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SWRK 258 -Social Policy

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Introduction:

The Mental Health Parity Act was created in response to the fact that health insurance providers and group health plans did not cover mental health or substance abuse benefits as they did medical and surgical benefits. This is partially due to the stigma that is associated with mental health and the failure to understand the magnitude of people who are affected by mental health issues and substance abuse in the US. According to the National Alliance on Mental Illness, one in five adults in the US, (20%) experiences mental illness in any given year yet only 41% of these people received mental health services. Of those who received the services, people of color received half the assistance that caucasians received. Apart from being an expensive cost to people who needed the assistance of mental health practitioners, the extra costs of getting mental health assistance was unattainable for the larger US population, especially people who are poor. An estimated amount of 26% of people who are homeless have mental illnesses and substance abuse disorders. The failure of to cater to mental health needs results in suicide (the 10th cause of death in America) and younger people tend to drop out of school due to failure to receive assistance. (NAMI) According to Michele Evans, it is also generally harder to get Minnesotans from MFIP (Minnesota's version of TANF) to SSI for people with mental health issues because it is

harder to prove mental health. This just comes to show the fact that mental health is still not a priority of the government thus the larger population.

Policy Description:

Policy Outline:

The aim of this policy is to recognize that mental health conditions and substance abuse are equal to physical illnesses thus be treated as such by different stakeholders. The Act ensures that medical plans cover mental health as much as it covers other health conditions which is unfortunate when you consider the fact that it is not mandatory for medical plans to cover mental health. The Act does not make it mandatory for health providers to cover mental health so although it reduces costs of getting mental services, it does not guarantee that everyone has access to mental health services. The Act covers people with medical insurance that recognizes and covers mental health and only disorders in the DSM are covered therefore people with “minor” addictions such as caffeine are not covered. The Act made it easier for working people to access these services although there are businesses that are exempt. These businesses are those that employ less than 50 people and those that incur an increase in total cost coverage of surgical, medical and mental health which get exempt for a year.

Implementation:

- During the initial phase of implementation of this Act, a Parity Diagnosis List was formulated. (Friedman, S.) This list consisted of the mental illnesses that would be recognized and relevant to the act. Any mental illnesses that are not covered by the Act have to be paid for, by the individual out of pocket and the Act does not apply to these. This list also ensured that health insurance providers still made a profit because if they catered to all diagnoses then they would barely make much profit for themselves.
- Education about the law: when research was done in California, (Rosenbach, M.F) they realized that the majority of people did not know what the new law entail therefore a large amount of time had to be spent on educating the people on their newly found rights when it comes to mental health parity and their financial responsibilities with their healthcare providers.
- Removal and addition of new services: health care providers had to remove inpatient and outpatient visit limits because prior to the revision of the Act, they could cap the number of times patients could go into the doctor's office for mental illnesses. They also had to add intervention services and nonresidential treatment to the list of services that they provided. However, there was no difference in the drugs and prescriptions because patients were not suddenly going to get new drugs.

- Oversight and guidance : for health providers who could not understand certain aspects of the Act, the government provided written clarifications about the law and the regulations that defined the diagnoses and services that were covered by the law. (Rosenbach, MF)

Goals and Outcomes:

- The main goal of the Act is to make mental health services more affordable to a wide array of people regardless of their background. (It serves to bridge the gap between those who need mental health services and cannot afford it and those who have it and utilize it more. As shown by the statistics in the introduction, most of the people in marginalised and vulnerable populations require a large amount of mental health attention but previously, they did not have the privilege of accessing it so this Act has made it possible for more people to access mental health services.
- The Act also reduces the out of pocket cost of health insurance because previously, people had to pay more for mental health services than they paid for other health services so the Act has made it possible for patients to receive all the assistance they need without paying an arm and a leg for it.
- One outcome from this is that private insurance providers have higher overall premiums because they still have to make a profit regardless of the Act. This makes it harder for people who work for businesses that are exempt from the law to access he services just because of the expense. As a result, poor people get poorer.

- There are also requirements for schools that provide mental health services to provide a Native American practitioner which is meant to help them deal with the intergenerational trauma that they face.

Funding and Coordination:

The main source of funding for this law comes from the premiums that are paid by people to their health insurance providers. The funding also comes from companies that pay for their employees' health insurance. Because the amount of money that people pay into insurance always exceeds the amount that is actually spent on their medical bills, this Act is not too much of a cost to people whose work pays for their insurance. It costs much more for people who pay for their own health insurance because of higher premiums. Health insurance providers are making less profit from this because they now cover an unlimited number of mental health services and bills.

The government also forks money towards fulfilling this Act through Medicaid and Medicare which they already fork money into to cover people who qualify for these programmes' medical bills.

