The Costs of Mental Health Parity

by Steve Melek

The Mental Health Parity Act of 1996 required that the annual and lifetime dollar limits of mental health benefits and medical benefits be equal for employers with at least 50 employees offering mental health coverage. Since its implementation, new federal proposals have been presented that would extend the 1996 Act, some requiring full parity for all categories of mental health conditions as listed in the DSM-IV (the Diagnostic and Statistical Manual of Mental Disorders). Opponents of such legislation argue that the combined pressures of general cost increases and a need to pay fully for mental health care will make it impossible for employers to continue offering affordable coverage, often citing initial estimates that placed resulting premium increases from full parity between 3.2 percent and 8.7 percent. However, as actual experience has emerged, it has become clear that these estimates were conservatively high. In fact, with implementation of mental health parity at the same time as managed behavioral health care, many states have discovered that overall health care costs increased minimally and in some cases were even reduced.

The three primary drivers of cost increases from mental health parity legislation have been identified by both sides of the issue, and include:

- The levels of mental health benefits already existing, including calendar year benefit limits and levels of insured coinsurance, copayments and deductibles.
- The degree of utilization management that existed or that would be implemented with parity.
- The degree of shift in services from the public sector to the private sector after parity.

While parity does not require mental health coverage to be offered by employers, when coverage is provided it may not be limited more than medical coverage. Thus, the impact of this legislation will be minimal if benefits offered under the current plan are similar in richness to mandated benefits. In the case that mandated benefits are significantly richer, utilization will likely increase. However, implementing managed care for behavioral health care may limit the effects.

As debate over the federal legislation continues, 35 states have enacted their own versions of mental health parity laws. The emerging results of their programs dispel the cost arguments of parity critics. These states are finding cost increases of less than 2 percent and in some cases cost *decreases* of up to 50 percent, depending on whether mental health care management was already in place. The following table summarizes the results from various state parity programs.

IMPACT OF STATE PARITY PROGRAMS

State	Parity Type	Managed Care Change	Cost impact
North Carolina, 1991	Full Parity for State Employees	Implemented at time of parity	Mental Health Costs changed from 6.4% of total health costs to 3.1% in 6 years
Texas, 1991	SMI type for State Employees	Implemented at time of parity	48% decrease in the cost of behavioral health care in managed care plans
Minnesota, 1995	Full Parity	No change	$0.26 pmpm increase for 1 large plan; 1-2% increase for state employees
Maryland, 1994	Full Parity	No change	0.6% increase in health care costs
Rhode Island, 1994	SMI Parity	No change	0.33% increase in health care costs

IMPACT OF STATE PARITY PROGRAMS (Cont'd)

State	Parity Type	Managed Care Change	Cost impact
New Hampshire, 1994	SMI Parity	No change	1.5% increase projected; actual increases in health care costs less than that or even flat
Maine, 1995	SMI Parity	No change	Behavioral health care costs as a % of all health care costs changed from 4.66% to just 4.67% of total
Colorado, 1997	SMI Parity	No change	Increase in total health care costs of 0.2%
Vermont, 1997	Full Parity	No change	BCBS Plan found that behavioral health care costs rose from 2.30% to 2.47% of all health care costs

SMI parity designates parity for severe mental illnesses only (such as schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder and panic disorder) as defined within the legislation.

There is also evidence, besides the emerging experience of these states, that the initial cost projections for mental health parity programs were too high. Industry experts have made more recent projections based on current data, the most telling of which are highlighted below.

- In March of 1998, RAND published a case study of the Ohio State Employee Program's experience for mental health and substance abuse parity. The main result of the study was that costs for behavioral health care remained low and even declined under managed care. According to the authors, "the implementation of managed care by far overwhelmed the effect of benefit expansion."

- In October 1999, RAND provided testimony to the U.S. House of Representatives Subcommitee on Criminal Justice, Drug Policy and Human Resources that the additional cost of adding full parity for substance abuse benefits to a plan that previously had provided no substance abuse benefits is in the order of 0.3 percent for HMOs.

- In June 2000, the National Advisory Mental Health Council (NAMHC) updated their 1998 estimate (ranged from 1 percent to 4 percent by plan type) for the cost of mental health parity to an aggregate increase of 1.4 percent, based on an evolution of assumptions in their model and new data. In a report to Congress entitled "Parity in Coverage of Mental Health Services in an Era of Managed Care," the NAMHC found that "based on empirical studies and economic stimulations across diverse populations, managed care approaches and parity structures suggest that the introduction of parity in combination with managed care results in lowered costs and lowered premiums (or, at most, very modest cost increases) within the first year of parity." They also included "these findings do not support earlier concern about potentially high financial costs caused by parity."

In 2000, PricewaterhouseCoopers produced a mental health parity report for the American Psychological Association. They reported that "to date, there are no examples where mental health parity has been enacted in a state and costs have dramatically increased," and that there "are no examples where mental health parity has been enacted in a state and a measurable increase in uninsured has been detected."

- The Office of Personnel Management (OPM) is responsible for implementation of the 2001

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parity coverage for the Federal Employee Health Benefit Plan (FEHBP). They expected increases in total health care benefit costs of 0.2 percent to 0.5 percent due to parity.

- In July 2001, RAND provided additional testimony that "parity in employer-sponsored health plans is not very costly under comprehensively managed care, which is the standard arrangement in today's marketplace. The total cost of providing parity-level benefits is less than the increase of benefit expansion claimed by recent actuarial studies."

- In August 2001, PWC projected that the Mental Health Equitable Treatment Act of 2001 would cost employers 1 percent or $1.32 per enrollee per month. Parity in this Act is required for in-network services only, where providers have typically agreed to discount their fees. The CBO estimated that this Act would raise health insurance premiums by 0.9 percent.

- In February 2002, Mathematica submitted a report on the California Mental Health Parity Law to the California HealthCare Foundation. The California bill, effective in July 2000, included SMI and SED (serious emotional disturbances in children). Mathematica found "the law did not appear to have had any adverse consequences on the health insurance market to date, such as large increases in premiums or decreases in health insurance offerings by employers. Although employers faced premium increases of 10 percent to 20 percent in 2001, little of the increase was attributed to parity."

- In 2004, the CBO modified their estimate of the expected cost impact of national mental health parity to 0.8 percent of total health care costs (down from their prior estimate of 0.9 percent). This reflects the aggregate expected impact on all states given the current status on mental health parity by state.

The combination of actual state-specific experience under various parity programs with the revised downward projections of several key organizations narrow the expected cost impact of national mental health parity legislation to a reasonable range. The bottom line is that evidence now exists supporting the argument that mental health parity laws have very little impact on the overall health care costs. Offering mental health benefits at the same level as medical benefits may be an efficient, affordable way to improve the quality of the insureds' lives and protect them from catastrophe.

It should be noted that mental health benefits in health insurance policies typically include services provided by specialty mental health providers such as psychiatrists, psychologists, masters-level social workers, and other approved mental health specialists. Services provided by primary care physicians and psychotropic drugs are considered to be medical benefits and are not restricted by limited mental health benefits. The use of these and other medical services to treat behavioral health conditions have soared in recent years. This is discussed in greater detail in the preceding article in this edition, "The Bottom Line on Behavioral Health-Care Costs."

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