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Mental Health Parity: A Brief Policy Analysis

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According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2002 National Survey on Drug Use and Health (NSDUH), more than five million individuals meeting criteria for serious mental illness "perceived themselves as having an unmet need for treatment in the year prior to the survey" (Bender, 2003). Of these, almost half cited inability to afford treatment as the primary reason for their needs not being met. This means that mentally ill individuals who want appropriate treatment but are unable to afford it constitute more than one percent of the entire adult population of the United States, a condition which represents a public health crisis and should be addressed.

There are a number of ways in which this issue can be conceptualized and corresponding actions which can be taken. One way in which legislators and advocacy groups have attempted to remedy the problem is through the proposal and institution of "parity" measures for mental health service coverage as it applies to American workers and other insurance consumers. Mental health parity, as an ideal, would make mental health and substance abuse services available to consumers on a level equal to the availability of general medical and surgical services. This can be accomplished either by forcing employers to add the additional benefits onto their group insurance plans, or by forcing insurance companies to include equal mental health coverage as a standard part of all health plans that they offer. The purpose of this analysis is to examine the arguments for and against mental health parity as well as the implications of the available alternatives.

Issues & Arguments

Advocates of mental health parity measures like U.S. Senator Paul Wellstone (2002) argue that failure to offer equal coverage for mental illness constitutes a form of discrimination much like that which was practiced by insurers against patients diagnosed with HIV/AIDS before legislative intervention was enacted. He points out that under the most common health care plan in New York City, a firefighter suffering from an injured back and PTSD both acquired at ground zero would enjoy full coverage for his back treatment, but coverage for only 20 psychotherapy sessions per year regardless of how devastating the symptoms of PTSD might be for him.

Opponents of parity legislation like Anthony J. Knettel, vice president for health affairs for the ERISA Industry Committee, argues that full parity is essentially a blank check for mental health care providers to seek reimbursements for treatment of transient and non-serious conditions such as jet lag, caffeine addiction, and voyeurism (Carroll, 2004). American Psychiatric Association President Paul Appelbaum, MD describes this argument as a red herring, explaining that “the status quo for people who have coverage is that DSM-IV is the guiding diagnostic manual. Both now and under the proposed legislation, insurers would still determine whether medical necessity [for treatment for a DSM-IV-listed condition] exists — a task they have never had difficulty performing” (Carroll, 2002). Furthermore, an analysis conducted by the American Managed Behavioral Healthcare Association (AMBHA) found that 85% of mental health claims submitted by providers are for serious mental illnesses, with lesser disorders such as jet lag and night terrors constituting only 0.006 percent of claims, totaling about \$32 for every million dollars in claims. An analysis by the largest managed behavioral health care company,

Magellan Health Services, estimated that the total cost of mental health services is likely to increase by about 20% if full parity is introduced. This figure represents a total cost increase of only about 1.5% for most managed care organizations (Carroll, 2002), and is consistent with the increases that have been realized in the 38 states that have already enacted mental health parity legislation.

Opponents of comprehensive parity legislation argue that with any insurance regulation, the workers affected by the legislation are sure to lose some of their other, unprotected benefits in order to restore costs to their previous levels. This has largely been the case with the passage of the Mental Health Parity Act of 1996 (MHPA), which simply disallowed employers from setting lower lifetime or annual dollar limits for mental health services than for general medical or surgical benefits, and did not require parity for co-payments, deductibles, out-of-pocket payments, or caps on the number of inpatient or outpatient visits. The National Association of Social Workers reports that the “U.S. General Accounting Office reported in May 2001 that 86 percent of employers surveyed reported that they had complied with the requirements of the 1996 Act. Nevertheless, the vast majority of those employers substituted new restrictions on mental health benefits, thereby evading the spirit of the law” (NASW, 2002, Background and legislative history section, ¶ 10).

Additionally, the 1996 Act did not make any provisions for the treatment of substance abuse or chemical dependency disorders, despite these disorders potentially presenting the largest economic impact of all mental illness. The U.S. Office of National Drug Control Policy estimated the total economic cost of drug abuse in the U.S. at nearly \$181 billion. This figure reflects the often severe and expensive direct health consequences of drug and alcohol abuse,

secondary health impact on the families of drug and alcohol abusers, as well as the impact of lost productivity in the workplace.

