

# Toward Full Mental Health Parity And Beyond

Managed behavioral health care has made full parity affordable—and therefore thinkable.

by Daniel P. Gitterman, Roland Sturm, and Richard M. Scheffler

**ABSTRACT:** The 1996 Mental Health Parity Act (MHPA), which became effective in January 1998, is scheduled to expire in September 2001. This paper examines what the MHPA accomplished and steps toward more comprehensive parity. We explain the strategic and self-reinforcing link of parity with managed behavioral health care and conclude that the current path will be difficult to reverse. The paper ends with a discussion of what might be behind the claims that full parity in mental health benefits is insufficient to achieve true equity and whether additional steps beyond full parity appear realistic or even desirable.

68

PARITY &  
BEYOND

THE 1996 MENTAL HEALTH PARITY ACT (MHPA) was devised with a sunset provision to expire in September 2001. Although the rhetoric emphasized the removal of unfair barriers, the narrow scope of dollar limits (which permitted day and visit limits, as well as differential cost-sharing provisions) guaranteed that the actual effects were primarily symbolic rather than substantive. These were not unintended consequences.<sup>1</sup>

This paper examines what the MHPA accomplished and possible steps toward parity of mental health benefits with other medical coverage. We explain parity's strategic and self-reinforcing link with managed behavioral health care and conclude that the current path might be difficult to reverse. We end with a discussion of what might be behind the claims that full parity in benefits is insufficient to achieve true equity and whether additional steps beyond full parity appear realistic or even desirable.

## What Has The MHPA Accomplished?

Although the 1996 MHPA has been criticized for what it did not do, it did place parity on the agenda and enabled state legislatures to experiment with more-comprehensive parity provisions. A majority of states mandate full parity: Plans are prohibited from any terms,

.....  
*Daniel Gitterman is assistant professor of public policy, University of North Carolina at Chapel Hill. Roland Sturm is a senior economist at RAND in Santa Monica, California. Richard Scheffler is Distinguished Professor of Health Economics and Public Policy, University of California, Berkeley.*

conditions, or benefits that place a greater financial burden on access to diagnosis or treatment for mental health conditions than for other health conditions. However, the Employee Retirement Income Security Act (ERISA) of 1974 preemption limits the scope of state action and exempts self-insured plans from state regulation.

The first evaluations found no major effects of parity laws on mental health coverage, use of any mental health services or specialty services, or number of specialty visits by 1998.<sup>2</sup> Persons suffering from mental disorders even reported that access to care became more difficult and coverage got worse between 1996 and 1998, although this was before most state parity laws had taken effect.<sup>3</sup>

In states without full parity, the U.S. General Accounting Office (GAO) found that most employers were complying with the MHPA by 2000 but that other benefit limitations remained highly prevalent. That survey does not inform about full parity, because it did not include states with comprehensive parity laws.<sup>4</sup>

At the national level, preliminary data from the Healthcare for Communities employer survey found that there have been virtually no changes in the prevalence of limits over the past five years.<sup>5</sup> The main difference is that limits in 1995 and 1997 were split between dollar and day or visit limits, whereas in 2000 virtually all limits were on days or visits. In fact, only about one of five persons with employer-sponsored mental health insurance had no day or visit limits in 2000. Also, limits on coverage were very low: More than half of all plan members were covered for twenty or fewer outpatient visits, and about 60 percent, for thirty or fewer inpatient days. Limits are the most problematic differences in benefits because plans with limits partially insure people against smaller expenses but leave them at full risk for high expenses that exceed the limits. In fact, limits protect the insurer, not the insured person, against high costs.

Outpatient copayments for mental health and medical care also continue to differ. According to the same survey, four of five employees have medical copayments of less than \$20 per visit, but only two of five have mental health copayments of that amount. The others have visit copayments of \$20 or more or coinsurance.<sup>6</sup>

## What Is The Next Step?

It is becoming clear that more-comprehensive state parity laws will not lead to broad changes in employer-sponsored mental health coverage, largely because of ERISA. State statutory regulation affects many plans, but it fails to apply to a large proportion of the population. Thus, full parity in mental health benefits in the private sector is unlikely to happen unless the 1996 MHPA is amended. The 107th Congress now faces a set of choices: (1) allow the sunset of

mental health parity; (2) reauthorize parity in its current form; (3) mandate parity and require all group plans to provide equal coverage; (4) mandate “full” parity if coverage is already offered—that is, in addition to annual and lifetime dollar limits, require the same inpatient day and outpatient visit limits, deductibles, and out-of-pocket maximums in mental health benefits as in medical and surgical benefits; or (5) end or amend the small-employer and 1 percent claim increase exemption.

