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ISSUE BRIEF
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Mental Health Parity: Often Separate, Usually Unequal

The federal Mental Health Parity Act of 1996 went into effect on January 1, 1998. The Act does not, however, mandate that health plans include mental health benefits. Instead, it simply prohibits health insurers and self-funded employers that offer mental health benefits from limiting the total annual and lifetime dollars spent on mental health per person to a lower dollar amount than that for other medical care. Nevertheless, plans still have two ways to provide a lower level of mental health benefits. The first is to apply "inside limits" to mental health benefits, that is to limit the number of mental health office visits per year or number of days in the hospital for mental health. The second is to impose higher cost-sharing for mental health visits, services, or hospital admissions than for other medical care. Initially, some health insurers and self-funded employers reacted to the Act by eliminating all mental health benefits from their health plans. The other and more common reaction was an increased use of inside limits or greater member cost-sharing for mental health benefits.

Current proposals would extend mental health parity requirements by removing these methods of providing lower mental health benefits. A potential move to more comprehensive mental health parity raises concerns that its additional costs would exacerbate the problem of access to affordable health care coverage.

Mental health costs under full parity could be affected by increased utilization in mental health treatment and prescription psychotropic drug usage. Costs could also be transferred from the public sector to the insured population if services currently covered by Medicaid were shifted to private health plans. On the other hand, proponents of more comprehensive mental health parity argue that adequate and appropriate mental health care could lead to reduced medical costs and less lost time at work. Under expanded parity, the use of mental health managed care techniques could prevent rapidly escalating mental health costs by controlling over-utilization while still providing needed services.

To develop a balanced solution, it is important to better understand current mental health parity requirements and how group plans[1] typically address mental health coverage, as well as the cost implications of parity requirements. In this issue brief, we first describe current mental health parity requirements and how group insurance plans have responded to these requirements. We next discuss the cost implications of expanded mental health parity requirements, including the impact on other medical costs.

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Mental Health Parity Requirements

Health insurance coverage often treats mental health services differently than other medical services. The need for mental health care can be more subjective than the need for medical care, and the setting, term, or extent of mental health care depends on various factors including whether insurance coverage is present and if so, the nature and extent of covered services.

Implicit in the term parity is the ability to compare two or more things fairly but mental health care is, by its nature, difficult to compare with other medical services. Existing laws and additional proposed laws attempt to create more parity between mental health coverage and other medical coverage. Nevertheless, how parity requirements are applied can vary greatly under various laws and proposals.

Mental health parity requirements are defined differently across states and also at the federal level. Proposals to expand parity requirements can also differ regarding specific provisions. The aspects that can vary include:

- **Treatment setting:** inpatient versus outpatient versus alternative settings
- **Diagnoses covered:** biologically-based diagnosis versus all diagnoses
- **Substance abuse coverage:** mental health only versus the inclusion of substance (drug and alcohol) abuse treatment
- **Cost-sharing:** the same or similar cost sharing as medical and surgical
- **Insurance type:** health insurance versus disability insurance versus other coverages
- **Period of treatment:** acute versus long-term stays

Federal Mental Health Parity Law. The Mental Health Parity Act of 1996 legislated that the annual and lifetime limits on mental health must be greater than or equal to the annual and lifetime limits on medical and surgical benefits. The law applies to all self-insured employers and fully insured employers with more than 50 employees that provide mental health coverage. Federal parity requirements do not, however, encompass coverage for substance abuse or chemical dependency treatments.

