The Politics And Economics Of Mental Health 'Parity' Laws

Key tenets of managed care may limit the effectiveness of the new mental health parity amendment passed last fall by Congress.

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PROLOGUE: "Politics is the art of the possible," Otto von Bismarck once said. In the political saga described here, the "possible" turned out to be an amendment (Domeneci-Wellstone), originally intended to mandate full parity between mental health and medical/surgical benefits, that mandates instead only partial parity ("the same annual and lifetime limits on plan spending"). In addition, the amendment became part of a totally nonhealth-related appropriations bill instead of its original target, the Kassebaum-Kennedy bill. An irony of this "historic victory," says lead author Richard Frank, is that the final amendment regulates "a market that isn't there anymore."

In this paper Frank and his colleagues Chris Koyanagi and Tom McGuire describe the economic forces that traditionally limited coverage of mental health care, the tortuous journey of the new parity amendment, and the challenges of ensuring access to mental health care in today's managed care world. Frank is a professor in the Department of Health Care Policy at Harvard University and a research associate with the National Bureau of Economic Research. He and McGuire are writing a book on mental health/substance abuse finance reform as a result of their joint 1994–1996 Robert Wood Johnson Foundation Investigator Award in Health Policy. Koyanagi is director of legislative policy at the Bazelon Center for Mental Health Law, in Washington, D.C. Her particular areas of responsibility are mental health care financing and children's mental health services. McGuire is a professor of economics at Boston University. He is the recipient of two sequential five-year Research Scientist Awards from the National Institute of Mental Health.

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ABSTRACT: The enactment of the Domenici-Wellstone amendment in September 1996, which calls for the elimination of certain limits on coverage for mental health care under private insurance, is being hailed as a major step forward in the quest for "parity" in mental health coverage. Parity legislation is being introduced in a number of state legislatures and is finding new enthusiasm in Congress. In this paper we consider the efficiency rationale for these laws and examine their likely impact in the era of managed care. We conclude that although such successes represent important political events, they may offer only small gains in the efficiency and fairness of insurance markets.

During the debate on the "Kassebaum-Kennedy" health care reform bill in April 1996, the U.S. Senate took the historic step of approving an amendment to require employer-based health plans that provide coverage of mental health services to do so "without imposing treatment limitations or financial requirements . . . if similar limitations or requirements are not imposed on coverage for services for other conditions."[1] "Parity"—equal coverage for mental and physical conditions—has been a goal of mental health advocates since the 1950s. The legislative progress has fueled new enthusiasm in the mental health community for laws that move private insurance coverage toward complete parity.

As finally passed, a more modest version of the Domenici-Wellstone amendment (attached to an appropriations bill) was signed into law 26 September 1996. It goes into effect 1 January 1998 and sunsets (its provisions end unless reauthorized) 30 September 2001. The amendment prohibits different treatment of mental health care in lifetime caps and annual reimbursement ceilings. It only affects plans that already have mental health benefits and does not mandate inclusion of mental health coverage in the benefit package. Plans that now have mental health coverage may drop coverage entirely. The final version of the legislation allows health plans to continue to place annual day and visit limitations on covered services and to use higher levels of cost sharing for mental health care than for other services.

Parity laws are aimed at redressing the limited coverage of mental health care that emerges in markets. The economic forces traditionally pointed to as responsible for limited coverage are moral hazard and adverse selection. These issues are tied to the rationale for legislation such as the Domenici-Wellstone amendment, and we discuss them below. In this paper we also review the origins of such legislation and provide a chronicle of the development of the enacted parity legislation. Finally, we identify the forces that govern the prospects for parity legislation and their likely impact on parity. Although parity in benefits is becoming easier to achieve, it is at the same time becoming less meaningful.

Economic Forces Affecting Limited Coverage

Parity legislation and other federal and state health insurance regulation take place in the context of market forces determining coverage for mental illness and other conditions. Understanding these influences is important to understanding the effects of parity and why parity legislation may help or hurt insurance market functioning. Coverage for mental health care has been substantially more restricted than coverage for general medical care. The theory of insurance tells us that the most valuable types of coverage protect individuals and their families against big, not small, losses. In mental health, the insurance market stands notions of optimal insurance on their head. Typical mental health coverage consists of thirty inpatient days per year and twenty outpatient visits with 50 percent cost sharing.[2]

■ **Moral hazard.** One reason why coverage for mental illness has been less than that for other conditions is the problem of moral hazard—the tendency for people to demand more services as the price they pay for services falls. Since insurance by its nature drives a wedge between the total costs of care and the price paid by the insured person, moral hazard will inevitably result. In fact, the dilemma of insurance is that it protects individuals and families against risk but creates incentives for overuse.