The 2001 Mental Health Equitable Treatment Act (S. 543), co-sponsored by Sen. Pete Domenici (R-NM) and Sen. Paul Wellstone (D-MN), is a step toward full parity. This amendment provides that plans offering mental health coverage cannot impose treatment limitations or financial requirements on mental health benefits unless comparable restrictions are imposed on medical and surgical benefits. The treatment provision prohibits restrictions on frequency of treatment, number of visits or days covered, or other limits on the duration or scope of treatment; the financial provision precludes use of different deductibles, coinsurance, copayments, and other cost sharing. Mental health benefits refer to services for all mental health conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR). The small-employer exemption is limited to firms of twenty-five or fewer.<sup>7</sup>

Policymakers are risk-averse and reluctant to make large changes because of the unpredictability of consequences, especially cost. As a result, the failure or success of parity legislation often hinges on its estimated or perceived cost. A big change in the congressional policy environment since the 1996 MHPA debate is that policymakers have increasingly accepted that full parity in benefit design is feasible without dramatically raising costs within the context of comprehensively managed care.<sup>8</sup> In contrast, during debates on the 1996 MHPA, legislators had to rely on calculations by the Congressional Research Service (CRS), which lacked data about managed care. The resulting estimates turned out to be higher by a factor of 4–8 than the actual costs in managed care plans that had already implemented parity or calculations based on newer managed care data.<sup>9</sup>

## Parity And Managed Behavioral Health Care

Parity and managed behavioral health care have been linked in a self-reinforcing sequence, which has changed the policy terrain and led us down a particular path that might be irreversible. Early stages in a sequence can place particular aspects of policy onto distinct tracks, which are then reinforced through time. Parity has been a path-dependent sequence, starting with minimum mental health benefit mandates in the 1970s and 1980s. States began to experiment

with parity for state employees in the early 1990s, and five states moved on parity before the 1996 MHPA; Congress enacted the MHPA; states matched the MHPA or opted for full parity; and President Bill Clinton issued an executive order and implemented full parity in the Federal Employees Health Benefits Program (FEHBP). Employers, plans, and insurers reacted to each step, often with a shift to managed care, resulting in none of the adverse consequences claimed by opponents to the initial legislation. This in turn set the stage for further policy developments, encouraging further growth of managed behavioral health care.

The economic and political interests of buyers, sellers, providers, and advocates are important to our understanding of why parity and managed care are linked. Mental health advocacy groups, such as the National Alliance for the Mentally Ill (NAMI), are fully aware of the consequences of increased managed care yet have found this trade-off for patient financial protection to be very attractive. In fact, NAMI and the American Managed Behavioral Healthcare Association (AMBHA)—the trade organization of managed behavioral health care plans, or carve-outs—joined together as founding members of the Coalition for Fairness in Mental Illness Coverage. Provider groups, aware of possible implications for clinical autonomy and incomes, certainly do not oppose policies that appear to protect patients and expand access to mental health services. Now that even some of the largest employers and business groups support (or at least do not oppose) the idea of parity-level benefits, the traditional insurance industry (and to a lesser extent traditional health maintenance organizations, or HMOs) are left as the primary opponents of mental health parity.<sup>10</sup>

In several states, legislatures included specific language permitting mental health benefits to be delivered under a managed care system.<sup>11</sup> Twenty-one states wrote specific provisions to encourage the use of managed care or allow for use of incentives to encourage in-network rather than out-of-network care. In implementing President Clinton’s executive order on parity in the FEHBP, the Office of Personnel Management (OPM) encouraged health plans to manage mental health care and to use carve-outs or consider other managed care approaches.

**Beyond Full Parity**

Many observers have commented that rationing through the supply side drives a wedge between nominal benefits (coverage defined by parity regulation) and the effective benefits (services actually received by a beneficiary).<sup>12</sup> The NAMHC (1997) predicted early that “partial or full parity generates strong incentives for plans to replace

the loss of demand side tools with new mechanisms on the supply side.” This is not unique to mental health, as unmanaged health benefits have largely disappeared outside Medicare.<sup>13</sup>