The Department of Health and Human Services conduct evaluations for the program to see how effective it is. The Department of Labour evaluates the impact of the Act because workers who are employed by companies that provide health insurance answer to this government department.

Health insurance providers also have a say in the evaluation process because they should benefit from this Act as much as their customers do. Employers who are

tied to the Act are also responsible for providing feedback about how the law affects them because they contribute a lot of funding into the law's implementation.

There are health associations that are involved in the monitoring and evaluating of the program which includes; American Medical Association and National Alliance for Mental Illness also work to provide feedback on the Act, among others. So far, these two comment the government's paying attention to mental health and recognizing that it matters as much as physical health.

Effectiveness and Longevity:

There are three criteria used in order to determine the effectiveness of the Act:

1. Access and availability of services: the existence and location of mental health practitioners to where they are needed is a big factor. This is because there is no use in having affordable mental health services if there are no practitioners available in an area. The range of services provided also determines how useful the act is because if it covers services that are not provided or available to people then it is as good as useless.
2. Continuity and coordination of care: the care that patients receive should be the ones that are covered by the Act. One of the things that were added in 2008 is intervention services and nonresidential treatment which both require continuation therefore, this factor determines the success or failure of the Act.
3. Utilization management and benefit coverage: the extent to which people use their benefit and for the illnesses that it covers is an important factor. If the

majority of people have illnesses that are not covered but the insurance covers illnesses that people do not have then the list should be altered.

Considering that there are missing factors such as having all health insurers cater for mental health services, there is a long way to go with this Act. The Act also gets reviewed quite frequently so there is a high chance of it getting better instead of going into obsolescence.

Policy Analysis:

Legality:

The policy, in its intended form, is legal because it is an enacted law that was approved by the congress. (Harris, P.A) However, there is a challenge with health providers who still erect hurdles to make it difficult for people to access the services. This is ideally illegal but policy makers are doing nothing to ensure that the law is enforced.

There is a lack of proper measures or a committee to go around verifying that health insurance providers are not charging people extra or putting caps on the number of times that people can access mental health assistance. Instead, the government takes feedback that they receive from the providers and take their word for it regardless of the fact that they will obviously be biased - in order to look good. There is also a lack of people to evaluate the efficiency even though there are interested stakeholders who constantly write commentary on the Act - nobody holds companies accountable to the Act.

Social Equality:

The intended goals of the policy work towards social equality- granted they are carried out properly. This is because everyone who is enrolled with insurance that covers mental health can go to a physician without worrying about extra costs as they did before preparity.

However, we cannot escape the fact that the majority of people who are poor, people who are homeless and people who are unemployed still do not have health insurance and these people need mental attention and are prone to mental illness due to the stress that they face on a daily basis. This means that the gap between people in these groups and people who are privileged to not worry about these issues increases drastically. People in these groups would require private insurance because they unlikely have jobs that cover insurance for them whereas private insurance providers have the autonomy to increase premiums because they must still make profit from these transactions therefore a lot of socially marginalised people are excluded from the benefits of the Act.

Redistribution of Resources:

There is a higher number of mental health practitioners and they are found in more areas than they did before so accessibility of these services are no longer limited to wealthy people and mobile (in terms of transport and physical ability) but are also accessible to the greater public.

Companies that provide insurance to their employees are sensitized to the fact that their employees may have mental illnesses and also pay into the treatment of their

employees which is great for efficiency and productivity because mental illnesses cost the US a lot of money annually.

The general public lacks information on the policy therefore they are not aware of their rights and entitlements that the Act provides. This is an issue because they cannot use the benefits of the act to their maximum fulfillment. The goals of the policy can redistribute these among the population only if the public knows what the policy entails.

There is still racial disparity amongst people who access the services and even though this is not related to the policy, it affects the redistribution. It is uncommon for people of color to seek mental illness help because the different cultures frown upon mental illnesses. Instead, the majority of people who require assistance end up incarcerated because they receive mental checkups for free there. White people overall access these services more than other groups because it is less stigmatized in their communities.

Quality of Life Improvements:

There is an increase in the number of mental health practitioners in general so the target population receives attention and treatment as required, without any restrictions and limits. They also receive enough treatment until they get better instead of receiving it until they reach their quota.

The targeted population also receives enough help for them to be reintroduced to societies in a better state than they were before and they can, therefore be better citizens who work to their full potential. However, there is very little assistance post-release from these services therefore there is a high chance of relapse because

people return to the situations that forced them into the mental illnesses or even addiction so there is a high need for follow throughs with the patients.

Overall, if the US can improve accessibility and availability of mental health services, there will be a reduced level of stigma around mental illness because people will realize that everyone needs attention in one way or another. In addition, it could potentially increase the amount of money that the country loses in productivity to mental illnesses. The suicide levels could also reduce significantly.

