

## health policy prescriptions

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## The Stealth Mental Health Parity Act: An Attack on Innovation and Choice in Health Care

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- The freshly passed Wellstone-Domenici Mental Health Parity Act, which was loaded onto Congress' bailout bill for Wall Street, demonstrates why government should not be allowed to determine health benefits.
- While Wellstone-Domenici alone is not very expensive and may be redundant for many large groups, it adds to an already sky-high pile of health benefits which the government orders but individuals must pay.
- By forcing the design of mental health and substance-abuse benefits into a straightjacket, the government interferes with the ability of providers, patients, and payers to best navigate this complex area of health care.

If anyone wonders why the government should not decide which benefits health plans must provide, let him observe the troubled birth of the "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008." Wellstone-Domenici had languished in Congress for a full 16 years and got passed as part of the Wall Street bailout bill chaotically rushed into law earlier this month.

We already have a federal Mental Health Parity Act, passed in 1996. Like the new law, it controls health benefits for groups of at least 50 persons, and does not require health plans to offer benefits at all. However, if a plan does offer mental health benefits, the original law requires only that annual or lifetime dollar limits on those benefits be at least equal to those for medical or surgical benefits. Nor does it apply to substance abuse or chemical dependency. This was not good enough for advocates of a stricter definition of mental health parity, who demanded that treatment limits, co-payments, and deductibles should be exactly the same for mental health benefits as medical and surgical benefits. They also demanded that mental health benefits include treatment for substance abuse.

Like any bill, this one was supported by heavy lobbying, but also by legislators with a significant personal stake in the issue. Senator Paul Wellstone first introduced the bill in 1991, speaking "passionately and frequently

about his family illnesses and the difficulty in finding adequate insurance coverage to protect against this kind of catastrophic illness," according to former U.S. Senator Dave Durenberger. Republican Senator Pete Domenici became a supporter because of his mentally ill daughter. Another ally was Republican congressman Jim Ramstad who, according to Senator Durenberger, "walked out of a Sioux Falls, SD drunk tank in 1982 right into addiction treatment and he's been helping others with similar ills ever since."

Senator Wellstone died in a plane crash in 2002, leaving his allies to move the bill forward. In 2007, it was re-introduced in the House by Representative Patrick Kennedy, whose alcoholism led him to a car crash on Capitol Hill in 2006.<sup>2</sup> Representative Kennedy successfully moved the bill through the House and it was sent to the Senate last March. Since then, lobbyists from every relevant interest group have shaped it so that it was gradually becoming acceptable to all of them: health plans, employers, advocates, doctors, as well as a number of senators.<sup>3</sup>

And then, for some reason, the entire Emergency Economic Stabilization Act (HR 1424) was piled on top of it, and it moved immediately through the Senate to the President of the United States for signature. (Actually, it was likely because the Constitution requires that spending bills originate in the House, which initially failed to pass the bailout bill. In order for the Senate to seize the initiative, it had to load the bailout onto a bill that the House had previously sent over.)

On its own, Wellstone-Domenici is not very expensive. Nevertheless, it carries a significant cost. Last November, the Congressional Budget Office (CBO) estimated that it would increase spending of \$1.3 billion this year, or 0.4 percent of premiums for those insured in large groups. However, this estimate is before "accounting for the responses of health plans, employers, and workers to the higher premiums that would be charged under the bill. Those responses would include reductions in the number of employers offering insurance to their

employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered (including eliminating coverage for mental health benefits and/or substance abuse benefits), and reductions in the scope or generosity of health insurance benefits, such as increased deductibles or higher co-payments." The CBO expects that more than half of the cost of the mandate will be borne through these adjustments, so that only 0.2 percent of the costs will show up in increased premiums for those who retain coverage with mental health benefits.<sup>4</sup>

This might not look like a big contributor to health care spending. However, the federal mandate intertwines with other mental health mandates passed by the states. The federal parity mandate describes the minimum government interference. If state mental health mandates are more burdensome, health plans must follow them, too.5 This makes it difficult to disentangle the effect of each mandate on the cost of private health insurance, especially because states' mandates usually also govern individually purchased policies and plans for small groups of fewer than 50 persons. 6 Indeed, some state laws require health plans to cover all conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, whereas Wellstone-Domenici (on its own) would allow them to opt out of some, such as "caffeine intoxication," and "sleep disorders resulting from jet lag."7

Today, few people would argue that mental illness is not as "real" as physical illness. The real challenge for payers, however, is to determine the desirable outcome of mental health or substance-abuse treatment. Indeed, one scholar has argued that if we examine the most clearly measurable outcome, avoidance of suicide, mandated mental health benefits provide no measurable improvement.8

The entire question of mental health coverage is so fraught with complexity that the obstacles facing politicians trying to get it right are daunting. As expressed by a joint report of the U.S. Department of Justice and the Federal Trade Commission: "For mandates to improve the efficiency of the health insurance market, state and federal legislators must be able to identify services the insurance market is not currently covering for which consumers are willing to pay marginal costs. This task is challenging under the best of circumstances—and benefits are not mandated under the best of circumstances. In practice, mandates are likely to limit consumer choice, eliminate product diversity, raise the cost of health insurance, and increase the number of uninsured Americans."