However, what differs between mental health and medical care is the management of care. In contrast to the primary care gatekeeping model (the prevalent managed care mode for most medical services), carve-outs provide incentives to use a larger range of techniques, including concurrent utilization review by clinical care managers, guideline implementation, and disease management systems. Moreover, carve-outs use a different mix of mental health providers (such as social workers and psychologists) and services than traditional indemnity plans use.<sup>14</sup> (Indemnity plans generally excluded intermediate type of services from coverage, such as intensive outpatient or day hospitalization.) Also, carve-outs encourage time-limited versus long-term treatments and favor alternatives to inpatient care. As a consequence, carve-outs have been more successful in controlling costs than HMOs have been, many of which are now subcontracting benefits to a managed behavioral health care plan. During 1992–1998 the number of enrollees in these plans more than doubled, from fewer than 80 million in 1992 to about 160 million in 1998, and the three largest managed behavioral health care organizations (Magellan, Value Options, and United Behavioral Health) cover more than 100 million Americans.<sup>15</sup>

The move to carve-outs in the private sector appears to have had positive effects: Costs have been contained, while access to any behavioral specialty care has tended to remain constant or even increase.<sup>16</sup> The picture is gloomier in terms of cost savings in the public sector, although the bleakest results come from systems in which care is not really managed but providers are put at full risk in the absence of external oversight.<sup>17</sup> Among private-sector plans, quality—measured by the National Committee for Quality Assurance (NCQA) indicators of follow-up care after inpatient discharge and rehospitalization rates—appears better under carve-outs than under other arrangements.<sup>18</sup> Carve-outs offer direct access to specialists and reduce the reliance on primary care gatekeeping. Quality of care for mental health in primary care has been problematic, with low detection rates of mental illness, low rates of guideline-concordant care among detected cases, and large variations in quality across practices.<sup>19</sup>

However, there is growing opposition to specialized care management. Following the lead of the American Psychiatric Association, the American Medical Association (AMA) has defined managed behavioral health care through carve-outs as discriminatory in principle.<sup>20</sup> The AMA suggests that behavioral health care should be

*“By confronting the MHPA sunset, Congress is likely to take one more step toward ‘full’ mental health parity.”*

managed and administered as other health care services are. This suggests not a next sequential step, but either returning to a prior equilibrium of limited mental health benefits (as it destroys the policy bargain) or shifting managed care into a new positive direction with greater integration of mental health with primary care.

Kevin Hennessey and Howard Goldman (in this volume) echo this sentiment and claim that full parity in benefit design represents a “sequential” step rather than a final stop on the journey toward achieving equity. They seem to suggest that policymakers need to pay more attention to how the disparity between nominal and effective benefits differs from medical care but do not provide a diagnosis or treatment plan for these potential ailments.<sup>21</sup>

This leaves Congress in a real bind as it confronts the political economy of mental health parity. Managed behavioral health care, meaning carve-outs, has made parity more affordable and increased the probability that pivotal policymakers will support it.<sup>22</sup> But now we are told that full parity in benefits is an insufficient next step and that it may even exacerbate discrimination.

What is the likely source of these warnings about inequity caused by specialization in managed care? A big chunk of the reduction in mental health care costs has been through lower payments to providers, part of selective contracting and market power. For example, when Pacific Bell carved out behavioral health care, the costs per outpatient visit dropped by 13 percent, and the costs per inpatient day, by 40 percent.<sup>23</sup> Thus, managed behavioral health care has led to an income redistribution from providers to purchasers (and eventually employees). As compared with rationing care, using contractual rates rather than “usual and customary” charges does not hurt patients.

However, these redistributive consequences may be of primary concern to provider organizations. The AMA resolution deplors that “the carve-out phenomenon has resulted in a disproportionate reduction in resources allocated for mental health and chemical dependency treatment” and that psychiatry was “the canary in the mineshaft.” Thus, the attempt to link behavioral managed care to discrimination is also intended to be a preventive step toward stopping the “spread of medical carve-outs.”<sup>24</sup>

■ **Toward full parity and beyond.** As of press time, the 107th Congress had yet to revisit the 1996 MHPA; the power shift in the

Senate made the scheduling of hearings uncertain. If Congress permits the MHPA to sunset by not acting before 30 September 2001, employers and insurers in states that have not passed their own parity laws may revert to pre-parity inequities. There is now a multitier system of mental health parity mandates in place, and the actual legal status of mental health benefits in health plans varies from state to state. By confronting the MHPA sunset, Congress is likely to take one more step toward "full" mental health parity; to encourage further innovation and experimentation in state legislatures; and to require further GAO evaluation of the impact of expanded parity on costs, access, and quality.