The RAND Health Insurance Experiment (HIE) provides convincing evidence that the moral hazard problem in mental health care is more serious than it is in general medical care.[3] The reported responses to reduced cost sharing in mental health care were nearly twice as large as those observed in general medical care. According to HIE data, going from no insurance to full insurance doubles ambulatory medical expenses but quadruples ambulatory mental health expenditures. A natural response to this problem by employees' insurers is to impose higher cost sharing for mental health care. This is the correct response, given the greater degree of moral hazard.

From the standpoint of efficient resource use, the problem with demand response (or moral hazard) is that insurance induces persons to use medical services that they would not have used had they been paying full cost. There is a presumption that the extra care used with insurance is inefficient—that is, not worth the cost. An important implication of this argument is that it is the demand response (quantity increases by a factor of four with insurance), not the level of demand (mental health is 10 percent of total plan costs), that governs optimal cost sharing. Thus, studies that show that mental health coverage costs less under managed care (parity is less costly) do not imply that parity is more worthwhile.[4] To counter the

traditional moral hazard argument, one needs to show that the demand for mental health services is less responsive to insurance under managed care arrangements, not that it is simply less expensive.

Adverse selection. Mental health coverage may be restricted for a second reason. Adverse selection occurs when potential enrollees differ in their risks, know more about their health risks than do health plans, and enroll in health plans that are paid premiums that do not fully reflect those differences in risks. People tend to choose the plan that is most likely to serve their expected health care needs. Since many mental and addictive disorders are more persistent than other illnesses, health plans have an incentive to reduce the likelihood that they will be chosen by persons with mental illness, who are generally "bad risks." A plan that becomes known as the "good mental health" plan may not prosper financially.

One way to achieve a favorable selection of enrollees is to strictly limit mental health benefits. This happened clearly under the Federal Employees Health Benefits Program (FEHBP) in the 1970s when Aetna offered a parity benefit but Blue Cross did not. Aetna quickly attracted a "needier" population of enrollees, began losing money, and rescinded its benefit.[5] Competition in this situation took the form of avoidance of "bad risks" by reducing coverage.[6] With adverse selection (as opposed to moral hazard), market competition can lead to an inefficient outcome: too little mental health coverage. A long-standing problem for policymakers has been to determine whether restricted benefits for mental health are there for a "good reason" (moral hazard) or a "bad reason" (adverse selection). There is ample evidence that both have been at work.

SAFETY NET

Safety-net system. A third explanation for patterns of private insurance coverage in the United States is the existence of a large, publicly funded set of mental health and substance abuse providers that offer free care to the indigent. The public mental health care system resembles catastrophic insurance in that it acts as a social safety net. However, individuals and families availing themselves of this delivery system typically have had to exhaust their financial resources before being eligible for free care. Thus the public system does not furnish insurance-like protection for ruinous financial consequences of mental and addictive illnesses. Nevertheless, the presence of the public system may encourage employers to offer only limited catastrophic coverage in the belief that they are not leaving employees without any resort. As public welfare systems become less like safety nets and more like programs for defined groups (for example, the indigent meeting criteria for long-term care services), employers' ability to shift costs on to the public system by limiting coverage will be undermined.

Policy Toward Mental Health Insurance

The Domenici-Wellstone amendment and other so-called parity legislation follow in the tradition of insurance benefit mandates that have been enacted by both federal and state governments and are aimed at limiting the consequences of adverse selection. The efficiency rationale for regulating insurance was an important point recognized by the U.S. Supreme Court in upholding the right of states to regulate the business of insurance.[7]

■ **State-mandated benefits.** The first attempts to devise a legislative public policy solution to selection-related problems occurred in the 1970s when a number of states mandated mental health benefit laws. More than a dozen states enacted laws requiring health plans operating in the state to offer a specific minimum set of mental health benefits, typically twenty outpatient sessions and thirty inpatient hospital days, sometimes with some coverage of day hospitalization, as well. Other states enacted laws requiring insurers to "offer" plans with such coverage, along with other products.

