

Issues in Mental Health Care Benefits: The Costs of Mental Health Parity

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- This *Issue Brief* discusses issues in mental health care benefits. It describes the current state of employment-based mental health benefits and discusses studies and issues regarding full mental health parity. It also includes an analysis of the effect of full mental parity on the uninsured population and the effects of the limited mental health parity provision contained in the VA-HUD appropriations bill. The final section discusses the implications of mental health parity for health plans and health insurers.
- When employers began to provide health insurance benefits to their employees and their families, they extended coverage to include mental health benefits under the same terms as other health care services. Many employers continued to add mental health benefits through the 1970s and early 1980s until cost pressures required employers to re-examine all health care benefits that were offered. They quickly found that, while only a small proportion of the beneficiaries used mental health care services, the costs associated with this care were very high. As a result, employers placed limits on mental health benefits in an attempt to make the insurance risk more manageable.
- The general strategies employers have used to manage their health care costs are cost sharing, utilization review, managed care, and the packaging of provider services. Employers' cost management strategies may be restricted, however. Five states have mental health parity laws, but three of the states—Rhode Island, Maine, and New Hampshire—apply these laws only to the seriously mentally ill. In addition, 31 states mandate that mental health benefits be provided. However, state mandates apply only to insured plans, not to self-insured employer plans, which are exempt from state regulation of health plans under the Employee Retirement Income Security Act of 1974 (ERISA).
- A number of recent studies have examined the effect of mental health parity on health insurance premiums in a "typical" preferred provider organization and on the uninsured. In general, the studies concluded that mental health parity could increase health insurance premiums, decrease health insurance coverage for non-mental health related illnesses, and increase the number of uninsured individuals.
- All studies of mental health parity, and mandated benefits in general, assume that there is a strong likelihood that increased health benefit costs would be passed along to workers in the form of higher cost sharing for health insurance, lower wage growth, or lower growth in other employee benefits.

Table of Contents

Text

Introduction	3
Mental Health Benefits	4
Mental Health Costs	4
Cost Management Strategies	4
(chart 1)	
Level of Coverage	5
Preferred Provider Organizations	6
(table 1)	
Employee Assistance Programs	7
Research	7
(table 2, table 3)	
Parity and the Uninsured	10
(chart 2, chart 3, chart 4, chart 5)	
Limited Parity	11
Implications	12
References	13

Charts

Chart 1, Annual Change in Average Total Health Benefit Cost for Active and Retired Employees, 1987–1995	5
Chart 2, Employment-Based Health Insurance among Individuals Aged 0–64, 1987–1995	10
Chart 3, Percentage of Uninsured Americans Aged 0–64, 1987–1995	11
Chart 4, Civilian Wage and Salary Workers Aged 18–64 Offered Health Insurance by Their Employer, by Firm Size, 1988 and 1993	11

Chart 5, Percentage of Workers Whose Employer Fully Finances Health Insurance, All Workers with Coverage in Their Own Name, 1988–1995	12
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Tables

Table 1, Percentage of Large Employers That Offer Mental Health/Substance Abuse Benefits Through a Specialty Preferred Provider Organization (PPO) and Offer an Employee Assistance Program (EAP), 1993–1995	6
Table 2, Typical Plan Provision of Hypothetical Preferred Provider Organization Used in Watson Wyatt Worldwide and Melek and Pyensen Reports	8
Table 3, Comparison of Assumptions and Effects of S. 298 from Selected Studies on Mental Health Parity	9

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Introduction

The cost of mental health and substance abuse is an issue of growing concern to employers and

society. The cost of treatment for mental health has been increasing more rapidly than that for other types of health care, and the consequences of lack of treatment may also be costly. The National Institute for Mental Health has estimated that more than 30 million Americans suffer from mental illness, yet only 20 percent of those in need seek any mental health services (Regier et al., 1988). **The direct cost of treating all mental health disorders was \$67 billion in 1990 (National Institute for Mental Health, 1993). However, the total cost of mental illness and substance abuse due to lost productivity and property damage, in addition to treatment, is even higher and was estimated to be as high as \$130 billion in 1985 (Rice et al., 1990).** Mental health has also been shown to be an important factor in the decision to retire early (Mitchell and Anderson, 1989). There is some evidence that the diagnosis and treatment of mental health problems lower the costs of other types of health care, but that still means higher aggregate costs.¹ The nature of mental health care makes it challenging to insure and makes the efficacy of cost management techniques problematic. Employers and society, as a result, have continued to struggle with the difficult question of how to finance appropriate treatment without incurring unmanageable increases in health care costs. As was well documented in the recent debate over health care portability, many individuals do not continue health insurance coverage

because the premiums are greater than they can or will pay.

After a long debate, **President Clinton signed legislation on September 26, 1996, that will amend the Employee Retirement Income Security Act of 1974 (ERISA) to require mental health parity, a measure contained in the Veterans Affairs-Housing and Urban Development appropriations bill (VA-HUD, P.L. 104-204). This bill was essentially a less restrictive version of the full parity bill, The Equitable Health Care for Severe Mental Illness Act (S. 298), which was included with the original Kassebaum-Kennedy bill.² The final bill requires health plans, beginning in 1998, to set the same annual lifetime dollar limits on mental health benefits as they do for non-mental health benefits when both are provided by a health plan. The law affects only health plans that choose to offer mental health benefits. Health plans will not be required to offer mental health benefits (unless they are required to under state mandates) and will be allowed to set higher deductibles and copayments and impose requirements that distinguish between acute and chronic care (within the guidelines of the federal Health Maintenance Organization Act). Another amendment states that any group health plan will become exempt from the parity requirement if it can show that the parity provision resulted in an increase of at least 1 percent of its costs.³ Employers with 50 or fewer workers are exempt from the requirements.**

This *Issue Brief* discusses issues in mental health care benefits. It describes the current state of employment-based mental health benefits and then discusses studies and issues regarding full mental health

¹ According to the most recent review of the literature, these "offset" effects vary between 5 percent and 80 percent of mental health and substance abuse costs. Frank and McGuire (1995) argue that any offsets from existing benefits have already been accounted for in current health care costs and that the existing evidence on offset effects is relevant when examining initial treatments rather than marginal treatments.