If revisiting the 1996 MHPA were only an incremental rather than a final step toward the broad goal, however, one wonders what could be more likely sequential next steps. Congress's action on a patients' bill of rights could also have implications for consumers in managed behavioral health care. Fifteen mental health professional organizations are also pushing a Mental Health Patient Bill of Rights that sets forth fundamental principles necessary to ensure high-quality mental health care and to protect the rights of those seeking mental health and substance abuse treatment.<sup>25</sup>

An alternative step beyond full parity might be direct regulation of managed care practices, but this appears to be costly, complex, difficult to monitor, and possibly a legal morass that no politician wants to be associated with. A final step is vast improvement in measuring the quality of mental health services and the performance of managed behavioral health care plans. There remain barriers to care in managed behavioral health care. Small steps to protect consumers in managed behavioral health care plans are far more likely to succeed than is returning to the earlier fee-for-service system or even trying to prevent specialization in managed care.

Parity in benefits reduces the financial risk to individuals and maintains the insurance function that was somewhat undermined by moral hazard and adverse selection in the past. This is a positive step made possible by the policy bargain. Much less clear is whether additional steps that recreate the original problems by negating managed care are in the interest of patients or payers.

---

*The authors gratefully acknowledge support from the Robert Wood Johnson Foundation (RWJF), sponsor of the HealthCare for Communities studies, and the National Institute of Mental Health (NIMH) grant (MH-18828-11) to the University of California, Berkeley, Center for Mental Health Services Research. They also acknowledge their collaboration with Rosalie Liccardo Pacula and Marcia Peck. The views expressed do not necessarily represent the perspective of the RWJF or NIMH.*

## NOTES

1. In a compromise worked out between Senate Majority Leader Trent Lott (R-MS) and House Speaker Newt Gingrich (R-GA), provisions were added to exempt small employers and to clarify that the MHPA was not a mental health mandate. See CQ Almanac, 104th Cong., 2d sess., Vol. LII (1996), 10–91. Also, see R.G. Frank, C. Koyanagi, and T.G. McGuire, “The Politics and Economics of Mental Health ‘Parity’ Laws,” *Health Affairs* (July/Aug 1997): 108–119.
2. R. Sturm and R.L. Pacula, “State Mental Health Parity Laws: Cause or Consequence of Differences in Use?” *Health Affairs* (Sep/Oct 1999): 182–192; R.L. Pacula and R. Sturm, “Mental Health Parity Legislation: Much Ado about Nothing?” *Health Services Research* (February 2000): 263–275; and R. Sturm, “State Parity Legislation and Changes in Health Insurance and Perceived Access to Care among Individuals with Mental Illness: 1996–1998,” *Journal of Mental Health Policy and Economics* (forthcoming).
3. R. Sturm and K. Wells, “Health Insurance May Be Improving—But Not for the Individuals with Mental Illness,” *Health Services Research* (February 2000): 253–262.
4. See U.S. General Accounting Office, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited*, Pub. no. GAO/HEHS-00-95 (Washington: GAO, 2000).
5. R. Sturm and R.L. Pacula, “Datapoints: Mental Health Parity and Employer-Sponsored Health Insurance in 1999–2000: I. Limits,” *Psychiatric Services* 51, no. 11 (2000): 1361.
6. R. Sturm and R.L. Pacula, “Datapoints: II. Co-Payments and Coinsurance,” *Psychiatric Services* 51, no. 12 (2000): 1487.
7. U.S. Senate, *Mental Health Equitable Treatment Act of 2001* (S. 543).
8. National Institute of Mental Health, *Insurance Parity for Mental Health: Cost, Access, and Quality: Final Report to Congress by the National Advisory Mental Health Council* (Rockville, Md.: U.S. Department of Health and Human Services, June 2000).
9. R. Sturm, “How Expensive Is Unlimited Mental Health Care Coverage under Managed Care?” *Journal of the American Medical Association* 278, no. 18 (1997): 1533–1537; R. Sturm et al., “How Expensive Are Unlimited Substance Abuse Benefits under Managed Care?” *Journal of Behavioral Health Services and Research* 26, no. 2 (1999): 203–210; and P.B. Peele et al., “Benefit Limits in Managed Behavioral Health Care: Do They Matter?” *Journal of Behavioral Health Services and Research* 26, no. 4 (1999): 430–441.
10. Washington Business Group on Health, *Large Employer Experiences and Best Practices in Design, Administration, and Evaluation of Mental Health and Substance Abuse Benefits: A Look at Parity in Employer-Sponsored Health Benefit Programs* (Washington: WBGH, March 2000).
11. D. Gitterman et al., “Why Mental Health Parity in the U.S.? Political and Economic Determinants of Policy Change” (Paper presented at the Tenth NIMH Biennial Research Conference on the Economics of Mental Health, “Economics of Parity for Mental Health,” Washington, D.C., 18–19 September 2000).
12. See Frank et al., “The Politics and Economics of Mental Health ‘Parity’ Laws”; M.A. Burnam and J.J. Escarce, “Equity in Managed Care for Mental Disorders,” *Health Affairs* (Sep/Oct 1999): 22–31; D. Mechanic and D.D. McAlpine, “Mission Unfulfilled: Potholes on the Road to Mental Health Parity,” *Health Affairs* (Sep/Oct 1999): 7–21; R. Frank and T. McGuire, “Economics and Mental Health,” in *Handbook of Health Economics*, vol. 1, ed. A.J. Culyer and J.P. Newhouse (New York: Elsevier Science, 2000); and R. Frank and T. McGuire, “Parity for



