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Parity: An ongoing challenge and research opportunity

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Until recently, health plans typically imposed higher co-pays and limited benefits for treatment of mental health and substance abuse disorders. The co-pays and benefit restrictions discouraged unnecessary use of services and reduced the health plans' economic risks (1;2). After many years of seeking comprehensive reforms in these discriminatory policies, mental health and substance abuse advocates succeeded when Congress passed the Mental Health Parity and Addiction Equity Act of 2008. The legislation prohibits health plans that include behavioral health benefits from imposing greater quantitative limits (e.g., co-pays and limits on the amount of care) and more restrictive non-quantitative limits (e.g., pre-authorization) for mental health and substance abuse disorders relative to the benefits provided for general health care – parity.

Prior to the implementation of parity, opponents voiced concerns about increased costs to the health plans and to employers purchasing health plans. Analysis of the costs of care following imposition of parity requirements in the Federal Employees Health Benefits Program found no consistent increase in total costs of care due to parity and reductions associated with parity in out-of-pocket expenditures in three of five health plans (3). To implement parity for federal employees, health plans were encouraged to manage the utilization of care (i.e., to use non-quantitative limits) and more stringent care management may have contributed to lack of a significant increase. A more recent analysis of Oregon's implementation of a strong parity initiative that prohibited more restrictive quantitative and non-quantitative limits on services for mental health and substance use disorders found a trend toward increasing costs of care that was consistent among individuals affected and unaffected by parity requirements and no apparent effect due to parity (4).

Empirical evidence consistently finds little or no impact on costs related to the introduction of parity. Busch and colleagues in this issue add to the analysis of parity (5). A difference-in-difference analysis of utilization and cost data from the evaluation of the Federal Employee Health Plan (FEHP) parity policy examined the effects of diagnosis before and after the implementation of parity relative to employed individuals who were not federal employees. Difference in difference means that both the federal employees and the control non-federal employees were compared between an earlier period when they both lacked parity and a later period when the federal plan had parity and the control plans did not. The differences between the two periods for each group were then compared for the final analysis, a difference between groups in the difference between the two time periods. Three mental health diagnostic groups that typically differ in severity were extracted from the data set – individuals with bipolar disorder (federal $n = 2,557$; comparison $n = 1,117$) (the most severe diagnostic group), individuals with major depression ($n = 10,412$ and $5,245$), and individuals with adjustment disorder ($n = 6,125$ and $4,099$) (least severe diagnostic group). The analysis found that the utilization of services for mental health and substance use disorders declined slightly relative to the non-federal comparison group but did not differ from zero. As expected, out-of-pocket spending declined significantly in each diagnostic group. Total spending declined significantly among individuals with a history of an adjustment disorder; the total spending declines within the bipolar and major depression groups did not differ from zero. The only significant change in service utilization was a 12%

decline in psychotherapy visits among individuals with a history of adjustment disorder. The discussion notes that parity decreased out-of-pocket costs across the three diagnostic categories without reducing access to services among individuals with bipolar and major depression diagnoses (the most severe diagnostic groups examined). Because this parity policy was associated with encouragement to manage care more assertively, the decline in use of psychotherapy services among individuals with the least severe diagnosis (adjustment disorder) may reflect increased care management. The paper concludes that parity provided increased financial protection (reduced out-of-pocket spending) without erosion in access to care (5).

With each analysis we learn more about the impacts of parity. Implementation of parity continues and with continued implementation and time, there is more opportunity for analyses of impacts. A relatively surprising observation is the lack of an increase in utilization of mental health and substance abuse services. No studies have found increased use. The primary impact has been reduced out-of-pocket expenditures. It does not appear that more individuals enter care.

Parity may have many benefits. Health plans have less incentive to select for lower risk members (1) and stigma toward people with mental health and substance abuse diagnoses may decline. Mental health and substance use disorders, however, remain under treated. Until systems of care develop more aggressive screening protocols, need for care will continue to exceed demand for care. Parity and the Affordable Care Act may help move the conversation beyond the impacts of parity (6) and toward the real goal – more effective systems of care for treatment of alcohol, drug and mental health disorders. Whether parity reduces stigma and increases utilization of care is still to be determined.

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