The existing federal law does not require that a plan provide any mental health benefits. For plans offering benefits, the federal law allows plans to define what conditions are covered and to adopt various limiting features on mental health benefits, such as higher cost-sharing requirements or limits on the number of inpatient days or outpatient visits. These are common features in many benefit plans offered today. Groups that can demonstrate that the law led to more than a 1 percent cost increase were also exempted from the law's requirements.[2]

Mental Health Definition in Federal Proposals. Since its implementation, new federal proposals have been presented that would extend the 1996 Act. A major initiative recently considered in Congress is the Sen. Paul Wellstone Mental Health Equitable Treatment Act of 2003 (S. 486), which would prohibit reduced benefits for mental health illnesses compared to other medical benefits. The proposal defines mental health benefits to include services for all mental health conditions listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) if such services are included as part of an authorized treatment plan (although the bill specifically excludes the extension of its requirements to the treatment of substance abuse and chemical dependency). In other words, insurers would not be allowed to exclude specific illnesses. However, plans would retain the ability to exclude coverage for specific services. Moreover, the proposal would still not require plans to provide mental health coverage.

State Mental Health Parity Laws. Nearly all states have passed legislation parallel to the limited federal Mental Health Parity Act of 1996. Approximately 30 states have passed broader mental health parity laws

since the early 1990s, although they use no common language or approach. Some states include a broad definition of mental health, others limit the parity benefits to selected biologically based mental health illnesses,[3] and others specifically exclude coverage for substance abuse and/or chemical dependency.

Implementation of Current Mental Health Parity Requirements

Most health plans include some form of mental health coverage, especially those involving managed care. At a minimum, they cover what is required by the state, but some health plans cover more than the statutory required minimum. The statutory required minimum for mental health benefits varies by state. Each state may also require health carriers to make additional mental health benefits available to commercial groups under a mandatory "make available" rider. The employer group then has the choice of whether to spend extra for the additional benefits. Particularly in the small-group market, these additional elective mental health benefits tend to be purchased by those employer groups that are more likely to use them. As a result, premium rates are higher for these riders because of adverse selection costs.

As mentioned above, plans that offer mental health benefits can meet parity requirements, yet still limit mental health benefits. Methods to provide mental health benefits that are lower than other medical benefits include the following:

- Limits on the number of inpatient days covered per member per year for mental health, but not on other types of inpatient care such as medical or surgical stays;
- Limits on the number of office visits per member per year for mental health;
- Limits on the amount of benefit cost per member per year for inpatient mental health coverage; (Note that such limits are impermissible under HIPAA for mental health, but allowable with respect to substance abuse coverage.)
- Greater member cost-sharing (e.g. deductibles, copayments, coinsurance, out-of-pocket maximums) on mental health than for other types of service

Many employers and health plans reacted to the 1996 Act by increasing the use of inside limits on mental health or by increasing member cost-sharing for mental health. In 2004, it is still common for some HMO health plans to require higher copayments for some or all mental health services than for other medical care, and other health plans require higher coinsurance rates for mental health. Of all the possible inside limits on mental health, limiting the number of hospital inpatient days has the most impact and thereby reduces premium rates by more than any other inside limit on mental health. Although there are typically no limits on the number of inpatient days for other medical conditions, payers of health benefits generally believe that there is far more subjectivity to length of hospital stays for mental health than medical health admissions. Thus, plan sponsors typically advocate for the inside limit on mental health inpatient days.

Health plans may also limit mental health care by type of diagnosis or service. For example, many plans do not cover learning disabilities and family counseling. All services must also meet the health plan's criteria for "medical necessity" and "acute care".[4] As a result, many plans do not cover marriage counseling or biofeedback.

There are other more subtle ways that payers may limit mental health coverage relative to most other medical coverages. First, the pre-authorization process that is used for mental health inpatient care, outpatient, and office visits is often very stringent. For instance, members may need special referrals and authorization for mental health office visits or hospital care. Second, the network of mental health

providers in any managed care plan, whether PPO or HMO, could be very restrictive, and this might not be readily apparent to regulatory or accreditation agencies or smaller purchasers. Finally, the plan's prescription drug formulary may be less generous (e.g., require more second- and third-tier member cost-sharing) with respect to mental health medications than other medications.

Costs of Mental Health Parity Requirements

An analysis of the implications of mental health parity legislation is not complete without considering the subsequent effects on medical care and costs. Clinicians believe that mental and physical health are not independent; both have an influence on an individual's overall health. In this section, we examine the effect of mental health parity requirements on health insurance costs, including the potential impact on other medical costs.

