Pro/Con Analysis of SB07-36

For the Health District of Northern Larimer County Board of Directors

Bill Title: Concerning the Inclusion of Certain Additional Mental Disorders in the Mandatory Health Insurance Coverage for Mental Illness

Issue Summary: The bill would require health plans offering mental health care to implement full parity for all mental disorders. The bill would not affect small group, nongroup or self funded health plans.

Date of Overview: February 7, 2007

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Background

SB07-36 requires health insurance plans to cover mental disorders as defined in the 9th revision of the international classification of diseases (ICD-9). Under current law, group health care policies are subject to mandatory coverage provisions which require coverage of "biologically based mental illness and mental disorders" defined as schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. The law does not apply to small group and nongroup health insurance policies or to health plans that are self funded. The bill would expand the definition of mental disorders covered under a policy to any condition defined as a mental disorder in the International Classification of Diseases, Ninth Revision (ICD-9), excluding the codes for homosexuality and tobacco use disorder.

What Do We Mean by Parity?

Parity can have a number of definitions and parity laws in the states vary considerably. The federal Mental Health Parity law merely eliminated dollar limits on mental health care that were more restrictive than those for medical care. State laws regarding parity sometimes only provide parity for certain biologically based mental disorders, usually schizophrenia, bipolar disorder, major depression and obsessive compulsive disorder. In the context of this analysis and much of the research on mental health and substance abuse parity, we regard full, comprehensive parity to mean a law or legislation that eliminates health plan benefit designs that are more restrictive for mental health and substance abuse than for medical benefits and that compel coverage of the full range of mental disorders including all mental disorders in the ICD-9 codes.

Current Federal Law

In 1996 Congress passed the Mental Health Parity Act. The law applied to businesses with over 50 employees and prohibited annual or lifetime dollar limits on mental health services that were less than the limits for medical services. Small businesses, the nongroup market and group plans that experienced an increase in claims costs of greater than 1% were exempted. The law did not address health plan restrictions on mental health services such as inpatient days or outpatient visits that were more restrictive than limits for medical services. In 2000, the United States General Accounting Office (GAO) completed an evaluation of the impact of the 1996 law, specifically examining the extent to which employers were complying with the law, the effect on claims costs and what federal agencies had done to ensure compliance. The GAO report found that the law had a "negligible effect" on claims costs. However, the majority of employers who were complying with the law with regard to the dollar limit prohibition had plans that contained more restrictive mental health benefits than medical benefits. None of the employers surveyed by the GAO had dropped coverage of either mental health or health benefits since the adoption of the law.

This year Congressman Patrick Kennedy (D-RI) and Congressman Jim Ramstad (R-MN) will reintroduce federal legislation to require group health plans to cover mental health and substance abuse treatment on the

same terms that medical services are covered. The law will prohibit health plans from charging higher copayments or deductibles or imposing lower hospital days or outpatient visits than are provided for medical services.

Experiments in Full Parity

In 1999, President Clinton directed the Office of Personnel Management to implement parity for mental health and substance abuse treatment in the Federal Employees Health Benefit Program (FEHBP). Health plans were encouraged to manage care. In 2006 the New England Journal of Medicine published a study of the implementation of comprehensive parity in the FEHBP.[1] The study compared 7 FEHBP plans with a matched set of plans that did not have comprehensive parity for mental health and substance abuse services. The study concluded that in the context of managed care there was no evidence of a significant increase in spending due to the implementation of parity. In addition, comprehensive parity significantly lowered plan participant's out-of-pocket spending. Finally, the authors found that although there was an increase in the use of mental health services after the implementation of parity, this increase was consistent with secular trends and could not be attributed to parity implementation.

Why is this issue important?

The impact of mental illness on individuals, families and our society cannot be overstated. The World Health Organization conducted its Global Burden of Disease study and found that mental illness ranks second in the burden of disease in established market economies.[2] The Surgeon General's report noted that, "Untreated, mental disorders can lead to lost productivity, unsuccessful relationships, and significant distress and dysfunction. Mental illness in adults can have a significant and continuing effect on the children in their care."[3]

Reasons to support bill:

- This is an issue of basic fairness. People who purchase health insurance should not have to pay more or have benefits limited simply because they have a disease of the brain.

- The body of research available on the impact of full parity indicates that implementing parity does not raise costs or raises costs a negligible amount. A 2006 review of the impact of parity in the context of managed care published in *Health Affairs* concluded, "…the relevant research implies that parity implemented in the context of managed care would have little impact on mental health spending and would increase risk protection."[4] The authors went even further concluding "…opposition to parity on the basis of increased total spending no longer constitutes an evidence-based objection."

- Available evaluations of the effect of comprehensive parity indicate that out-of-pocket spending for health plan members is significantly reduced.

- Even in light of the fact that an increase in required benefits may result in a small rise in costs causing some people to drop coverage, the overall net benefit from parity is likely to be great enough to justify it. The potential cost offsets in medical care realized when parity is implemented combined with potential benefits to businesses in terms of increased productivity of workers would likely result in a net cost savings. In addition, the potential cost savings to society as a result of increasing access to mental health and substance abuse treatment should be considered when thinking about the net effects of parity.

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[1] Goldman, H.H., Frank, R.G., et al, *Behavioral Health Insurance Parity for Federal Employees*, New England Journal of Medicine, 354:13, March 30, 2006

[2] Mental Health: A Report of the Surgeon General. 1999

[3] Ibid.

[4] Barry, C.L., Frank, R. G., and McGuire, T.G., *The Costs of Mental Health Parity: Still an Impediment?*, Health Affairs, Vol. 25, No. 3, May/June 2006

In other words, rising health insurance premiums are a problem but that concern alone does not provide a strong enough reason to reject parity.

Reasons to oppose bill:

- The objection to parity is that it is a mandated benefit that will increase costs. These additional costs will lead to a loss of coverage for some people.
    - At the Mental Health Caucus and the Senate State, Veterans and Military Affairs Committee hearing on February 5, members referred to a statistic that a 1% increase in premiums resulted in some unspecified increase in uninsured. It is possible that members are referencing a 1997 study by the Lewin Group prepared for the American Association of Health Plans which calculated that a 1% real increase in premiums would result in a coverage loss of 427,000 persons. In 1999, the Lewin Group revised the estimate based on improved methodology and concluded that a real increase in premiums of 1% would result in a loss of coverage for 293,000. Similar studies have found a similar estimate.[5]

- While there have been studies on the cost impact of comprehensive parity, there is no research examining the impact of behavioral health managed care carve-outs on mental health treatment quality. We do not know what the impact of managed care carve-outs have on the quality of care people are accessing. In examining available research, it is possible to hypothesize that managed care carve-outs achieve savings by moving more patients from inpatient to outpatient care.

- Available research has not found that parity has a dramatic affect on access to mental health treatment.[6] There may be a number of reasons for this, including the stigma associated with obtaining mental health treatment.

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. Analyses are based on bills or issues at the time of their consideration by the Board and are accurate to the best of staff knowledge. It is suggested that people check to see that a bill has not changed during the course of a legislative session by visiting the Colorado General Assembly web page at www.state.co.us/gov_dir/stateleg.html. To see whether the Health District Board of Directors took a position on this or other policy issues, please visit www.healthdistrict.org/policy.

About the Health District

The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves.

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[5] Gilmer, T. and Kronick, R., *It's the Premiums, Stupid: Projections of the Uninsured Through 2013*, Health Affairs Web Exclusive, April 5, 2005

[6] Goldman