Mandated-benefit legislation had an immediate impact on the coverage of millions of people in the affected states and probably also made mental health coverage more generally accepted. However, mandates had important constraints on what they could accomplish. The mandatory levels of coverage seldom offered deep or catastrophic coverage against the financial risk of severe mental and addictive illnesses. Mandates applied only to health plans that were subject to state regulation. Large self-insured employers were exempted from state regulation by the Employee Retirement Income Security Act (ERISA). State-mandated benefit laws frequently exempted health maintenance organizations (HMOs) from the provisions. It should be noted that self-insured plans commonly provide coverage in excess of mandated levels. HMOs also have historically provided benefit levels comparable to most state mandates, due in part to federal qualification standards.

Most federal proposals addressing health care coverage have also included some required mental health coverage. When President Bill Clinton proposed to reform health care in 1994, a limited mental health benefit was part of the mandated package; parity was proposed for the future.[8]

■ **The Domenici-Wellstone amendment.** The Domenici-Wellstone amendment represents a variation on the traditional approach to mandated benefits. It adopted a less directly prescriptive approach by not proposing a specific minimum benefit package but using instead more general language to eliminate the "inequities" in mental health coverage under private insurance (the amendment did not apply to Medicare or Medicaid). As approved by the Senate on 18 April 1996

(but later dropped in conference), the Domenici-Wellstone amendment prohibited employee health benefit plans or group or individual health plans from imposing treatment limitations or financial requirements on any coverage of mental health services if similar limitations or requirements were not imposed on coverage for other conditions. It was thus intended to require full parity. The amendment also specifically permitted the use of certain managed care techniques (preadmission screening, prior authorization, or other mechanisms that would control use of services).

During Senate debate on the "Kassebaum-Kennedy" bill, several other amendments failed to pass, including a relatively popular amendment sponsored by Sen. Jim Jeffords (R-VT) to protect individuals against low lifetime limits in their health insurance coverage. Sponsors of the bill argued for "no amendments." Fearful of losing the entire bill if amendments from either the left or the right were accepted, Sen. Nancy Kassebaum (R-KS) and Sen. Edward M. Kennedy (D-MA) persuaded most senators to agree to vote against all amendments, even if they supported them in principle.

Three major forces served to increase the likelihood of passage of the mental health amendment, which was essentially an "unfunded mandate" on the private sector, by a legislature generally hostile to such regulation. The chief sponsor of the amendment, Sen. Pete V. Domenici (R-NM), holds an influential position in the Senate and made strong public and personal appeals for its passage.

A second factor aiding passage was the development of opposition to the measure. While mental health parity was being considered, more visible and broader amendments were also being considered that distracted attention from the mental health issue. In particular, Senator Jeffords' amendment prohibiting lifetime limits on coverage drew fire from the insurance industry. The Domenici-Wellstone amendment was not circulated ahead of time, and not knowing its full extent or content made informed opposition more difficult.

A third factor probably was the apparent public support for mental health coverage. For example, a poll conducted in 1994 by Mellman-Lazarus-Lake and RSM, Inc., found that 65 percent of registered voters wanted mental health benefits covered in the national health care reform package being debated at the time.[9] Forty-three percent rated mental health benefits as one of the most important or a very important component of the health care package. In a 1989 study of public attitudes toward persons with chronic mental illness, nine of ten Americans described mental illness as a serious problem, and 45 percent described it as a very serious problem.[10] This study also found that Americans understand several important

facts about mental illness: 74 percent believe that anyone can become mentally ill and that mental illness can be cured; more than half believe that with treatment, persons with mental illness can get well and return to leading productive lives.

Opponents and supporters of the parity amendment to the Kassebaum-Kennedy bill put forward a great range of cost estimates that, at the very least, made the amendment seem risky if not too costly. Five major private actuarial studies estimated that the amendment would result in insurance premium increases ranging from about 3 percent to 11.4 percent.[11] The Congressional Budget Office (CBO) estimated a 4 percent increase. As in previous public exercises, the estimates were based on differing baseline data and different assumptions about pre-policy insurance coverage, managed care impacts, cost shifting, and enrollment patterns.[12] The unfortunate fact is that with managed care changing the medical and insurance landscape, we do not know with any accuracy how much this or related changes are likely to cost.