² The research discussed later in this Issue Brief focuses on the effects of full mental health parity.

³ A preliminary Congressional Budget Office (CBO) analysis of limited mental health parity indicated that premiums would increase by less than 0.4 percent.

parity. The following sections address the effect of full mental health parity on the uninsured population and the effects of the limited mental health parity provision contained in the VA-HUD appropriations bill. The final section discusses the implications of mental health parity for health plans and health insurers.

Mental Health Benefits

When employers began to provide health insurance benefits to their employees and their families,

they extended coverage to include mental health benefits under the same terms as other health care services. Many employers continued to add mental health benefits through the 1970s and early 1980s until cost pressures required them to re-examine all health care benefits that were offered. They quickly found that, while only a small proportion of the beneficiaries used mental health care services, the costs associated with this care were very high. As a result, employers placed limits on mental health benefits in an attempt to make the insurance risk more manageable.

Mental Health Costs

Employers' health benefit costs have become a major component of total compensation. In 1970, health benefits represented 2.4 percent of total compensation and 23 percent of total benefits. By 1993, health benefits accounted for 7.3 percent of total compensation and 40.9 percent of all benefits.⁴ Surveys of employers have found that health care costs were increasing as fast as 17 percent per annum in 1990, although recent growth in

health care costs has stabilized (chart 1).

In 1993, employers report that mental health and substance abuse benefits accounted for an average of \$209 per employee in an indemnity plan and \$264 per employee in a preferred provider organization (PPO) (Foster Higgins, 1994). This amounts to 4.5 percent of all medical claims costs in the indemnity plan and 5.0 percent of all claims costs in the PPO.⁵ Employers are finding the costs of an episode of mental health care to be two to three times the cost of an episode of care for other types of ailments. Mental health care costs accounted for about 4 percent of employers' total health care expenditures in 1995.

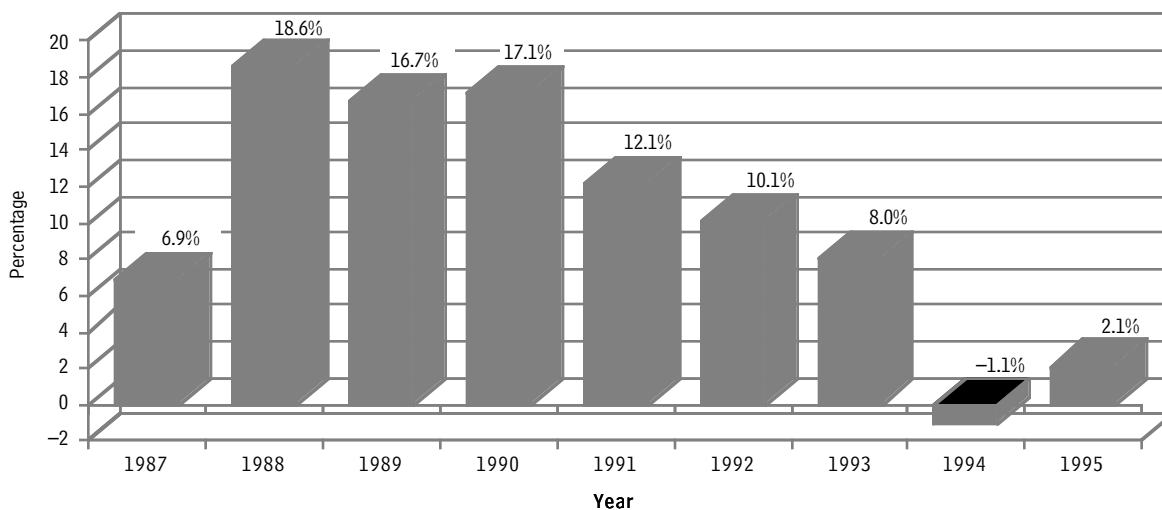
Cost Management Strategies

The general strategies employers have used to manage their health care costs are cost sharing, utilization review (UR), managed care strategies, and the packaging of provider services. Cost sharing includes adding deductibles and coinsurance to health plans, increasing existing deductibles and coinsurance rates, and requiring employees to pay a portion of the premium. UR includes a number of strategies for intervening in the decision to purchase health care. These strategies may include preadmission certification, in which care is reviewed before it is given to determine its appropriateness; concurrent review, or case management, in which care is monitored as it is provided; and retrospective review, which reviews care after it is given. Managed mental health care utilizes early intervention, research-based practice guidelines, and selective contracting with mental health care providers. Finally, the packaging of provider services alters the reimbursement of providers from fee for service to some bundle of services ranging

⁴ These are national averages and include employers that do not offer health insurance benefits. For employers that offer health insurance benefits, health benefits as percentage of total compensation will be much larger.

⁵ This implies that the total cost was \$4,644 per employee for an indemnity plan, and \$5,280 per employee for a preferred provider organization (PPO). These numbers are larger than the national averages (\$3,836 for an indemnity plan and \$3,622 for a PPO) because the sample includes only those employers that provided mental health and substance abuse benefits.

