



## Forum Session Meeting Announcement

**Friday, July 8, 2005**

11:45 am — Lunch

12:15–2:00 pm — Discussion

# Parity Is in the Eye of the Beholder: Evaluation of Mental Health Parity Under the FEHB Program

### Presentation by:

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### With Reactions and Commentary from:

**Michael J. O'Grady, PhD**

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Department of Health and Human Services

**James W. Mays**

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*Senior Vice President*

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America's Health Insurance Plans

**Ron Gresch**

*Senior Actuary for Health Programs*

Office of Personnel Management

### Location

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# Parity Is in the Eye of the Beholder: Evaluation of Mental Health Parity Under the FEHB Program

## OVERVIEW

*This Forum meeting will review the key findings of a recent evaluation of the mental health parity policy implemented under the Federal Employees Health Benefits (FEHB) program in 2001. The significance of these findings for the current debate surrounding federal parity legislation will be explored.*

## SESSION

Mental health disorders are remarkably common, yet, more often than not, these disorders are left untreated. A recent survey funded by the National Institute of Mental Health indicates that over one-quarter of the population shows symptoms of some type of mental health impairment.<sup>1</sup> Although most of these impaired persons have relatively mild conditions, 6 percent of Americans experience serious limitations in their daily functioning due to mental illness. Despite the relatively high prevalence of mental health disorders, most people do not receive treatment for these conditions or delay treatment for years.

Although the causes of this treatment gap are complex, insurance benefit designs have long been viewed as a major barrier to access for mental health services. Historically, health insurance policies have imposed more onerous restrictions—such as higher-cost sharing requirements, greater limitations on the number of services covered, and lower annual or lifetime dollar limits—on mental health services than on other types of medical care.

Insurers have imposed these restrictions in light of concerns that mental health services are particularly vulnerable to moral hazard, the tendency of insurance to change people's behaviors and increase service utilization.<sup>2</sup> The factors driving these observed increases in utilization of mental health services in response to reduced out-of-pocket spending are not entirely clear but likely reflect the decisions of both patients and providers. Persons with mental illness are known to be high-cost patients, both because of their mental health treatment needs and their higher-than-average use of general medical services. The expense associated with these patients has led insurers to impose mental health benefit restrictions in order to guard against adverse selection. By ensuring that benefits do not appear

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attractive to persons with mental illness, insurers hope to avoid disproportionate enrollment of these people in their plans.

Critics argue that such policies are discriminatory and counterproductive, leading to unnecessary suffering and significant costs to society. Parity for mental health, or equal coverage for both mental and physical ailments, is viewed by many as an important public policy goal, both to ease the stigma of mental illness and to ensure that people can access treatment for mental health disorders.

An improved evidence base surrounding mental health care, persistent advocacy, and changing clinical practice patterns spurred in part by managed behavioral health care have facilitated a movement toward parity. At least 46 states have enacted some type of law addressing mental health coverage, but these laws vary considerably in scope.<sup>3</sup> Some require that some type of mental health benefit be included in insurance products, others establish a minimum acceptable mental health benefit, and still others mandate parity if mental health services are covered. At least 16 states require full parity, meaning they require that mental health benefits be included in all group plans and that coverage is on par with other health services in all respects.<sup>4</sup>

State laws include a wide variety of exemptions and limitations, such as applying only to services for serious mental illness or excluding insurance products sold through individual and small-group markets. The reach of these laws is limited in that (a) they generally do not apply to federally funded programs, such as Medicaid and Medicare, and (b) all self-insured plans, typically offered by large employers, are exempt under the Employee Retirement Income Security Act (ERISA).

In 1996, Congress passed the Mental Health Parity Act (MHPA), amending ERISA and the Public Health Service Act. The MHPA prohibits group plans from establishing annual or lifetime dollar limits for mental health services that are more restrictive than those imposed for other types of medical care. Plans may still impose differential cost sharing or utilization limitations and are not required to cover mental health services. Employers with fewer than 50 employees are exempt from the law, and any employer experiencing an increase in claims cost greater than 1 percent due to MHPA compliance can seek an exemption from the Department of Labor.

