Parity in Insurance Benefits for Mental Health Services and Substance Abuse

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Insurance benefits for mental health services vary widely across the country and may be different from the benefits for physical health care. Equal benefits are considered parity. Parity has various forms in federal and state laws. There are three varieties of parity:

- There is true "parity" or equal coverage that requires insurers to provide the same level of benefits for mental illness, serious mental illness, or substance abuse as are provided for other physical disorders and diseases. (20 states, including Montana, for severe mental illness)
- Minimum mandated mental health benefit laws require some level of coverage to be provided for mental illness, serious mental illness, or substance abuse and may allow discrepancies in the level of benefits, visit limits, copayments, deductibles, and annual or lifetime limits. (12 states, including Montana, for mental disorders (not severe) and chemical dependency)
- Mandated mental health "offering" laws do not require or mandate benefits but can require that an insurer offer the option of coverage to the insured, and if benefits are offered by the insurer, then they must be equal or as specified in law. (14 states) (Rosenberg, 2005)

Many states have forms of parity laws that vary on the definitions of mental illness, serious mental illness, or substance abuse and differ as to which types of insurance the laws apply (i.e., individual, group, and government plans). States are precluded by federal law in regulating self-funded plans, but federal law applies. Many states have exempted employers of less than 50 employees (same as the federal law). In Montana, such an exemption would provide no relief to the majority of the uninsured. Of those who are insured, 51% of households are covered by employer-based insurance, and of the uninsured, 77% are employed by an employer that has 50 employees or less. (State Planning Grant Final Report, 2004)

Montana has a combination of parity provisions found in Title 33, chapter 22, part 7, MCA. Montana has a "partial" parity law enacted in 1999 (Ch. 348, L. 1999), which requires coverage for seven disorders defined as "severe mental illness". For these illnesses, an insurer must

provide a level of individual and group benefits that may be no less favorable than for other physical illness generally. Montana also allows "barebones" individual health benefit plan or managed care plan policies in a demonstration project to exclude parity or equal coverage for severe mental illness (Ch. 325, L. 2003).

Montana has a minimum mandated benefit for group insurance coverage for mental illness, alcoholism, and drug addiction and allows set benefit levels, including 21 days of inpatient treatment and annual and lifetime maximum benefits. Legislators last changed the benefit levels in 1999 (Ch. 477, L. 1999). The mental illness benefit is higher for inpatient treatment, or partial hospitalization may be traded 2 for 1 for inpatient benefits. Inpatient and outpatient treatment of alcoholism and drug addiction, excluding medical detoxification, is subject to a combined maximum annual benefit of $6,000 and a lifetime maximum limit of $12,000, after which the benefit may be reduced to $2,000 a year. Outpatient treatment benefits are subject to a maximum yearly benefit of no less than $2,000.

The benefits are oriented toward higher-end services, such as inpatient hospitalization or partial hospitalization (in institutions with long-standing relationships to insurance). Outpatient services include those provided by a hospital, physician, mental health or chemical dependency treatment center, or licensed psychiatrist, psychologist, professional counselor, social worker, or addiction counselor. With the newer emphasis on community-based services and, especially for children, on in-home services, the "medical" model may be restrictive and in need of expanding to the services needed for effective treatment.

NCSL reports that 7% of adults and 5% to 9% of children have serious mental problems that last for more than a year and that about half of them have a chronic illness. These stricter lifetime limits for mental illness or substance abuse are easily exceeded for a small number of Montanans with chronic conditions. (NCSL, 2001)

Congress has addressed mental health parity, but the terms of the federal Mental Health Parity Act of 1996 result in little impact in Montana. That Act requires that annual or lifetime dollar limits on mental health benefits be no lower than any dollar limits in a group health plan. However, the federal law gives employers discretion regarding the extent and scope of mental health benefits, such as cost-sharing, limits on visits or days of coverage, and medical necessity requirements. It also does not apply to individual plans, nor does it apply if it would result in an increase in the cost of coverage of at least 1%. Most significantly, it doesn't apply to employers

who have between 2 and 50 employees on the payroll. In this state, 57% of the uninsured are employed by employers with between 2 and 50 employees. (State Planning Grant Final Report, 2004)

A study by Mathematica on Vermont's implementation of mental health and substance abuse parity concluded that employers did not drop health insurance coverage. Also, access to outpatient mental health services improved, consumer spending declined, and health plan spending did not rise substantially. The drawbacks were that access to substance abuse treatment declined, and consumers were apparently largely unaware of benefit changes and required more education. Vermont used managed care to help control costs, which was also found to be important in a study on the effect of federal mental health parity. (Rosenbach and Lake, 2003) Sufficient consumer education and controlling declines in substance abuse treatment levels would be relevant concerns in Montana.