Chart 1
ANNUAL CHANGE IN AVERAGE TOTAL HEALTH BENEFIT COST FOR ACTIVE AND RETIRED EMPLOYEES, 1987-1995^a



Source: Foster Higgins, *National Survey of Employer-Sponsored Health Plans, 1987-1995* (New York, NY: Foster Higgins, 1988-1996).

^aFor employers with 500 or more employees.

from an inpatient stay (as in Medicare's prospective payment system)⁶ to payment per enrollee (as in health maintenance organizations (HMOs)).

Employers' cost management strategies may be restricted, however. Five states have mental health parity laws, but three of the states—Rhode Island, Maine, and New Hampshire—apply these laws only to the seriously mentally ill (Bazelon Center for Mental Health Law, 1996). In addition, 31 states mandate that mental health benefits be provided (Capitol Publications, Inc., 1994). However, state mandates apply only to insured plans, not to self-insured employer plans, which are exempt from state regulation of health plans under ERISA.

Level of Coverage

The Bureau of Labor Statistics (BLS) found that, **while coverage for mental health benefits remained around 98 percent, the percentage of participants whose mental health benefits for inpatient care were the same as those for other illnesses fell from 54 percent in 1980 to 14 percent in 1993. In 1993, 3 percent of all participants were in plans that did not differentiate between outpatient mental health care and care for other illnesses** (U.S. Department of Labor, 1995).

Limitations on inpatient mental health benefits most often took the form of limits on covered inpatient days per year. Coverage for outpatient mental health care differed from that for other illnesses in its limits on the number of visits and on the dollar benefit, its reduced coinsurance rates, and its lack of a ceiling on out-of-pocket expenditures. In addition, cost sharing for mental health benefits is often more severe than cost sharing for other health care benefits, especially for outpatient care (Custer, 1990). Pharmaceutical benefits, on the other hand, are typically the same for mental health benefits and other health benefits. The difference in levels of coverage for inpatient and outpatient care determines in part where care is delivered.

The effects of cost sharing and limits on insurance coverage on the demand for mental health care have been extensively researched. Keeler et al. (1986), reporting results from the RAND health insurance experiment, found that:

- Economic considerations seem to play a larger role in decisions to buy mental health care than in medical decisions;
- Coinsurance sharply reduces the number of episodes of treatment but has only a small effect on the duration and intensity of use within an episode; and
- An upper limit on out-of-pocket expenses has a big effect on use, especially at higher levels of cost sharing.

Other studies have also found that mental health care is significantly more responsive to cost-sharing arrangements than other medical services in the outpatient

⁶ Medicare's prospective payment system (PPS), implemented in 1983, provides incentives designed to lead to more efficient production of services within the hospital. See Fronstin (1996) for more detail on the Medicare PPS.

setting (Frank and McGuire, 1995). However, far less is known about the price sensitivity of mental health care in the inpatient setting when compared with other medical services provided on an inpatient basis.

Preferred Provider Organizations

About 20 percent of large employers offered separate PPOs for mental health and substance abuse in 1995, up from 7 percent in 1993 (table 1). These employers receive discounts on the fees charged by providers on the panel.

Numerous managed care organizations have reported savings in mental health care costs of between 25 percent and 35 percent (Bachman, 1993). Some studies have suggested that lower costs were due to fewer outpatient visits per user of mental health services, greater reliance on group rather than individual therapy, and greater utilization of nonphysician mental health providers. However, many critics of managed care claim that managed care organizations have controlled costs not by providing better coordinated and more efficient treatment but by limiting care. Critics contend that a restrictive mental health benefit design has been responsible for HMO cost savings. However, it is uncertain whether the "actuarial" value of mental health benefits in an HMO is lower than that in other types of plans. HMOs are more likely than other health plans to impose a copayment rather than coinsurance for outpatient

Table 1
PERCENTAGE OF LARGE EMPLOYERS^a THAT OFFER MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS THROUGH A SPECIALTY PREFERRED PROVIDER ORGANIZATION (PPO) AND OFFER AN EMPLOYEE ASSISTANCE PROGRAM (EAP), 1993-1995

	1993		1994		1995	
	PPO	EAP	PPO	EAP	PPO	EAP
All Large Employers	7%	57%	19%	55%	20%	62%
Region						
West	13	50	21	51	35	70
Midwest	4	58	18	57	20	61
Northeast	9	61	24	63	14	64
South	5	55	14	47	18	57
Industry						
Manufacturing	7	52	19	55	25	65
Wholesale and retail trade	6	48	4	36	14	51
Services	4	53	11	44	13	41
Transportation, communications, and utilities	10	56	34	67	27	83
Health Care	7	74	10	70	24	74
Finance	14	69	39	65	18	73
Government	8	56	26	73	34	89
Firm Size						
500-999	5	49	13	40	16	55
1,000-4,999	6	60	21	67	23	66
5,000-9,999	22	79	28	77	29	73
10,000-19,999	20	75	38	70	34	78
20,000 or more	23	86	44	81	50	81

Source: Foster Higgins, *National Survey of Employer-Sponsored Health Plans*, 1993, 1994, and 1995 (New York, NY: Foster Higgins, 1994, 1995, and 1996).

^aWith 500 or more employees.

mental health care, which probably results in a considerably lower cost to the patient. In addition, while HMOs are more likely than other types of plans to use separate inpatient and outpatient day limits, they are less likely than other plans to use inpatient and outpatient dollar limits (U.S. Department of Labor, 1995).

