

POLICY BRIEF: MENTAL HEALTH PARITY

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History:

The recent debate on mental health parity is one segment of an incremental march toward enhancement of mental health and substance abuse services that began in the 1970's and 1980's with state mandated minimum mental health benefits. In the early 1990's states began experimenting with parity for state employees and 5 states enacted their own parity laws before the federal government enacted the Mental Health Parity Act of 1996 (MHPA) which took effect in 1998. The MHPA mandated limited mental health (MH) parity, requiring that annual and lifetime dollar limits be equal to those of medical and surgical benefits. The MHPA did not address other types of benefit limitations such as day or visit limits, and it did not address deductibles or co-payments. The MHPA did not require that MH services be covered and exempted small firms (50 or fewer employees) and non-group plans. States were required to either match the MHPA or opt for full parity. Another major step took place in 1999 when President Clinton ordered that the Federal Employees Health Benefits Program (FEHBP) adopt full MH parity by 2001.

There is little argument that the MHPA itself has had minimal effect on access to benefits due to the ability of plans to place other types of restrictions on benefits (Burnam & Escarce, 1999; see also Glitterman, Sturm, Pacula, & Scheffler, 2001; Glitterman, Sturm & Scheffler, 2001; Harrison, 2002; Hennessey & Goldman, 2001; Jacobi, 2003; Mechanic & McAlpine, 1999; Otten, 1998). The Government Accounting Office confirmed this in 2000 with a report finding that 87% of plans still had other types of restrictions on access to care and that employees did not experience increases in access to care. What the MHPA appears to have done is place the issue of parity on the national agenda. 33 states now have some form of parity, most exceeding MHPA requirements.

What Does "Parity" Mean?

One of the difficulties of discussing parity is that "parity" is a very general term that encompasses the full spectrum of parity levels and options. States have been experimenting with parity laws: 4 states have comprehensive parity laws, 4 more states have near comprehensive benefits, another 25 states have limited parity (most of these states focus on providing protections for the severely mentally ill, often due to interest in protecting children from losing coverage) and 14 have minimal mental health mandates.

Here are some of the more specific terms used in discussions about parity:

Type of Parity Law	Definition	Examples
<i>Comprehensive Parity</i>	1. Broad definition of mental illness. 2. Includes substance abuse. 3. No exemptions.	Vermont, Connecticut, Maryland & Minnesota's state parity laws

<i>Full Parity</i>	<ol style="list-style-type: none"> 1. Broad definition of mental illness. 2. One or two exemptions, including small business exemptions, exclusion of substance abuse or cost increase caps. 	Federal Employee Health Benefit Plan Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003 Indiana, New Mexico, Kentucky & Rhode Island state parity laws
<i>Limited Parity</i>	<ol style="list-style-type: none"> 1. Law limits protections to certain diagnoses or certain populations. 2. Often includes other exemptions, cost increase caps or addresses only certain types of discrimination. 	Mental Health Parity Act of 1996 25 state parity laws
<i>Mental Health Mandates</i>	<ol style="list-style-type: none"> 1. Minimum mandated benefit law requires a minimum of mental health services, or 2. Mandated benefit offering law requires that at least one choice in the benefit package offer mental health parity. 	14 States (including Michigan)

What Does Parity Cost?

When serious discussion of federal parity legislation began in the early 1990's the debate focused on estimates of premium increases which varied wildly from 2.5% to 11.4% (GAO, 2000 & Harrison, 2002). Due to the enactment of full parity laws in several states and the adoption of full parity policies by some large employers, there is significantly more information on the actual costs of parity laws. This experience has demonstrated that the costs of parity are significantly less than had been anticipated, largely due to the adoption of managed care models in behavioral health care.

Current estimates of premium increases associated with legislation mandating *full parity* now are approximately 1%:

- The Congressional Budget Office estimates an average premium increase of 0.9% if the Senator Paul Wellstone Mental Health Equitable Treatment Act was passed (CBO, 2001).
- PricewaterhouseCoopers estimates a 1% premium increase or \$1.32 per member per month (Bachman, 2003).
- The Office of Personnel Management reports that full MH parity has led to a 1.3% increase in premiums for the FEHBP (Lehmann, 2001).
- Magellan Health Systems reports that Magellan clients generally experience premium increases ranging from 0.2% to 0.8% (Harbin, 2002).
- A RAND Corp study estimated that removing a \$25,000 annual limit would cost \$1 per member per year (Sturm, 1997).
- BCBS of Vermont spending on substance abuse (SA) and MH services increased by 4% or 19 cents per member per month. MH/SA spending accounted for 2.47% of all of

BCBSVT spending. This was up from 2.3% before Vermont's comprehensive parity mandate (Rosenbach, Lake, Young, et al., 2003).