Other studies report that most state parity laws are limited in scope or application and have had a minimum effect on premiums and that mental health costs have not shifted from the public to the private sector. Mental health restrictions commonly found include lower service limits (number of hospital days or outpatient office visits or higher cost-sharing). In 1997, the State Auditor of Hawaii studied the issue and found that the need and demand in Hawaii were not significant enough to warrant parity; less than 5% of the uninsured used benefits, and fewer than 7% reached limits. Yet, Hawaii passed parity laws in 1999 and in 2005, expanding the disorders that could be considered serious mental illness for the purposes of parity.

States that pass parity legislation do not experience a significant increase in the use of mental health services by the insured. However, in states wtih comprehensive parity legislation, there is a slight increase in use of services among those with poor mental health. Providing unlimited benefits (in a fee-for-service managed care plan) would be more expensive by about $1 per enrollee per year than setting a $25,000 annual limit. Plans with benefit limits of 30 inpatient days and 20 outpatient visits cost only about $7 per enrollee per year, less than those plans would be without limits. In a study of managed care plans with unlimited benefits for substance abuse, it was found that removing a $10,000 annual limit would result in a cost increase of 6 cents per member per year and that removing a $1,000 limit would merit an increase of $3.39 per member per year. (NCSL, 2001)

During NCSL's Web-Assisted Audioconference on “Mental Health Parity: Sound Investment or

Budget Buster?", one of the speakers stated that managed care was an important point in controlling costs for mental health parity. When asked how parity would work in a rural state without a lot of managed care, he stated that there was a greater risk of increasing expenditures and that managed care was important to keep costs down. However, even states without managed care have not experienced runaway costs, and it may indeed stimulate development of managed care in rural states. The managed care does not have to be elaborate, but can be as simple as a requirement to develop a treatment plan for extended outpatient visits past the first couple of visits.

The important variables in determining the cost of parity are the extent of the development of managed care, the current limits, who the target population is (the insured or those in poor mental health), and the amount of cost-shift to employees or to the public.

In attempting to insure the uninsured, costs of health care coverage are important factors in whether individuals or families can afford health insurance or whether employers will offer it. Costs also determine how many people may be eligible under government programs and the services. Any kind of mandate will contribute to the cost of insurance, but policymakers must balance concern over direct insurance costs with the costs or cost-shift of not providing services and the potential benefit of covered prevention and treatment of certain disorders. Other related concerns regarding mandates for parity for mental illness and substance use disorders in private health insurance are the services covered in government-funded programs, such as Medicaid, CHIP, prescription drug assistance, workers' compensation, and state or other government employee benefits.

An argument in favor of the use of parity is that it assists the small number of insured with excess costs when they reach the annual or lifetime limits on mental health services. It may also assist those with poor mental health to access more mental health services. It may stem the tide of the shift to public services for the costs that could be paid through private insurance and thereby keep uncompensated care or other societal costs of not receiving care down (public health and mental health systems, jails, county governments, and the criminal justice system). Arguments against parity are the potential increased costs that can raise premiums and discourage individuals from obtaining insurance coverage or employers from offering insurance coverage to

employees. States have also struggled with the difficulty of defining which mental disorders

should be covered.

Some options that may warrant future research and discussion are:

- the adequacy of the definition of mental illness or severe mental illness in the insurance code. How does it compare with the definition of "severe disabling mental illness" or "serious emotional disturbance" used by the public mental health system?
- the adequacy of the definition of outpatient benefits. Should it include other services, such as in-home services or other providers?
- the adequacy of limits for mental illness, alcoholism, and drug addiction for additional coverage. Is a change warranted at this time?
- the adequacy of current coverage for mental illness in government-funded health care, such as CHIP, Medicaid, the State Employee Health Plan, and the Montana Comprehensive Health Association Plan.

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