Many critics of managed care believe that prepayment plans give providers incentives to reduce the intensity of services provided. They argue that this incentive has caused managed care organizations to compromise the quality and outcomes of their mental health services. A recent RAND Corporation study found that, among patients of prepaid HMO and independent practice association plans, those suffering from severe depression acquired, over time, new limitations in role/physical functioning, such as being prevented from working around the house or at a paying job. Those receiving fee-for-service care did not acquire new limitations. This result may be related to the finding that depressed patients under prepaid care were one-half as likely as those under fee-for-service care to receive ongoing care by a psychiatrist. There were no significant differences in outcome by plan type for patients with less severe forms of depression. An earlier study found similar results for schizophrenia (Rogers et al., 1993). However, a more recent study found that the research comparing mental health outcomes in managed care and fee-for-service settings is mixed (Boyle and Callahan, 1995). Many studies show similar out-

In general, little information is available to answer questions about the quality of managed mental health services because the measurement of mental health outcomes has proven very difficult.

comes and quality in the managed care and indemnity settings. As a result, it may be possible to compare outcomes and quality across plan types. Many prepaid plans do not pay health care providers on a prepaid basis. In fact, many health care providers participating in a prepaid health plan are paid on a fee-for-service basis. In addition, many health care providers that are reimbursed on a capitated basis often have additional protection minimizing exposure to financial risk.⁷

In general, little information is available to answer questions about the quality of managed mental health services because the measurement of mental health outcomes has proven very difficult. Quality of health care is often confused with the quantity of health services provided. However, higher quantity of services provided does not necessarily translate into higher quality. Current research suggests that the quality of mental health care in the fee-for-service setting is similar to the quality provided in a managed care setting (Boyce and Callahan, 1995). It may be premature to generalize about which circumstances would work best for the administration of mental health care.

Employee Assistance Programs

One approach some employers have adopted is to “carve out” mental health benefits from other health benefits. Separate programs such as mental health provider networks, UR, and prepaid groups for mental health care can be focused specifically on mental health care. Such an approach often makes use of employee assistance programs (EAPs) to detect and refer employees who might be having mental health or substance abuse problems.

EAPs are intended to help employees with substance abuse problems, problems associated with

stress and mental health, or needs such as financial planning. These programs provide referral services and short-term therapy for employees. A 1995 survey by Foster Higgins

found that 62 percent of responding employers offered EAPs, up from 46 percent in 1988 (table 1)(Foster Higgins, 1996). The most prevalent rationale for offering an EAP is to encourage those who could benefit from assistance to receive it. More than one-half of the surveyed employers have used EAPs as gatekeepers to the mental health system, with financial incentives in the form of lower deductibles and coinsurance rates for employees who access the mental health care system through the EAP. **Most employers (76 percent) reported that using an EAP as a gatekeeper has helped reduce mental health or medical plan costs. The coordination of an EAP with other measures such as case management and provider networks offers the potential for employers to detect problems and provide necessary care without incurring unduly high mental health care costs.**

Research

A number of recent studies have examined the effect of mental health parity on health insurance

premiums in a “typical” PPO (see table 2) and on the uninsured. These studies are based on the requirements originally stipulated in S. 298, The Equitable Health Care for Severe Mental Illness Act, which was subsequently adopted as an amendment to S.1028 but dropped in conference. The amendment would have required that all private health insurance include coverage for treatment of severe mental illness that is equivalent to that provided for other serious illnesses. Employers and health plans could equalize the benefits by increasing the limits imposed on mental health care to the equiva-

⁷ For example, specific medical procedures, such as immunizations and obstetrics, are often carved out of the capitation schedule. In addition, the provision of stop-loss coverage minimizes the risk associated with capitation.

lent corresponding limit levels of other serious health illnesses. Alternatively, employers and health plans would continue to have the option of reducing coverage for non-mental health related illnesses.

In general, the studies concluded that the amendment could increase health insurance premiums, decrease health insurance coverage for non-mental health related illnesses, and increase the number of uninsured.

According to a study prepared by Watson Wyatt Worldwide (WWW) for the Association of Private Pension and Welfare Plans (APPWP), it is estimated that S. 298 would increase total health plan expenses in a typical PPO⁸ between 8.3 percent and 11.4 percent (\$433 to \$595 per year for family coverage in 1995),⁹ if benefits were equalized by increasing limits on mental health care (table 3). The increase in total costs is based on an increase of between 152 percent and 207 percent in mental health expenses, which is due to the removal of benefit limits, reduced beneficiary cost sharing, and increased demand for mental health care among plan participants. If, on the other hand, employers responded to mental health parity by reducing coverage for other health care services, the study found that either copayments would increase from \$10 to \$27–\$30.50 or a new comprehensive deductible of between \$150 and \$198 would need to be imposed. This study did not attempt to calculate any offsetting effects if increased mental health benefits produce savings from reductions in other health care services, nor did it take into account the effect of “SMI creep”—i.e., the possibility that health care provid-

⁸ A “typical” PPO was chosen for the analysis because 41 percent of the respondents to a recent survey reported that the primary plan offered was a PPO.

⁹ According to the study, consumers and employers could pay an additional \$192 for health insurance coverage over the next five years.

Table 2
TYPICAL PLAN PROVISIONS OF HYPOTHETICAL PREFERRED PROVIDER ORGANIZATION USED IN WATSON WYATT WORLDWIDE AND MELEK AND PYENSEN REPORTS

Service Category	In-Network	Out-of-Network
Hospital Inpatient		
Medical	100% paid by plan	70% paid by plan \$250 deductible per admission
Behavioral	\$100 copay per day, up to 30 days per year	50% paid by plan, up to 30 days per year \$250 deductible per admission
Outpatient		
Medical	\$10 copay per visit	70% paid by plan
Behavioral	\$10 copay per visit, up to 20 visits per year	50% paid by plan, up to 20 visits per year
Prescription Drugs	\$10 copay per prescription	60% of charges paid by plan

Source: Watson Wyatt Worldwide, *The Costs of Uniform Plan Provisions for Medical and Mental Health Services: An Analysis of S. 298, The “Equitable Health Care for Severe Mental Illness Act”* (Washington, DC: Association of Private Pension and Welfare Plans, 1996); and Stephen P. Melek and Bruce S. Pyenson, *The Cost of Non-Discriminatory Health Insurance Coverage for Mental Illness* (Milliman & Robertson, Inc. 1996).

ers may reclassify nonsevere mental health conditions as severe mental illness (SMI)—or the effect of the elimination of lifetime limits for mental health care services.