In examining the impact of MHPA, the General Accounting Office (GAO) found that employers were generally in compliance with the law and that costs had not risen dramatically due to this compliance. However, group plans had increasingly used other types of restrictions to limit the use of mental health services, such as utilization limits or higher cost-sharing requirements for mental health services.<sup>5</sup> Given the variability and limited reach of state parity legislation and the limited scope of existing federal law, many Americans still have health insurance that offers less coverage for mental health services.

Congress continues to debate the need for more expansive federal parity protections. Since 2001, a number of similar bills have been considered that would expand MHPA to require that group plans offering mental health benefits establish the same utilization limits and cost-sharing provisions for mental health as those used for medical and surgical services. Although widely supported, these bills have failed in Congress, largely due to concerns regarding the impact on health care costs, insurance premiums, and employers' willingness to continue to offer group health insurance. Originally slated to sunset in September 2001, the more targeted MHPA has been extended on an annual basis and is currently set to expire on December 31, 2005.

In the 109th Congress, the Paul Wellstone Mental Health Equitable Treatment Act of 2005 (H.R. 1402) was introduced in the House of Representatives on March 17, 2005. The bill stipulates that group health plans can not impose treatment limits or financial requirements on mental health services unless comparable limits are put on medical or surgical benefits. Key provisions of the bill include the following:

- Plans are not mandated to provide coverage for mental health services.
- The medical management of mental health benefits is explicitly permitted.
- Parity requirements apply only to in-network benefits, provided plans ensure "reasonable" access to in-network providers and facilities. In-network refers to the services provided under contractual agreement by a select group of providers.
- Groups with fewer than 50 employees are exempted.
- The full range of disorders identified in the *Diagnostic and Statistical Manual of Mental Health Disorders*, fourth edition (DSM-IV) is afforded parity protection.
- State laws offering greater parity protections would not be preempted.
- GAO would be required to study the effects of the law on insurance costs and availability, as well as quality of care.

A similar bill has not yet been introduced in the Senate in this Congress.

The parity protections guaranteed federal workers are seen by many as an instructive model for broader federal parity legislation. The federal Office of Personnel Management (OPM) implemented full parity for all health plans offered through FEHB program in 2001. Although the parity provisions under FEHB program are generally similar to those outlined in H.R. 1402, OPM policy differs in requiring plans to offer mental health and substance abuse coverage for all medically necessary treatment for all diagnoses listed in the DSM-IV. However, as in H.R. 1402, OPM parity provisions apply only to services provided "in-network."

A comprehensive, four-year evaluation of the FEHB program parity experiment commissioned by OPM and the Department of Health and Human Services examined parity effects in nine different health plans through a pre/post design while controlling for secular trends in mental health and substance abuse services use and spending. Earlier evaluations in states that had enacted parity legislation and private plans that had implemented parity provisions have generally found that parity is typically implemented along with care management techniques and has had limited impact on costs. However, these evaluations studied less expansive parity provisions relative to those implemented by FEHB program. The OPM/DHHS-sponsored evaluation of FEHB program parity was released on June 20, 2005, and is available at <http://aspe.hhs.gov/daltcp/reports/parity.htm>.

## SPEAKERS

The Forum session will feature **Howard Goldman, MD, PhD**, the principal investigator of the Office of Personnel Management/Department of Health and Human Services-sponsored evaluation of mental health parity under the Federal Employees Health Benefits program. Dr. Goldman will review the evaluation's methodological design and summarize its key findings. Dr. Goldman is a professor of psychiatry at the University of Maryland School of Medicine, where he is the director of mental health policy studies and the co-director of the Center for Mental Health Services Research. Dr. Goldman is an expert in evaluating mental health services and financing demonstration programs. He works extensively with state mental health program directors and various federal government agencies and private foundations in the United States and the United Kingdom. Dr. Goldman is director of the MacArthur Foundation Network on Mental Health Policy Research and a consultant to the President's New Freedom Commission on Mental Health.