- Mental Health and Substance Abuse Care under Managed Care," *Journal of Mental Health Policy and Economics* 1, no. 4 (1998): 153-159.
13. J.R. Gabel et al., "Withering on the Vine: The Decline of Indemnity Health Insurance," *Health Affairs* (Sep/Oct 2000): 152-157.
14. R.M. Scheffler, S.L. Ivey, and A.B. Garrett, "Changing Supply and Earnings Patterns of the Mental Health Workforce," *Administration and Policy in Mental Health* (November 1998): 85-99.
15. R.M. Scheffler, "Managed Behavioral Health Care and Supply-Side Economics," *Journal of Mental Health Policy and Economics* 2, no. 1 (1999): 21-28.
16. K.L. Grazier et al., "Effects of a Mental Health Carve-Out on Use, Costs, and Payers: A Four-Year Study," *Journal of Behavioral Health Services and Research* (November 1999): 381-389; and W. Goldman, J. McCulloch, and R. Sturm, "Costs and Use of Mental Health Services Before and After Managed Care," *Health Affairs* (Mar/Apr 1998): 40-52.
17. K. Kapur et al., "The Economic Impact of Capitated Care for High Utilizers of Public Mental Health Services: The Los Angeles PARTNERS Program Experience," *Journal of Behavioral Health Services and Research* (November 1999): 416-429; and W.G. Manning et al., "Outcomes for Medicaid Beneficiaries with Schizophrenia under a Prepaid Mental Health Carve-Out," *Journal of Behavioral Health Services and Research* (November 1999): 442-450.
18. E.L. Merrick, "Treatment of Major Depression Before and After Implementation of a Behavioral Health Carve-Out Plan," *Psychiatric Services* 49, no. 11 (1998): 1563-1567; and B. Stein et al., "The Effect of Copayments on Drug and Alcohol Treatment following Inpatient Detoxification under Managed Care," *Psychiatric Services* (February 2000): 195-198.
19. K.B. Wells et al., *Caring for Depression* (Cambridge, Mass.: Harvard University Press, 1996); W. Katon et al., "Are There Detectable Differences in Quality of Care or Outcome of Depression across Primary Care Providers?" *Medical Care* (June 2000): 552-561; and K.B. Wells et al., "Quality of Care for Primary Care Patients with Depression in Managed Care," *Archives of Family Medicine* (Nov/Dec 1999): 529-536.
20. AMA House of Delegates, Resolution 702: Elimination of Mental Health and Chemical Dependency Carve-Outs, 26 October 2000, <www.ama-assn.org/meetings/public/interim00/reports/rcg/702.doc> (20 January 2001); and M. Galanter et al., "The Impact of Managed Care on Substance Abuse Treatment: A Report of the American Society of Addiction Medicine," *Journal of Addictive Disorders* 19, no. 3 (2000): 13-34.
21. K.D. Hennessy and H.H. Goldman, "Full Parity: Steps toward Treatment Equity for Mental and Addictive Disorders," *Health Affairs* (July/Aug 2001): 58-67.
22. Gitterman et al., "Why Mental Health Parity in the U.S.?"
23. Goldman et al., "Costs and Use of Mental Health Services."
24. American Medical Association, "AMA Wants Insurers to End Mental Health Carve-Outs," *amednews.com*, 25 December 2000, <www.ama-assn.org/scipubs/amnews/pick\_00/bisb1225.htm> (20 January 2001).
25. American Psychological Association, "Mental Health Patient's Bill of Rights," no date, <www.apa.org/pubinfo/rights/rights.html> (16 April 2001).