Another study on the effects of S.298 was prepared by Milliman & Robertson, Inc. (M&R) for the Coalition for Fairness in Mental Health Illness Coverage (Melek and Pyenson, 1996). This study found that mental health parity would result in an increase in premiums of 2.5 percent (\$148 per year for family coverage) for a typical PPO. Alternatively, if the employer or health plan decided to increase copayments or impose a deductible, copayments would have to increase from \$5 to \$10, or deductibles of \$35–\$40 would need to be imposed. This study used the same “typical” PPO as that used by WWW and also did not include estimates of offset effects or the effect of SMI creep.

The premium rate estimates of the M&R study and the WWW study differ significantly. WWW assumed a total increase of between 152 percent and 207 percent in mental health expenses, while M&R assumed a total increase of 55 percent. The difference can be attributed to differences in the assumed effects of benefit limit removals, reduced cost sharing, and induced demand. WWW assumed that inpatient days would increase 50 percent and outpatient visits would increase 50 percent. M&R assumed that inpatient days would increase by 20 percent and outpatient visits would increase by 30 percent. In addition, WWW based its induced demand assumption on estimates from the RAND health experiment, which may or may not be appropriately generalized to a typical PPO because the RAND study relied on data from largely traditional fee-for-service health insurance from the 1970s (Manning et al, 1989).

Table 3
COMPARISON OF ASSUMPTIONS AND EFFECTS OF S. 298 FROM SELECTED STUDIES ON MENTAL HEALTH PARITY

	Watson Wyatt Worldwide	Milliman & Robertson	Price Waterhouse	Coopers and Lybrand	Congressional Budget Office
	Percentage Increase in Mental Health Expense				
Assumption					
Effect of benefit limit removal	42%	17%	8.5%	a	a
Effect of reduced cost sharing	28	13	17.7	a	a
Effect of induced demand	39–69	17	30.3	a	a
Effect of loss of management intensity	a	a	12	a	a
Effect of public to private coverage shift	a	a	41	a	a
Total Compound Effect on Mental Health Care Expenses	152–207	55	162.9	a	a
Total Effect on Health Insurance Expenses or Premiums	8.3–11.4 for typical PPO	2.5 for typical PPO	10 for PPO/QOS, ^c 9.9 for FFS, 2.9 for HMO, ^d 8.7 overall	3.2 overall	5.3 for FFS, ^b 4 overall
Effect on the Size of the Uninsured Population	1.1–3.2 million	a	1.7 million	a	800,000

Source: Watson Wyatt Worldwide, *The Costs of Uniform Plan Provisions for Medical and Mental Health Services: An Analysis of S. 298, the "Equitable Health Care for Severe Mental Illness Act"* (Washington, DC: Association of Private Pension and Welfare Plans, 1996); Stephen P. Melek and Bruce S. Pyenson, *The Cost of Non-Discriminatory Health Insurance Coverage for Mental Illness* (Milliman & Robertson, Inc., 1996); Price Waterhouse LLP, *Analysis of The Mental Health Parity Provision in S. 1028* (1996); Coopers & Lybrand, *An Actuarial Analysis of the Domenici-Wellstone Amendment to S. 1028, "Health Insurance Reform Act" to Provide Parity for Mental Health Benefits Under Group and Individual Insurance Plans* (Atlanta, GA: Coopers & Lybrand, 1996); Congressional Budget Office, *Preliminary Federal Cost Estimate: Limited Mental Health Parity Proposal*. Draft memo (June 4, 1996).

^aUnavailable

^bFee for service

^cPreferred provider organization/point of service

^dHealth maintenance organization

A third study of S.298 was conducted by Price Waterhouse LLP (PW) for the APPWP, The Business Roundtable, The ERISA Industry Committee, and the National Association of Manufacturers (Price Waterhouse LLP, 1996). The researchers found that PPO premiums would increase 10 percent. This study also estimated the effects of mental health parity by plan type. It found that fee-for-service premiums would increase 9.9 percent, and HMO premiums would increase 2.9 percent, for a combined total effect of 8.7 percent on premiums (\$550 per year for family coverage). The significantly lower premium effects for HMOs results from their use of case management techniques for both mental and other health care services. This study defines substance abuse treatment as a mental health benefit, resulting in a higher premium estimate than would be obtained if substance abuse treatment were not so classified.¹⁰ The study subsequently concludes that employers will ultimately switch to HMOs to minimize the effects of mental health parity.

