of the MHPAEA to individual and small group plans and Medicaid alternative benefit plans ensures that millions of previously uninsured Americans now receive MH/SUD benefits ***with*** the parity protections once available only to people in large group ESI plans.

Through these provisions, the ACA substantially increased MH/SUD coverage both in the private insurance market and in Medicaid. Table 1 shows how Congress has expanded the scope of parity protections in the private insurance market since 1996.

The ACA Medicaid expansion has increased access to behavioral health care in the United States. According to the GAO, Medicaid was the largest source of public funding for behavioral health treatment in 2014.[7] Of the estimated 3 million low-income uninsured adults who had a behavioral health condition before the Medicaid expansion, more than half lived in states that had expanded Medicaid as of February 2015.[11] Under the ACA and regulatory guidance from the Centers for Medicare & Medicaid Services (CMS), the MHPAEA applies to alternative benefit plans offered to Medicaid expansion enrollees under the ACA.[12,13] In 2016, CMS issued a final rule that established standards for applying the MHPAEA to alternative benefit plans, Medicaid plans offered by Medicaid managed care organizations, and CHIP.[14]

How Essential Health Benefits and Parity Protections Increase Access to Health Care for People With a Mental Illness or Substance Use Disorder

MHPAEA parity protections apply to financial and treatment provisions of insurance plans. Combined with ACA essential health benefit requirements and limits on annual and lifetime costs in individual and small group plans,

Table 1: Federal Parity Protections for Mental Health and Substance Use Disorder Benefits in the Private Insurance Market

Federal law	Year enacted	Types of benefits included	Plan provisions subject to parity requirements	Plans included
Mental Health Parity Act	1996	MH only	Annual and lifetime dollar limits only	Large employer-sponsored group health plans
Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA)	2008	MH and SUD	Annual and lifetime dollar limits, other financial requirements, quantitative and nonquantitative treatment limits	Large employer-sponsored group health plans
Affordable Care Act	2010	MH and SUD	Same as MHPAEA	Individual (nongroup) plans*
Affordable Care Act EHB regulations	2013	MH and SUD	Same as MHPAEA	Nongrandfathered small employer-sponsored group health plans

Sources: Mental Health and Substance Use Disorder Parity Task Force. Final Report. Washington: US Dept of Health and Human Services; 2016. https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.pdf. Department of Health and Human Services, Final Rule, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. 45 C.F.R. parts 147, 155, and 156. 78 Fed. Reg. 12834 (February 25, 2013). https://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

Notes: EHB = essential health benefits; MH = mental health; SUD = substance use disorder.

**Under the ACA, the MHPAEA applies to both grandfathered and nongrandfathered individual plans, but because grandfathered individual plans are not required to provide essential health benefits, MHPAEA protections only apply if grandfathered plans include MH/SUD benefits.*

people who are currently covered by nongrandfathered individual and small group plans have the following protections:[15]

- Coverage of MH/SUD benefits and prescription drugs as part of ACA essential health benefits.
- No lifetime or annual dollar limits on MH/SUD services (or on any other essential health benefits).
- Patient out-of-pocket costs (e.g., deductibles, co-payments, and coinsurance) for MH/SUD care cannot be more restrictive than those for medical care within the same general classification of benefits, and cumulative financial requirements within each classification must include both medical and MH/SUD services. The six classifications of benefits are:
  - Outpatient in-network
  - Outpatient out-of-network
  - Inpatient in-network
  - Inpatient out-of-network
  - Emergency care
  - Prescription drugs
- Quantitative treatment limitations (e.g., limits on the number of days for inpatient coverage or on the number of visits to a provider) cannot be more restrictive than those for medical care within each of the six classifications.
- Nonquantitative treatment limitations (e.g., medical management, step therapy, and pre-authorization requirements) for MH/SUD benefits must be comparable to and applied no more stringently than such limitations for medical benefits, within each of the six classifications.
- MH/SUD benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to such benefits.
- If a plan provides for out-of-network medical benefits, it must provide for out-of-network MH/SUD benefits.
- Plan standards limiting the scope or duration of benefits (e.g., geographic or facility type limits or network adequacy standards) for MH/SUD benefits must be comparable to and applied no more stringently than those for medical benefits.
- Criteria for medical necessity determinations and reasons for any denial of benefits for MH/SUD services must be provided upon request.

These parity protections help ensure that consumers receive meaningful MH/SUD coverage and that these benefits are comparable to and not subject to more restrictive financial and treatment limitations than medical benefits.