Social Relations:

People get the help that they need with less financial restrictions until they re-enter their communities. The fact that there are no extra costs to people means that they can get the maximum help that they need without any extra worries.

There is no follow-up with patients who are released from different facilities so the chances of them relapsing supersede the chances for making a positive impact on their communities. However, those who do not relapse do make a positive impact because they are more prepared to enter the workforce and live in communities without causing any problems.

There is overall a society of healthy individuals. Health refers to both physical and mental health because if you can equally access all the help you need for a healthier you, then the overall state of the society, at large, improves.

Considering the fact that a lot of mentally ill people end up incarcerated, there is a high chance that with the reduced costs of treatment more people have access which can reduce the number of people in prison.

Political Feasibility:

This Act is constantly being debated and improved because most ideally, it would be relevant to all insurance providers, especially independent ones. It promises to reach its most ideal state soon, if the different stakeholders continue to advocate for it. Another addition that is being proposed is that the Act sees through what happens after people have been released from rehabilitation centers because they need care so that they do not relapse.

There is also a call for politicians to enforce the Act because creating, moderating it and changing it constantly does not ensure that it is being followed by insurers.

Economic Feasibility:

Studies of the Act have discovered that behavioral services are 2 or 3 times higher than non-behavioral services. (Melek, S) This means that illnesses that are more dormant require less financial top ups from patients. The stakeholders that finance the Act therefore have to hope that more patients require non-behavioral services which is why insurance providers tend to put a cap on the frequency of visits that they cover. Without enforcement, they get away with this.

There is also growth in the share of inpatient spending for mental health. This is because there is overall a larger number of people who seek these services compared

to preparity. Patients therefore pay higher premiums to their providers so even though this is indirect, they are basically paying more. Therefore, the different stakeholders who pay into this Act will, at some point, have to pay very high amounts into ensuring that this act continues.

Administrative Feasibility:

The issue that the public has with policy makers is that they are not working hard enough to enforce the law. Members of the public are being ripped off by insurance providers in the name of the Parity Act. A board should be elected to evaluate the progress or lack of that has come up from the Act. The lack of education means that someone needs to educate the public on what the Act entails so that they can stand against these insurance providers.

There is also a higher need for mental health practitioners because there is an increased number of people who can access this help after the parity Act was passed. In addition, there is also a need for more diverse physicians to cater to the needs of people of color and those of immigrants who barely speak English - as mentioned by Michele Evans.

Conclusion:

Overall, I would say that the Mental Health Parity and Addiction Act is a good start towards reducing the stigma towards those who seek mental health services because having more people access it would let people see the magnitude of mental illnesses thus normalizing seeking professional help. The fact that it is not mandatory for health insurance providers to cover mental health and addiction is a great weakness of

the Act in my opinion because it still enforces the perception that mental health is not as important as physical and surgical treatment. On a personal note, if mental health services were not free on campus, I know that the campus health insurance does not cover mental health so that would affect a lot of students who need assistance - me included. The government also needs to ensure that providers are sticking to the law and not altering the terms and conditions to work for them - which is a current issue. There is nobody enforcing the law so a certain measure needs to be taken to ensure that the providers stick to their end of the deal.

Sources:

1. Friedman, S., Azocar, F., Xu, H., & Ettner, S. (2018). The Mental Health Parity and Addiction Equity Act (MHPAEA) evaluation study. Drug and Alcohol Dependence, 190, 151.
2. Canady, V. A. (2016). Senators urge White House to improve mental health parity. Mental Health Weekly, 26(29), 3-5. doi:10.1002/mhw.30692
3. NAMI. (n.d.). Retrieved May 11, 2019, from https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers
4. Rosenbach, M. F., Lake, T. K., Williams, S. R., & Buck, J. A. (2009, December 1). Implementation of Mental Health Parity: Lessons From California [Scholarly project]. In Psychiatry Online. Retrieved May 1, 2019, from https://ps.psychiatryonline.org/doi/10.1176/ps.2009.60.12.1589

5. Mhpaea_factsheet. (2016, October 27). Retrieved May 1, 2019, from https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html
6. S. 110 S. 3712, 110 Cong., U.S. Dept. of Labor, Employee Benefits Security Administration (2008) (enacted).
7. Melek, S., Perlman, D., Davenport, S., Matthews, K., & Mager, M. (2019). Mental Health Parity and Addiction Equity Act: How Does the New Mental Health Parity Law Affect My Insurance Coverage? PsycEXTRA Dataset. doi:10.1037/e654352010-001
8. Harris, P. A., & Weber, E. (2018, December 07). Policymakers must help enforce mental health parity laws. Retrieved May 6, 2019, from https://www.statnews.com/2018/12/10/policymakers-must-help-enforce-mental-health-parity-laws/
9. Evans, M. (2019.) Holland Hall, MN.