A fourth study, sponsored by the American Psychological Association, found that mental health parity would increase health insurance premiums by

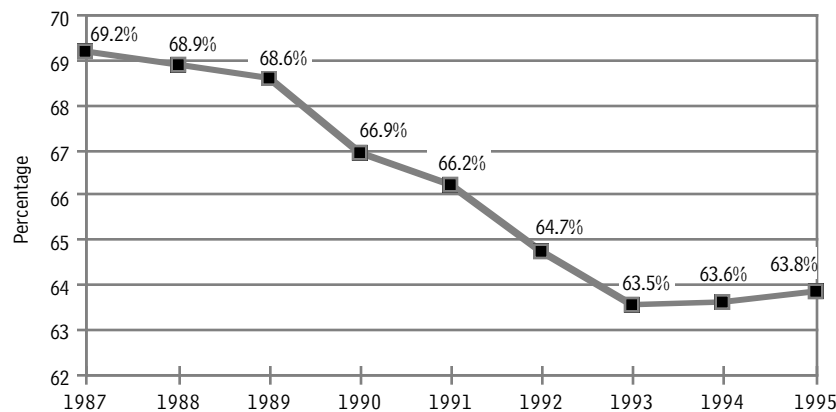
3.2 percent (Coopers and Lybrand, 1996). However, according to PW, this estimate may be the result of very low estimates of the effects of removal of benefit limits, reduced beneficiary cost sharing, and induced demand. The Congressional Budget Office (CBO) released an analysis of mental health parity for a typical indemnity plan. CBO estimated that mental health parity would impose a 4 percent increase in private health insurance premiums after reflecting the cost saving effects of managed care.¹¹ This estimate also includes the effects of defining mental health services to include treatment for alcoholism and substance abuse. Analogous to other studies, the CBO expresses concern about the responses of employers who are dropping coverage altogether, workers bearing the burden of mental health parity, and SMI creep.

One study has attempted to assess the impact of similar state legislation on mental health parity on health insurance premiums (Bazelon Center for Mental Health Law, 1996). This study examined the effects of mental health parity laws in Minnesota and Maryland. It concluded that mental health parity did not result in increased demand for mental health services and there-

¹⁰ For comparison purposes, the Milliman & Robertson study found that health insurance premiums in a typical PPO would increase 3.9 percent if mental health parity included the equal treatment of substance abuse benefits.

¹¹ CBO reported that health insurance premiums would increase 5.3 percent for indemnity plans that incorporated mental health parity.

Chart 2
EMPLOYMENT-BASED HEALTH INSURANCE AMONG INDIVIDUALS AGED 0-64, 1987-1995



Source: Employee Benefit Research Institute estimates from the March 1988-1996 Current Population Surveys.

fore did not significantly increase health insurance premiums. However, this study suffers from a number of major shortcomings. First, the Minnesota statute took effect in August 1995. While the Maryland statute took effect in July 1994, full parity was not implemented until July 1995. Not enough time has elapsed to conduct a comprehensive study in these states. Second, Minnesota and Maryland both have relatively high HMO penetration and therefore have already incorporated other cost management strategies to manage mental health care costs. As mentioned previously, according to the PW study, HMOs would experience the smallest increase in health insurance premiums due to mental health parity. Third, based on the observation that Blue Cross/Blue Shield was reducing premiums, this study concludes that mental health parity did not drive up health insurance premiums. However, premium levels are affected by many factors. Without conducting a significant amount of research on this matter, one could also conclude that in the absence of mental health parity, health insurance premium reductions would have been even greater. Fourth, ERISA plans were not affected by the state mandates. Fifth, Maryland was already experiencing a decline in inpatient mental health days, suggesting that parity may not increase the demand for mental health care if managed care is already playing an effective role in reducing utilization.

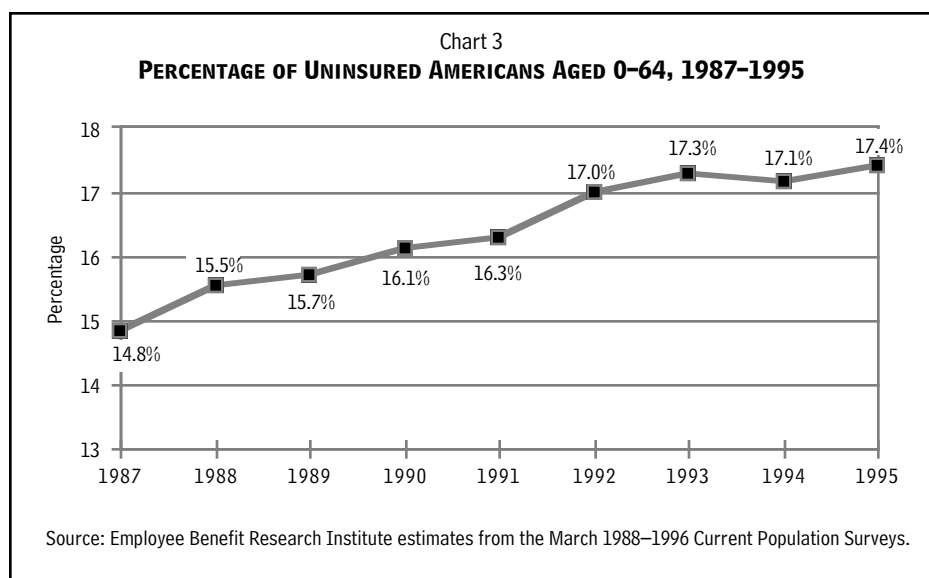
health insurance declined from 69.2 percent to 63.8 percent (chart 2). During the same period, the uninsured population increased from 14.8 percent of the U.S. population under age 65 to 17.4 percent (chart 3). The decrease in employment-based health insurance is partly a result of two underlying factors: small employers dropped coverage, and employers of all sizes shifted the cost of health insurance onto workers, with some workers choosing to forgo coverage.

In 1988, 79.3 percent of all wage and salary workers worked for an employer that offered a health insurance plan to at least some of its workers (chart 4). By 1993, this was down to 78.4 percent. While overall, very few workers were affected by employers dropping coverage, the effects were disproportionately felt among workers in small firms. Between 1988 and 1993, there was a six percentage point decline in the percentage of workers in small firms whose employer offered health insurance coverage, whereas there was virtually no effect on workers employed in firms with 250 or more workers. Small employers dropped health insurance coverage during this period for a number of reasons.