The mental health amendment was excluded from the Kassebaum-Kennedy bill when the House conferees opposed its inclusion. Although many senators (including Senators Kassebaum and Kennedy) supported inclusion of at least a compromise mental health provision, the final bill did not address the issue in any way.

But this was not the end of the tale. A compromise amendment that the sponsors proposed to the conferees on the Kassebaum-Kennedy bill was extremely modest and eventually passed and was signed into law. It requires that employer-based health plans (for employers with more than fifty employees) adopt the same annual and lifetime limits on plan spending for mental health benefits that apply to their medical/surgical benefits. Separate lifetime limits defined in terms of dollars of spending on mental health coverage are to be prohibited, unless they are the same as the lifetime limits on other benefits. Similarly, separate annual limits on plan spending cannot be imposed unless the same limits are imposed on other benefits. Plans may be required to eliminate certain limits (for example, a $10,000 cap on lifetime spending and a $1,000 limit on annual reimbursement for mental health care), but a benefit design can be structured to accomplish the same outcome. For example, cost-sharing levels can depend on the level of spending—so copayments could rise to 90 percent after $10,000 in spending.

In addition to its limited scope, the compromise amendment includes a provision allowing a total exemption for firms whose overall premium costs increase by at least 1 percent as a result of this mandate. Regulations interpreting this exemption will be critical. Projections of cost increases, based on actuarial estimates, could

easily be higher than 1 percent. If the regulations require employers to show actual cost experience, this exemption is likely to be little used.[13] If they permit use of cost projections, most employers may be able to find an actuarial estimate to fit the bill.

This more modest amendment was attached to the appropriations bill for the Departments of Housing and Urban Development and Veterans Affairs and related agencies, and it carried a very small official price tag. The CBO estimated a premium increase of 0.4 percent associated with enactment of the "parity" law, making the legislation palatable to Congress.

The Outlook For Parity

The mental health parity issue was not settled by passage of the compromise amendment, and more powerful regulations are expected to be introduced in the next Congress. Legislation aimed at establishing parity in benefits may well fall short of equalizing effective coverage for mental conditions. States will continue to face ERISA restrictions on regulation. To avoid federal preemption, states can regulate the terms of how insurance is sold, not the content of what employers can buy. By self-insuring, large employers can escape the provisions of state regulation.

State and federal regulators are faced with two other issues: the definition of *parity* and the influence of managed care on both the argument for parity based on adverse selection and the argument against parity based on moral hazard.

■ **Defining parity.** *Parity* has come to take on a variety of meanings. Some of the practical definitions are only remotely related to providing more protection against the financial consequences of mental illness. This is in part a result of the politics of passing legislation aimed at improving mental health insurance coverage. In some cases, parity applies to a set of severe or biologically based disorders (for example, schizophrenia and bipolar illness) in the context of a single insurance contract (for example, state employees in North Carolina and Texas).[14] In other cases, a benefit design for mental health that is the same as that for other medical conditions is specified. That is, inpatient and outpatient care must have the same copayments, deductibles, and limits. In these cases, there is no obligation by plans to provide mental health services that are not part of the basic medical plan (such as partial hospital and residential care). The State of Minnesota has adopted such a statute, and it applies only to plans that include some mental health care.

A third concept of parity is that persons afflicted with mental illnesses would have the same access to necessary care as do persons afflicted with other illnesses. This view of parity does not imply that

the same benefit design exists for both mental and other medical treatments. Instead, it focuses on parity in terms of providing access to treatment and financial protection. This concept would be more complicated to specify in regulations of insurance contracts.

A fourth approach claims "parity" for a minimum benefit statute that offers an improvement to a minimum benefit statute. Maryland's parity law is such a case. Cost sharing for outpatient care is 20 percent for visits 1 to 5, 35 percent for visits 6 to 30, and 50 percent beyond that, with no limit on visits. Minimum inpatient benefits have a thirty-day limit. Partial hospital care is covered for thirty days and halfway-house care for 120 days.