Effect of Enhanced Mental Health Parity Requirements on Mental Health Insurance Costs. Mental health parity requirements reduce patient out-of-pocket payments and increase plan costs for mental health benefits. The magnitude of the shift depends on the extent of disparity that exists in each plan's current coverage levels. Plans with only minor differences between medical and mental health benefit levels will obviously not be affected by parity legislation as much as those plans with significant differences in coverage levels. Although most states have passed some form of parity legislation, most do not require full equivalence and there is a wide variation in the extent to which additional coverage would become available under full parity legislation.

Medical Cost Offsets. When estimating the costs of mental health parity requirements, it is important to consider the impact on other medical costs. Some believe that medical costs will decrease more than the additional costs of mental health intervention. Effective mental health care may eliminate unneeded medical care when mental disorders have the appearance of general medical illnesses. Mental health care can also improve self-care and compliance with prescribed medical regimens.[5] The greatest medical savings may come from patients with mental illness and medical conditions requiring inpatient stay.[6]

Although there has been a significant amount of research on the topic of medical cost offsets in response to mental health care, it is difficult to apply the results directly to the issue of the costs of mental health parity. Some research compares medical costs for patients before and after the use of mental health services. Because medical care often increases near the time mental health care begins, the subsequent reduction in medical costs could reflect merely a return to normal health care spending. In addition, most research examining medical cost offsets compares the effect of receiving mental health care to receiving no mental health care. There has been much less research on the effect of changes in existing mental health coverage.

Research suggests that medical cost offsets are more likely to occur in a managed care environment than in a fee-for-service plan. For instance, medical cost savings among the Medicaid population on the island of Oahu more than offset the cost of mental health services, but only for those in a managed care environment.[7] Another study examining the effect of introducing behavioral health management and benefit expansions found simultaneous decreases in both behavioral health costs and medical costs.[8]

The Impact on Prescription Drug Usage and Costs. Discussions of mental health care costs often overlook the utilization and cost of psychotropic drugs. This is largely because these drugs are typically considered medical costs, not mental health costs. According to a 2003 Health Affairs report, psychotropic drug costs

represented 22 percent of mental health spending in 1992. By 1999, this had risen to 48 percent in employer-based private insurance.[9] Today, many commercially insured health plans that use a managed behavioral health care organization spend more for psychotropic drugs alone than all inpatient and outpatient mental health care combined.

It is unclear whether full (or enhanced) mental health parity will increase spending on psychotropic drugs. Current calendar-year limits on mental health benefits do not have much impact on these drug costs. Patients can see psychiatrists for medication management visits fairly infrequently during continued treatment and not run into maximum benefit limitations. However, if they are also receiving therapy treatment on a regular basis, the elimination of benefit maximums for mental health visits under full parity could contribute to more covered medication management visits. Additionally, reduced copayments for such office visits would increase plan costs and may even lead to additional visits.

An additional issue to consider regarding psychotropic drug costs is the amount of inappropriate and ineffective psychotropic drug spending that may occur when primary care physicians (PCPs) prescribe the majority of antidepressants. The PCPs, who may not be comprehensively trained in the identification and care of depression, often do not recognize the underlying condition and may instead treat a patient's physical symptoms. Even when depression is properly recognized, physicians may quickly prescribe antidepressants, but not provide adequate education about patient response, duration of treatment, side effects, and efficacy. Antidepressants take several weeks to start becoming noticeably effective by patients, and can have a multitude of side effects. Unfortunately, in the initial few weeks of treatment, many patients are not prepared for the side effects of the medication, become frustrated because they do not feel better, and stop taking the medications much too soon. This leads to ineffective treatment.

Impact of Mental Health Managed Care on the Cost of Mental Health Parity Requirements. The cost of mental health parity requirements will vary greatly based on the degree of mental health managed care that is in place in the marketplace. As noted above, in some of the actual state implementations of parity requirements, costs decreased when parity provisions were introduced together with an increased level of mental health managed care. The cost-reducing benefits of introducing mental health managed care, usually through a carve-out vendor who accepts capitation, comes from the vendor's higher level of provider discounts and an increased level of utilization management of behavioral health care services using medical necessity criteria.