Millions of People Are at Risk of Losing Coverage and Parity Protections for Mental Health and Substance Use Disorder Treatment Under Proposed ACA Repeal-and-Replace Measures

Everyone currently covered through the Medicaid expansion and the individual and fully insured small group markets is at risk of losing MH/SUD benefits and MHPAEA parity protections if Congress repeals and replaces the ACA. The Trump administration and congressional Republican leadership announced a three-step plan to repeal and replace the ACA: (1) use of the budget reconciliation process to repeal and replace certain provisions of the ACA; (2) significant deregulation efforts by the administration; and (3) legislation that budget reconciliation (under current rules) cannot address.[16]

On May 4, 2017, after several months of negotiation and numerous amendments, the U.S. House of Representatives passed the American Health Care Act, which would dramatically alter the ACA. Though it is unclear what will happen to the AHCA in the Senate, several provisions of the current bill could have a major impact on MH/SUD coverage and benefits.[17] The AHCA would allow states to waive EHB requirements in the individual and small group markets. Parity protections only apply to plans that offer MH/SUD benefits, so if EHB requirements are eliminated, states request the waiver, and insurers choose not to cover MH/SUD benefits, then the parity provisions alone would offer no access to coverage for mental illness or substance use disorder treatment.[18]

The AHCA would also phase out enhanced federal funding for the Medicaid expansion, eliminate the EHB requirement for Medicaid alternative benefit plans, and change Medicaid from an open-ended matching grant program to a block grant or per capita cap program under which federal funding for Medicaid would grow more slowly than under current law.[19]

The AHCA would eliminate cost-sharing subsidies and replace income-based tax credits with fixed age-based tax credits that would not be available to higher-income consumers. Finally, the bill would allow states to seek additional waivers enabling insurers to charge people higher premiums based on their health status if they experienced a gap in insurance coverage. These provisions could make private insurance unaffordable for many consumers who need MH/SUD treatment.

Some legislative action will be necessary to eliminate EHBs in the private insurance market. The ACA requires that health plans offered in the individual and fully insured small group markets include the essential health benefits package.[20] Although the ACA gives the Secretary of Health and Human Services significant authority to implement the EHB requirement, it also provides that he or she "shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary."[21] Because employer plans typically provided coverage for MH and SUD benefits before the ACA, any effort to eliminate MH/SUD coverage through regulatory action alone would likely meet with legal challenges.

Depending on the outcome of ACA repeal-and-replace efforts, the administration could initiate new rulemaking for essential health benefits and alter or eliminate the

extension of the MHPAEA to the small group market. Similarly, it may seek to amend the rule applying the MHPAEA to alternative benefit plans, Medicaid managed care, and CHIP. Whether the administration could succeed in doing so and whether such efforts would be subject to legal challenge is beyond the scope of this analysis.

Conclusion

Parity protections were developed to address significant health plan limitations on MH/SUD services. Before the MHPAEA was implemented, nearly two-thirds of people with ESI had special limits on inpatient behavioral health coverage, and three-quarters had limits on outpatient behavioral health coverage.[5] The Affordable Care Act provides coverage and parity protections for mental illness and substance use disorder treatment to millions of Americans, many of whom were previously uninsured. The elimination of any essential health benefits requirement likely would cause many, if not all, affected insurers to stop offering that benefit or to charge significantly more to include that benefit. Under the AHCA, states also might redefine the scope of MH/SUD benefits included in the EHB requirements, for example, by eliminating inpatient but not outpatient MH/SUD benefits or by eliminating SUD benefits but not MH benefits. Either approach would diminish access to the services newly excluded or limited, making necessary care unaffordable for many. Congress also could repeal the ACA provisions that extend MHPAEA parity protections to the individual market and to Medicaid alternative benefit plans for those plans that still offer MH/SUD benefits. But federal regulatory action alone will not eliminate those benefits and parity protections. The ACA filled a significant gap in MH/SUD coverage and, by extending parity protections to those benefits, helped eliminate financial and treatment barriers to MH/SUD services. Repealing and replacing the ACA could reverse the decades-long effort to reduce historical disparities in the treatment of mental illness and substance use disorders.

NOTES

1 In this paper, the term "medical" refers to both medical and surgical benefits and services.

2 President's New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America*. Washington: Substance Abuse and Mental Health Services Administration; 2003. http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport-1.htm.

3 42 U.S.C. § 300gg-26(c)(2).