A recent review of state parity laws indicates that while such legislation improves coverage, few laws call for either equal benefit design or equal access to appropriate care for mental illness.[15]

■ **Impact of managed care.** State and federal legislation to regulate insurance benefits in the context of managed care must confront a new issue. Managed care changes in fundamental ways key elements of the market being regulated. First, managed care arrangements appear to successfully address the moral hazard problem, at least in terms of limiting costs.[16] Recent case studies of "natural experiments" in managed behavioral health care carve-out programs show cost savings of 25–40 percent, often without reduced access to care.[17] Some evidence also indicates that specific illnesses and services are affected differently.[18] In fact, managed care technology seems to be so powerful at controlling behavioral health care costs that the abundant worry today is undertreatment.[19]

Managed care makes use of information systems, expert opinion, bargaining power, control of intake and referral, and financial incentives to constrain use and costs. In other words, managed care relies on administrative mechanisms, clinical protocols, and financial incentives in combination to achieve cost control. Professionals, the physician and others, become administrative instruments of the risk-bearing organization as well as agents of the patient. Managed behavioral health care (MBHC) companies promise to remedy past excesses of the fee-for-service indemnity insurance system by more appropriately matching patients and treatments. In its best incarnations, managed behavioral health care appears to save money by altering inefficient treatment patterns. Research by William Goldman and colleagues and Richard Frank and colleagues shows that savings from carve-out programs have in two specific cases been achieved by (1) reduced reliance on inpatient care, especially for substance abuse; (2) reduced prices paid to providers; and (3) shorter outpatient episodes of care.[20] These findings are drawn from both a large privately insured population and the Massachusetts

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Medicaid experience. In the versions of managed behavioral health care that concern so many observers and participants in the mental health care system, savings are achieved by across-the-board cuts, without regard to clinical circumstances.

The implications of relying on MBHC systems to control costs are several. First, having a generous benefit design in a health plan need no longer imply high levels of use and costs for mental health care. The utilization management techniques, the financial incentives to providers, and the size and composition of provider networks combine to exert a great deal of influence on use and costs of mental health care, given any benefit design. Benefit design is therefore increasingly taking a back seat to administrative arrangements and payment mechanisms as central elements affecting spending on mental health care.

Second, regardless of the benefit that is specified in the insurance contract, "the effective coverage" depends on a number of new factors that have become key features of health plans. A plan can institute administrative procedures that will discourage enrollment by persons with mental illness: for example, making partial hospital care difficult to access, contracting with residential programs located in out-of-the-way or undesirable neighborhoods, and so on. Thus, the adverse selection problem is at least as important today as it was in the past because a whole new set of health plan factors can now be used to affect enrollment patterns.

Third, the greater reliance on administrative, clinical, and financial mechanisms to control costs relative to benefit designs has great policy significance. It makes the fixes to selection-related inefficiencies much more complicated. For example, as we noted above, the state mandates of the early 1980s served to constrain the degree to which insurers could compete to avoid persons with mental illness by limiting their mental health coverage. This was relatively easy to do because insurance benefit plans only involve a few key parameters such as cost sharing and benefit limits. In the era of managed care, these regulations will not be sufficient to stem adverse selection and the erosion of coverage. This is because there is so much more involved in defining a health plan's mental health program than just its benefit design.

As managed care reduces costs, parity bills become less expensive. We strongly suspect that research will find that managed care

restrains demand response to coverage, as well as the level of demand, but such evidence is not yet in. It is this evidence that is required to lay to rest the moral hazard downside of parity.

All of this spells bad news for parity legislation's chances of attaining its policy objective. Policies aimed at mandating certain benefit design structures leave open to managed care many other ways to affect the effective coverage a plan provides an individual. No matter how comprehensive a parity law, management can be tailored to achieve premium goals within wide ranges. These management techniques will be largely immune from regulation. Dealing with nominal coverage limits is not addressing the actual tools that managed care companies use to limit costs.

Conclusion

Passage of the Domenici-Wellstone amendment was a remarkable achievement and a historic victory for the mental health community in many ways. Despite its limited scope and the changes in the health care market that will limit its effectiveness, the passage of this amendment is nonetheless significant. It reflects increased public understanding about and acceptance of mental illnesses and growing public confidence that treatments are effective. The importance of this achievement for improving public policy in the future should not be overlooked.

Managed care calls for a new consideration of how health plans function in providing access to mental health care and protection against the financial consequences of mental disorders. The potential of managed care (including carve-out programs) to attenuate the moral hazard problem offers a great opportunity. A key implication for policy is that dealing with selection-related inefficiencies in the context of managed care is a great challenge.

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NOTES

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