A response panel will comment on the conclusions of the parity evaluation and share their perspectives on the broader implications of these findings. The response panel will include the following:

**Michael J. O'Grady, PhD**, is the assistant secretary for planning and evaluation (ASPE) at the Department of Health and Human Services. ASPE is the principal advisor to the Secretary of Health and Human Services on policy development in health, disability, aging, human services, and science and data, and provides advice and analysis on economic policy. Coordinating an interagency and intradepartmental effort, ASPE funded and provided oversight for the Federal Employees Health Benefits program parity evaluation.

**James W. Mays** is vice president for management of the Actuarial Research Corporation (ARC). Since joining ARC in 1979, his major areas of analysis have included comprehensive national health insurance proposals, incremental private insurance expansion options, health insurance rating reform, Medicare prescription drug coverage, and comprehensive Medicare reform. He recently worked with the assistant secretary for planning and evaluation at the Department of Health and Human Services on reviewing the cost experience of Federal Employees Health Benefits program under mental health parity, compared with projections of expected mental health and substance abuse costs absent reform.

**Jeff Lemieux** is a senior vice president with America's Health Insurance Plans directing the new Center for Policy and Research. An economist specializing in health care and public finance, Mr. Lemieux is the author of centrist proposals for health coverage, Medicare reform, and balanced budgets and the creator of long-term projections of entitlement spending and federal budgets used by Congress and the policymaking community. While on staff at the Congressional Budget Office, he developed estimates on the cost implications of federal legislation for mental health parity.

**Ron Gresch** is the senior actuary for health programs with the Office of Personnel Management. Mr. Gresch is responsible for the negotiation of health insurance premiums in the Federal Employees Health Benefits program, which covers over 8 million members. He provides actuarial analysis for proposed legislation and policy decisions and performs the valuation of post-retirement health benefits used on both the agency's financial statements and the financial statement of the benefit program. He recently helped implement High Deductible Health Plans with Health Savings Accounts (HDHP/HSA) in the FEHB program and is presently working on the introduction of voluntary dental and vision plans for federal employees and annuitants.

## KEY QUESTIONS

- How does parity in insurance benefits affect utilization and cost of health care services?
- Does parity affect access to and quality of care? Should policymakers expect improvements in access and quality due to parity?
- To what extent have other characteristics of benefit design (such as pre-authorization policies, medical necessity requirements, and adequacy of provider networks) influenced the observed changes in access, cost, and quality?
- Does parity appear to have similar effects both for persons with severe mental illness and for those with less profound conditions?

- What are the implications of the FEHB program parity evaluation for the broader implementation of parity through federal legislation?
- In what ways is the FEHB program experience *not* a good predictor of the potential impact of federal parity legislation?

## ENDNOTES

1. U.S. Department of Health and Human Services, "Mental Illness Exacts Heavy Toll, Beginning in Youth," NIH News, June 6, 2005; available at [www.nih.gov/news/pr/jun2005/nimh-06.htm](http://www.nih.gov/news/pr/jun2005/nimh-06.htm).
2. C. Stephen Redhead, "Mental Health Parity," Congressional Research Service, updated December 29, 2003.
3. National Council of State Legislatures, "State Laws Mandating or Regulating Mental Health Benefits," March 2005; available at [www.ncsl.org/programs/health/Mentalben.htm](http://www.ncsl.org/programs/health/Mentalben.htm).
4. Kathryn Allen, U.S. General Accounting Office, "Mental Health Parity Act: Employers Mental Health Benefits Remain Limited Despite New Federal Standards," GAO/T-HEHS-00-113, testimony before the Committee on Health, Education, Labor, and Pensions, U.S. Senate, Washington, DC, May 18, 2000; available at [www.gao.gov/archive/2000/he00113t.pdf](http://www.gao.gov/archive/2000/he00113t.pdf).
5. Allen, "Mental Health Parity Act."



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