4 For a summary of the legislative history of federal parity efforts, see: Mental Health and Substance Use Disorder Parity Task Force. *Final Report*. Washington: US Dept of Health and Human Services; 2016. https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.pdf.

5 Frank RG, Beronio K, Glied SA. Behavioral health parity and the Affordable Care Act. *J Soc Work Disabil Rehabil*. 2014;13(0):31–43. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4334111/.

6 Beronio K, Po R, Skopec L, Glied S. *Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans*. Washington: Office of the Assistant Secretary for Planning and Evaluation; 2013. https://aspe.hhs.gov/system/files/pdf/76591/rb_mental.pdf.

7 Government Accountability Office. *Behavioral Health: Options for Low-Income Adults to Receive Treatment in Selected States*. Washington: Government Accountability Office; 2015. http://www.gao.gov/products/GAO-15-449.

8 Two sections of the ACA apply the MHPAEA to the individual market: section 1311(j) (affordable choices of health benefit plans) and section 1563(c)(4) (conforming amendments), codified at 42 U.S.C. § 300gg-26(a) (parity in mental health and substance use disorder benefits). ACA section 2001(c)(3) requires MHPAEA compliance in plans offered to people covered under the Medicaid expansion by entities that are not Medicaid managed care organizations.

9 The statutory language in the ACA applied to benchmark benefit and benchmark equivalent packages, but CMS uses the term "alternative benefit plans" to encompass both in its rulemaking. See 42 C.F.R. parts 438, 440, 456, and 457. 81 Fed. Reg. 18390 (March 30, 2016). https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of.

10 Department of Health and Human Services, Final Rule, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. 45 C.F.R. parts 147, 155, and 156. 78 Fed. Reg. 12834 (February 25, 2013). https://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

11 The GAO report included state-by-state estimates of low-income uninsured adults with behavioral health conditions. In March 2016, the Office of the Assistant Secretary for Planning and Evaluation published an analysis showing that approximately 1.9 million uninsured people who had a mental illness or SUD and had incomes below 138 percent of the federal poverty level lived in states that had not expanded Medicaid: Dey J, Rosenoff E, West K, et al. *Benefits of Medicaid Expansion for Behavioral Health*. Washington: Office of the Assistant Secretary for Planning and Evaluation; 2016. https://aspe.hhs.gov/system/files/pdf/190506/BHMedicaidExpansion.pdf.

12 Patient Protection and Affordable Care Act, section 2001(c)(3).

13 Mann C. Letter to state health officials and state Medicaid directors on application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and alternative benefit (benchmark) plans. Baltimore: Centers for Medicare & Medicaid Services; 2013. https://www.medicaid.gov/federal-policy-guidance/downloads/sho-13-001.pdf.

14 Centers for Medicare & Medicaid Services, Final Rule, Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans. 81 Fed. Reg. 18389 (March 20, 2016). https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of.

15 For a summary of MHPAEA protections, see: The Mental Health Parity and Addiction Equity Act (MHPAEA). Center for Consumer Information & Insurance Oversight website. https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html. The final rule applying the MHPAEA to the large group and individual markets can be found at 45 C.F.R. parts 146 and 147 (https://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf). This paper summarizes the specific provisions governing the private insurance market. Medicaid is structured differently than private insurance, so its parity protections are applied differently in some respects. The final rule applying the parity protections of the MHPAEA to Medicaid and CHIP can be found at 42 C.F.R. parts 438, 440, 456, and 457 (https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of).

16 The American Health Care Act. House Republicans website. https://housegop.leadpages.co/healthcare/.

17 Jost T. House passes AHCA: how it happened, what it would do, and its uncertain Senate future. Health Affairs Blog. Posted May 4, 2017. http://healthaffairs.org/blog/2017/05/04/house-passes-ahca-how-it-happened-what-it-would-do-and-its-uncertain-senate-future/.

18 An amendment to the AHCA added funding to cover maternity and MH/SUD care in a federally run "Patient and State Stability Fund," but states would have to apply for the funding.

19 Holahan J, Buettgens M, Pan CW, Blumberg LJ. *The Impact of Per Capita Caps on Federal and State Medicaid Spending*. Washington: Urban Institute; 2017. http://www.urban.org/sites/default/files/publication/89061/2001186-the_imapct-of-per-capita-caps-on-federal-spending-and-state-medicaid-spending_2.pdf.

20 42 U.S.C. § 300gg-6(a).

21 42 U.S.C. § 18022(b).

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