The application of utilization management and medical necessity criteria to mental health care includes:

- Pre-admission certification of acute hospital stays
- Identification of alternative treatment and diagnostic protocols that bypass acute care admission
- Concurrent review of treatment in acute care settings for optimal patient recovery
- Discharge to less acute settings such as residential treatment, partial hospital, day treatment or intensive outpatient services
- Greater use of lower cost professional providers when and where appropriate

Mental health care utilization management techniques have been shown to substantially reduce health care utilization and costs by eliminating unnecessary and inappropriate services, and by promoting more cost-effective, less restrictive care alternatives. When compared to potential savings of utilization management for medical health care, mental health care has historically had even greater savings opportunities. In a health care delivery system that has little utilization management, the implementation of even a moderate level of utilization management can reduce mental health care costs by a percentage of about twice what can be achieved in medical health care. In addition, managed care organizations have been able to achieve greater amounts of discounts to billed charges from mental health facilities and professional

providers than many of their medical health care counterparts, especially when specialty professional services are compared.

Although managed behavioral health care organizations have financial responsibility for mental health therapy and medication management services provided by mental health specialists, they do not have that responsibility when such services are provided by primary care physicians. Primary care providers typically prescribe two-thirds or more of all psychotropic drugs. This may result in steering patients to primary care physicians for psychotropic drugs rather than depending on therapies from mental health professionals.

Transfer of Public Mental Health Costs to the Private Sector. Patients who are continually a source of danger to themselves or others require longer inpatient care. Medical necessity may require mental health inpatient stays for conditions that do not improve sufficiently in an outpatient setting. And some individuals will require long-term care for mental health. Whether long-term care is covered by the health plan is a contractual matter, however, that depends on the health plan's specific language regarding covered services. Plans typically cover acute care only.

Currently, the states pay for individual long-term care treatment if families exhaust their means of payment and file for Medicaid coverage. If mental health parity is defined to include inpatient stays of longer than 30 or 60 days, this would effectively transfer some responsibility from the public sector to the private sector for individuals whose psychological needs exceed "acute care" as defined by private insurance.

Conclusion

As policymakers continue to debate whether and to what extent to expand mental health parity requirements, they should consider the impact that such legislation could have on the cost of health coverage and resulting access to care. While adequate and appropriate mental health care could reduce medical costs and lost time at work, there is a concern that mandating mental heath parity could further increase already high health care costs and exacerbate problems with access and affordability of health care coverage. Factors that should be weighed when developing mental health parity legislation include the current state of mental health parity coverage at both the federal and state levels, the effect on health insurance costs and prescription drug usage and costs, medical cost offsets, and the role of managed care. Any proposal requiring mental health parity should be structured so that appropriate and effective mental health care is provided while encouraging efforts to minimize potential over-utilization.

1 This issue brief comments only on mental health coverage in the group health insurance market, which may differ from mental health coverage sold to individuals or in the small group (50 employees and under) health insurance market.
2 It is the understanding of the American Academy of Actuaries' Mental Health Parity Work Group that few, if any, have applied for this exemption.
3 The definition of "biologically based mental illness" varies, but typically includes disorders such as, schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder and may include additional serious disorders.
4 As with other medical care, insurance plans typically specify that coverage is for acute care, not for long-term care.
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6 John L. Fiedler and Jonathan B. Wight. 1989. The Medical Offset Effect and Public Health Policy: Mental Health Industry in Transition, New York: Praeger.
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8 Brian J. Cuffle, William Goldman, and Herbert Schlesinger. 1999. "Does Managing Behavioral Health Care Services Increase the Cost of Providing Medical Care?" Journal of Behavioral Health Services & Research 26(4): 372-380.
9 T. L. Mark and R. M. Coffey, "What Drove Private Health Insurance Spending on Mental Health and Substance Abuse Care, 1992 1999?"

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