- Consumers paid a smaller share of the total amount spent. BCBS of Vermont out of pocket costs dropped from 27% to 16% of total MH/SA costs. Among those spending more than \$1000 annually, their costs were cut by more than 50% (Rosenbach, et al., 2003).
- Kaiser/Community Health Plan of Vermont estimated that spending for MH/SA services *decreased* by 9% following the implementation of Vermont's comprehensive parity mandate due to implementation of strategies to avoid inpatient stays (Rosenbach, et al., 2003).

Present Status

The MHPA is presently stalled. The legislation had a sunset provision scheduled to take effect in 2001. The sunset was postponed for a year in 2001, again in 2002 and again in 2003. A bill called the Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003 (HR.953/S.486) has been introduced into both the House and Senate. These bills have the support of 243 members of the House of Representatives and 68 members of the Senate. President Bush has also indicated support for this legislation. Supporters expect congressional action in early 2004.

This bill is very similar to a 2001 bill that passed in the Senate and stalled in the House and is modeled after the Federal Employees Health Benefits Program. The bills, which apply only to group health plans offering mental health benefits, have the following provisions:

- Prohibit more burdensome financial requirements, including higher co-payments and deductibles, than those for nonpsychiatric medical benefits.
- Prohibit more stringent treatment limitations, including fewer hospital days and outpatient visits, than those for other medical benefits.
- Provide full parity for mental health conditions listed in the latest version of American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, the industry standard manual used by Medicare, Medicaid, the Food and Drug Administration, the legal system, the Federal Employees Health Benefits Program (after which the legislation is modeled), and parity laws in 13 states.
- Provide coverage contingent on the mental health condition being included in an authorized treatment plan that follows standard protocols and meets medically necessary criteria.
- Exempt from compliance companies with 50 or fewer employees.
- No requirements for benefits related to alcohol or drug abuse.

Future Directions of the Debate

While managed care may have put the debate over cost to rest, it is also diminishing the impact of parity mandates. This is well known by parity advocates. The cost savings resulting from the application of managed care models have become one of their chief arguments in advocating for parity. This appears to be a trade-off that advocates are willing to take as indicated by the National Alliance for the Mentally Ill and the American Managed Behavioral Healthcare Association joining to form the Coalition for Fairness in Mental Illness Coverage.

Some observers expect that once parity is enacted mental health advocates will focus on managed care interfering with *equity* in mental health care relative to general medical care (Burnam & Escarce, 1999; see also Glitterman, Sturm & Scheffler, 2001; Harrison, 2002; Hennessey & Goldman, 2001; Jacobi, 2003). It is expected that advocates will argue that care is managed differently for mental health problems and they may focus specifically on carve-outs as discriminatory (Glitterman, Sturm & Scheffler, 2001).

Where Does Michigan Fit In?

Michigan is one of 17 states without any parity law. Michigan does have a mental health mandate requiring inpatient coverage be offered and \$1500 minimum coverage for outpatient and intermediate care (GAO, 2000).

The consumer advocacy group the National Mental Health Association has released grades for all 50 states and the District of Columbia regarding three important mental health care measures. Michigan was the only one of the 51 governmental units to receive a failing grade on all three measures – mental health insurance parity (equality) law, access to medications, and managed care protections (NMHA, 2003).

In 2003 full parity legislation was introduced into both chambers of the Michigan Legislature (SB 4 & 5) (HB 4888 & 4889). These bills include the following provisions (Layman & Angelotti, 2003 & Stutzky, 2003):

- Require health insurers to provide parity regarding coverage for MH *and* SA services.
- Require that cost-sharing requirements and benefit or service limitations for both outpatient and inpatient MH services and SA services could not place a greater financial burden on the insured, enrollee, or member than those requirements and limitations for outpatient and inpatient medical services.
- The bills would apply to group and nongroup certificates and expense-incurred hospital, medical, or surgical policies and certificates issued or renewed after January 1, 2004.