One primary reason was ever-increasing health insurance premiums. In 1988, employers with over 500 workers experienced an 18.6 percent increase in the average total cost of providing health benefits (chart 1). While some employers dropped health insurance coverage altogether, others passed along the cost increases to workers in the form of higher cost sharing for health insurance premiums. Between 1988 and 1995, the percentage of workers whose employer fully financed single employee coverage fell from 43 percent to 33 percent (chart 5). Employee contributions for family coverage increased as well between 1988 and 1995. In 1988, 37 percent of workers had their family health

Parity and the Uninsured

Between 1987 and 1995, the percentage of the U.S. population under age 65 with employment-based



insurance fully financed by their employer. By 1995, this was down to 27 percent.¹²

If mental health parity results in increased health insurance premiums, we can expect continued erosion in employment-based health insurance coverage. The CBO has estimated that as many as 800,000 workers and their dependents could lose health insurance coverage, while WWW estimated that between 1.1 million and 3.2 million individuals would lose coverage, and PW estimated that 1.7 million individuals would lose coverage (table 3). These estimates are highly uncertain because they usually fall within the

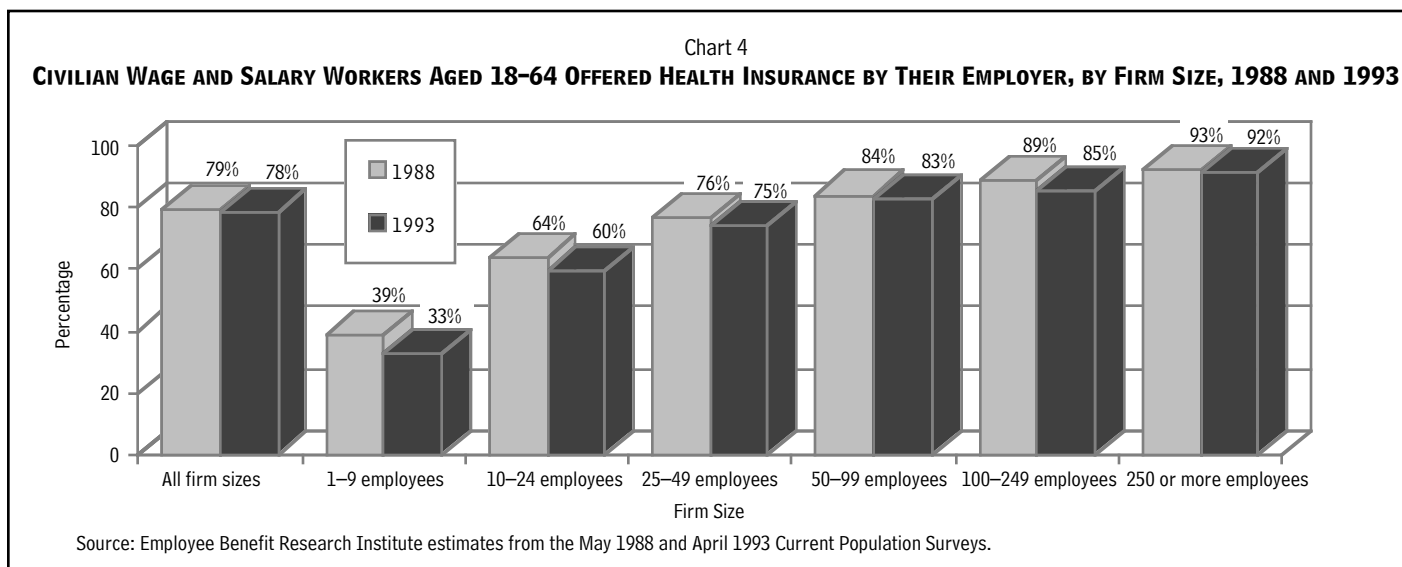
large margins of error. In addition, these results are based on full mental health parity requirements. We would expect limited mental health parity to have a much smaller impact on the uninsured population.