Americans' coverage for mental health treatment varies according to whether they are in a self-insured group plan, fully insured large or small group plan, or indi-

vidual plan, state by state, making analysis even more complicated. And our ability to measure the effects of these mandates is even worse than the data indicate. Studies assume full compliance with benefit mandates, and there is evidence that this is not the case. In 1995, the rate of non-compliance for states' mental health mandates was 10 to 15 percent.<sup>10</sup>

PRI recently published a review of the literature on the cost of mandated benefits, including recent reports indicating that mental health benefits account for a large share of the cost of mandated benefits. Most recently, the Maryland Health Care Commission concluded that that the total cost of mandatory benefits in that state was 15 percent of claims in the group market, and 19 percent of claims in the individual market, in 2007. Substance abuse and mental illness account for more than one-third of the total. 12

On the other hand, federally mandated mental health coverage for large groups—which are often not subject to state regulation—might be redundant. Even *prior* to the 1996 federal mental health parity mandate, workers in large companies were significantly more likely to enjoy mental health benefits than their colleagues in small ones. By 1995, a full 97 percent of workers in firms with 200 or more employees enjoyed mental health benefits equivalent to other health benefits, compared to only 63 percent of workers in firms with 50 or fewer employees.<sup>13</sup>

Coverage is often more sophisticated than demanded by statute. A self-insured employer's mental health benefit might provide case management, rather than the blunt "minimum numbers of inpatient days" that a state law demanded. Indeed, we are entering an era of consumer-driven health care, where patients control more of the dollars spent on their health care. We are still learning to balance higher co-payments and deductibles, an important factor in motivating patients to make cost-effective decisions, with the assurance that they do not shun appropriate preventive care because of cost. For the federal government bluntly to assume that the co-payments and deductibles for all types of health care need to be exactly the same erects a serious obstacle to innovation in designing health benefits.

Rather than helping those who suffer from mental illness, the Wellstone-Domenici Act subjects them to a straightjacket of government-dictated benefit design that is inflexible in the face of new learning. By relying on government power to get what they want in the short term, advocates for the mentally ill have jeopardized long-term innovation in this important area.

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## **Endnotes**

- Dave Durenberger, Commentary from Dave Durenberger (Minneapolis, MN: National Institute of Health Policy at University of St. Thomas, Opus College of Business, October 7, 2008).
- <sup>2</sup> Robert Pear, "Bailout Provides More Mental Health Coverage," New York Times, October 6, 2008, p. A13.
- <sup>3</sup> Ibid.
- Congressional Budget Office, Cost Estimate: H.R. 1424 Paul Wellstone Mental Health and Addiction Equity Act of 2007 (Washington, DC: Congressional Budget Office, November 21, 2007), pp. 4-7.
- For a list, and short description, of state mental health parity laws, see: Mental Health America, What Have States Done to Ensure Insurance Parity? (Alexandria, VA: Mental Health America, July 2008).
- <sup>6</sup> See CHBRP, Analysis of the Potential Impacts of Senate Bill 365: Outof-State Carriers, Report to the State Legislature 07-06 (Oakland, CA: California Health Benefits Review Program, April 19, 2007), p. 9, for a description of mental health benefits legislated by California in all markets.
- Ongressional Budget Office, Cost Estimate: H.R. 1424 Paul Wellstone Mental Health and Addiction Equity Act of 2007 (Washington, DC: Congressional Budget Office, November 21, 2007), p. 4; Robert Pear, "Bailout Provides More Mental Health Coverage," New York Times, October 6, 2008, p. A13.
- <sup>8</sup> Jonathan Klick and Sara Markowitz, Are Mental Health Insurance Mandates Effective? Working Paper No. 9,994 (Cambridge, MA: National Bureau of Economic Research, September 2003).
- <sup>9</sup> David A. Hyman, Sarah M. Mathias, Patricia Schultheiss, et al., *Improving Health Care: A Dose of Competition* (Federal Trade Commission, U.S. Department of Justice, Washington, D.C.: July 2004), p. 24.
- Gail A. Jensen, Kathryn Rost, Russell P. D. Burton, and Maria Bulycheva, "Mental Health Insurance in the 1990s: Are Employers Offering Less to More?" *Health Affairs*, Vol. 17, No. 3, (May/June 1998), pp. 201–207.
- John R. Graham, From Heart Transplants to Hairpieces: The Questionable Benefits of State Benefit Mandates for Health Insurance (San Francisco, CA: Pacific Research Institute, July 21, 2008).
- MHCC, Annual Mandated Health Insurance Services Evaluation, required under Section 15-1502 of the Insurance Articles (Baltimore: Maryland Health Care Commission, January 1, 2008), pp. 1–4.
- <sup>13</sup> Gail A. Jensen, Kathryn Rost, Russell P. D. Burton, and Maria Bulycheva, "Mental Health Insurance in the 1990s: Are Employers Offering Less to More?" *Health Affairs*, Vol. 17, No. 3, (May/June 1998), p. 203.
- <sup>14</sup> GAO, Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance, GAO/HEHS-96-161 (Washington, D.C.: U.S. General Accounting Office, August 1996), pp. 15–17 and references.
- While health plans' disclosure of how they cover preventive care in consumer-driven health plans is opaque, most of them do offer this coverage. See America's Health Insurance Plans, January 2008 Census Shows 6.1 Million People Covered By HSA/High-Deductible Health Plans (Washington, DC: America's Health Insurance Plans, April, 2008).