The House version has 36 cosponsors but the legislation has been stalled in the health policy committees of both chambers. In congressional committee testimony, Ronald Bachman, a PricewaterhouseCooper actuary, estimated that the premium increase from implementing MH and SA parity would be less than 1.3% and that MH only parity would cost 1% (2003).

References

- Burnam, M.A. & Escarce, J.J. (1999). Equity in managed care for mental disorders *Health Affairs*, 18(5): 22-31.
- Congressional Budget Office (2001, August 21). *Cost estimate: S. 543 Mental Health Equitable Treatment Act of 2001*.
- Glitterman, D.P., Sturm R., Pacula, R.L. & Scheffler, R.M. (2001). Does the sunset of mental health parity really matter? *Administration and Policy in Mental Health*, 28(5): 353-69.
- Glitterman, D.P., Sturm R., & Scheffler, R.M. (2001). Toward full mental health parity and beyond. *Health Affairs*, 20(4): 68-76.
- Government Accounting Office. (2000). *Mental health parity act: Despite new federal standards, mental health benefits remain limited* (GAO/HEHS-00-95). Washington, DC: Government Accounting Office.
- Harrison, B.M. (2002). Mental health parity. *Harvard Journal on Legislation*, 39(1): 255-79.
- Hennessey, K.D. & Goldman, H.H. (2001). Full parity: Steps toward treatment equity for mental and addictive disorders. *Health Affairs*, 20(4): 58-67.
- Insurance Coverage of Mental Health Benefits: *Hearings before the U.S. House Subcommittee on Health of the Committee on Energy and Commerce*, 107th Cong. (2002) (testimony of Dr. Darrel Regier M.D., M.P.H.)
- Jacobi, J.V. (2003). Parity and difference: The value of parity legislation for the seriously mentally ill. *American Journal of Law & Medicine*, 29(2):185-99.
- Lehmann, C. (2001). Parity Is Cost-Effective and Affordable, APA Tells Senators. *Psychiatric News*, 36(15): 1-27.
- Levinson, C.M. & Druss, B.G. (2000). The evolution of mental health parity in American politics. *Administration and Policy in Mental Health*, 28(2): 139-46.
- Mechanic, D. & McAlpine, D.D. (1999). Mission unfulfilled: Potholes on the road to mental health parity. *Health Affairs*, 18(5): 7-21.
- Michigan mental health parity testimony: *Hearings before the Michigan State Senate Committee on Health Policy*, (June 4, 2003) (testimony of Ronald E. Bachman).
- Layman, C. & Angelotti, S. (2003, May 28). *Bill analysis: Mental health parity S.B. 4 & 5: Committee summary*. Lansing, MI: Michigan State Senate Fiscal Agency.

- National Mental Health Association (2003). *Can't make the grade: NMHA state mental health assessment project*. [Online] Available at <http://www.nmha.org/cantmakethegrade/execSummary.pdf>.
- Otten, A.L. (1998, July). Mental health parity: What can it accomplish in a market dominated by managed care? Milbank Memorial Fund. [Online] Available at <http://www.milbank.org/reports/mrparity.html>
- Rosenbach, M., Lake, T., Young, C., et al. (2003). *Effects of the Vermont mental health and substance abuse parity law*. (DHHS Pub. No. [SMA] 03-3822). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003, H.R. 953 & S. 486, 108th Cong. (2003).
- Sing, M., Hill, S., Smolkin, S. & Heiser, N. (1998). *The costs and effects of parity for mental health and substance abuse insurance benefits*. (DHHS Publication No. MC99-80). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- Sturm R. & Pacula, R.L. (1999). State mental health parity laws: Cause or consequences of differences in use? *Health Affairs*, 18(5): 182-92.
- Sturm R. (1997). How expensive is unlimited mental health care coverage under managed care? *Journal of the American Medical Association*, 278(18):1533-1537.
- Stutzky, S. (2003, September 16). *Insurance: Parity for mental health and substance abuse*. Lansing, MI: House Legislative Analysis Section.
- Testimony of Dr. Henry Harbin: *Hearings before the U.S. House Committee on Education and the Workforce*, 107th Cong. (2002) (testimony of Dr. Henry Harbin, M.D.)
- Zuvekas, S.H., Reiger, D.A., Rae, D.S., Rupp, A. & Narrow, W.E. (2002). The impacts of mental health parity and managed care in one large employer group: Managed care can contain the expected cost increases of an expanded mental health benefit. *Health Affairs*, 21(3): 148-159.