Drug abuse is not the only type of psychological disorder with a demonstrable impact on physiological health or medical service utilization. O'Donohue & Cucciare (2005) report that "research consistently shows that patients with psychological problems use more [medical] services than those without diagnosable psychological problems." One recent four-year follow-up study of the influence of psychological comorbidity on medical rehospitalization found that psychological factors such as depressive or aggressive tendencies double both rates of readmission and the number of days of inpatient care utilized for patients admitted for the treatment of physiological conditions (Saravay, Pollack, Steinberg, Weinschel, & Habert, 1996).

Mumford, Schlesinger, Glass, Patrick, & Cuerdon (1998) describe a history of research demonstrating the effects of psychotherapy on medical service utilization going all the way back to 1965. They conclude:

Retrospective analysis of health insurance claims data and meta-analyses of time-series studies and prospective controlled experimental studies converge to provide evidence of a general cost-offset effect following outpatient psychotherapy. The widespread and persistent evidence of reduced rate of increase of medical expense following mental health treatment argues for the inseparability of mind and body in health care, and it also argues specifically for the likelihood that mental health treatment may improve patients' ability to stay healthy enough to avoid hospital admission for physical illness.

The clearest cost-offset effect appears largely in the reduction of inpatient rather than outpatient costs. As we noted in an earlier study, inpatient charges account for 75% of total medical charges and substantial savings would have to result from reduced hospitalization (p.85).

Alternatives

Opponents argue that rising health costs are already creating such an economic strain that it is unreasonable to mandate additional coverage of any kind, and so suggest that no change be made to current policy. However, such economic factors have not halted the enactment of previous legislation aimed at curtailing discriminatory insurance practices for the elderly or for HIV-positive individuals, and a similar moral issue exists in the case of individuals suffering from mental illness. A survey conducted by the American Psychological Association (n.d.) found that 85% of Americans believe that health insurance policies should cover mental health services, an indication that the vast majority of citizens see mental health care as legitimate and necessary.

Furthermore, a well-established body of research demonstrates that psychotherapy utilization has an inverse correlation with utilization of general medical services, particularly on inpatient care, which is far and away the most expensive variety of medical service. Based on this research, it is reasonable to conclude that increasing the availability of mental health services is a fast and effective means of decreasing the overall financial burden of medical costs and of improving the availability of medical services. In this context, it is difficult to see a downside to increased mental health coverage for governments, consumers, or payers.

Therefore, we are left with essentially two alternatives: to affect change directly through the insurance companies by establishing a legislative mandate for equitable mental health

coverage on all medical insurance policies; or to affect change through employers by establishing a mandate for increase mental health coverage on group plans, as was attempted in 1996 with the passage of the Mental Health Parity Act. The major problem with this latter approach, as occurred after the passage of the MHPA, is the inevitability of cost increases being accommodated for by decreases in other, non-mandated benefits.

Based on extensive data from various state-enacted parity mandates, it is reasonable to expect a total immediate increase in overall medical service utilization cost of no more than 1-2% were parity enacted at a federal level. As we have already discussed, there are very good reasons to believe that even over a relatively short term, these cost increases will be at least offset by corresponding decreases in general medical service utilization. This represents a direct financial benefit to healthcare payers.

A review of the literature reveals a far less robust research base related to the existence or nonexistence of productivity increases secondary to mental health service utilization. It is unreasonable to mandate that businesses pay increased insurance rates for the inclusion of services which are likely to decrease the total utilization of benefits when they are not likely realize any direct returns and, in fact, are almost certain to pay higher premiums regardless of this decrease. It is not unreasonable, however, to mandate that insurance providers offer equal benefits for mental illness, particularly when it is likely to result in a decrease in overall cost of service. This more direct approach to achieving mental health parity is likely to enjoy the benefit of being more easily enforceable, as it affects fewer organizations and is less prone to loopholes, and can therefore be more easily monitored to determine the actual costs and benefits of the mandate.

It is therefore recommended that the federal government establish a mandate for insurance providers and all other medical service payers—including all self-insured businesses—to place no economic limitation on mental health service benefits beyond that which is placed on general medical or surgical services, including co-payments, deductibles, out-of-pocket payments, caps on the number of inpatient or outpatient visits, or annual or lifetime dollar limits. It is furthermore recommended that this mandate encompass all treatments for psychological conditions causing significant occupational, educational, personal, or social impairment, including substance abuse and chemical dependency disorders.

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