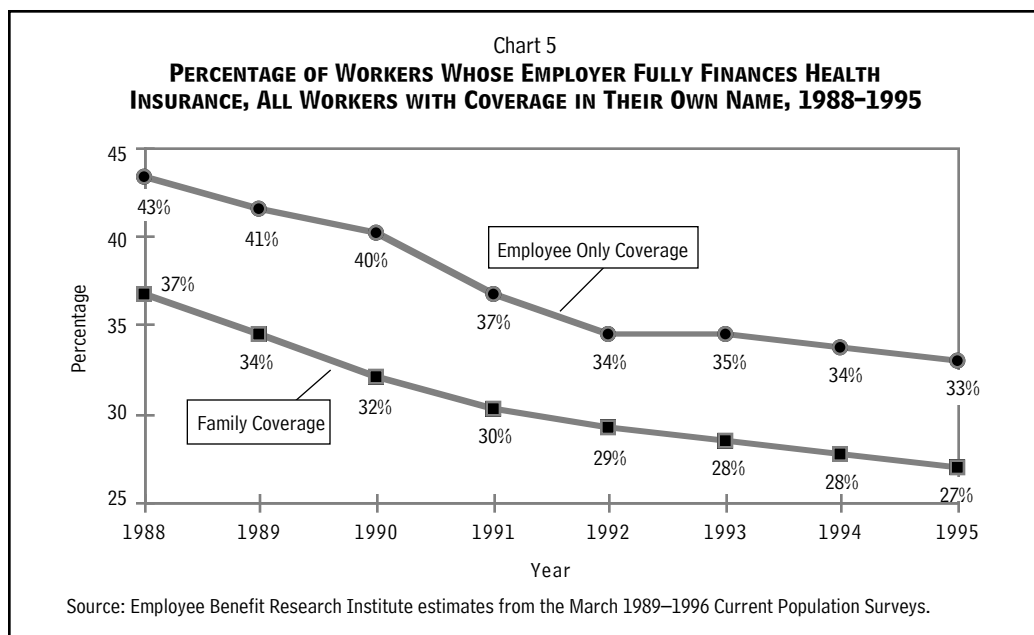
Limited Parity

Sen. Pete Domenici (R-NM) attached an amendment (no. 5194) to the VA-HUD

appropriations bill (P.L. 104-204) that requires health plans and health insurers to offer identical lifetime and annual dollar limits for mental and physical health benefits. However, the legislation is more limited in scope than previously proposed mental health parity

¹² The U.S. Department of Labor found that the percentage of full-time workers employed in medium and large private establishments whose employer fully financed employee-only coverage was as high as 74 percent in 1980. In addition, for family coverage it was as high as 54 percent in 1980.





legislation. It exempts employers with 50 or fewer workers and does not require health plans or health insurers to offer mental health benefits. Also, it is possible to interpret the legislative language as applying only to plans that offer both mental and physical health benefits. If this is the correct interpretation, any plan sponsor or health insurer could “carve out” mental health benefits (subject to the limitations of state mandates and the federal Health Maintenance Organization Act), offer them under a separate plan, and avoid being subject to the parity requirement on annual limits.

Additionally, the bill does not apply to substance abuse or chemical dependency treatment, nor does it require that mental health benefits be offered under the same terms and conditions that apply to physical health care. In other words, cost-sharing requirements, limits on inpatient days, and requirements based on medical necessity are not affected by this provision.

Finally, the bill exempts any plan if its costs increase by 1 percent or more. This is probably the most ambiguous section of the bill because it does not specify how or when the cost is to be calculated, who is charged with calculating the cost, or who is given the responsibility of certifying the exemption.

All studies on mental health parity, and mandated benefits in general, assume that there is a strong likelihood that increased health benefit costs would be passed along to workers in the form of higher cost sharing for health insurance, lower wage growth, or lower growth in other employee benefits. In addition, employers will continue to have the option of dropping coverage altogether or specifically eliminating mental health benefits

from a plan (given state mental health mandates). As a result, the limited mental health parity provision, which excludes specific populations from mental health parity requirements, may impose additional burdens on employers that are required to comply with the mental health parity requirements.

Implications

The U.S. policy toward mental health care is a direct result of the fact that many health plans and

health insurers treat mental health benefits differently from other health benefits. Some plans have higher deductibles, higher coinsurance rates, higher limits on annual out-of-pocket maximums, and lower limits on annual and lifetime benefits. In addition, some plans may impose limits on the number of outpatient visits or inpatient days. Many health plans have developed this two-tiered approach for health benefits in response to ever-increasing health care costs. However, it is still likely that U.S. mental health care policy will continue to support the elimination of this approach.

One problem with mental health care is that its benefits are difficult to quantify, even though it is understood that there are direct and indirect advantages to providing “quality” mental health benefits. For example, employers benefit directly by potentially reducing absenteeism and increasing productivity and also indirectly from employees’ increased morale, en-

hanced quality of life, lower health risk, and overall well-being.

Unfortunately, it is still difficult to measure the benefits of providing mental health care. There has been little research assessing the relative merits of the numerous treatments available for each type of mental illness. A number of studies show that the specific therapy chosen is much less important in determining effectiveness than the characteristics of the therapist and the context of the treatment (Custer, 1990). Researchers still do not understand how to measure quality accurately. In addition, the measurement of offset effects is still imperfect. In order to accurately evaluate the benefits of offering mental health care, researchers need more feedback on outcomes, costs, and value.

Because of the social stigma attached to mental health care and the subjectivity inherent in the patient's assessment of the need for this care, the demand for it is much more price sensitive than that for other forms of health care. This price sensitivity is apparent not only in the overall demand for care but also in the demand for specific providers and sites of care.

Individuals seeking treatment for mental health and substance abuse problems are thus influenced in large part by financial considerations. Their behavior is not only influenced by the economic incentives contained within the design of a health plan but also by the presence or absence of health insurance. Additionally, there is a good deal of evidence that the design of treatment programs itself is determined by the design of private or public health insurance plans. The challenge is to develop an insurance plan that provides access to, and financial assistance for, necessary care while minimizing costs and discouraging the frivolous use of mental health services. The distribution of utilization across treatment sites or providers will be determined by the features of a health insurance plan. The use of EAPs as gatekeepers for the mental health system, with lower deductibles and coinsurance rates as inducements to use these programs, would seem an effective way to begin to address some of the problems presented by mental health benefits, as

would the use of UR to make sure that only medically necessary services are provided.

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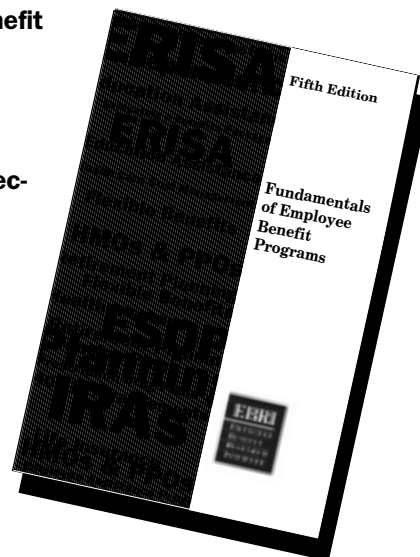
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