

Improving Mental Health and Addressing Mental Illness: Mental Health Benefits Legislation

Task Force Finding and Rationale Statement

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Task Force Finding and Rationale Statement

Context

In the United States, health insurance benefits for mental health services have been typically less than benefits for physical health services (American Psychological Association, 2010), resulting in potential financial burden for people with mental health conditions (Zuvekas et al., 1998).

A number of state and federal initiatives have aimed to address this issue by increasing parity for mental health coverage.

- At the state level, forty-nine states and the District of Columbia (Cauchi et al., 2011) have enacted some type of mandate legislation.
- At the federal level, the 1996 Mental Health Parity Act (Solis, 2012), the 2008 Mental Health Parity and Addiction Equity Act (Employee Benefits Security Administration, 2010), and the Affordable Care Act (Patient Protection and Affordable Care Act, 2010) have led to progressively stronger parity requirements.

Intervention Definition

Mental health benefits legislation involves changing regulations for mental health insurance coverage to improve financial protection (i.e., decreased financial burden) and to increase access to, and use of, mental health services including substance abuse services. Moving toward parity for mental health coverage is a key element of most mental health benefits legislation. Defined as having no greater restrictions for mental health coverage than physical health coverage (Employee Benefits Security Administration, 2010), parity can be considered on a continuum from limited to comprehensive. The latter requires coverage for a broad range of mental health and substance abuse disorders that places no greater restrictions on benefits (e.g., visit limits, treatment limits, annual dollar limits or deductibles) for mental health services than benefits for physical health services.

This review considered legislation and executive orders enacted at the state or federal level.

- Parity laws cover a continuum of benefits.
 - Limited parity may cover specific mental health conditions, including substance abuse, or allow more restrictions in benefits compared to physical health (e.g., visit limits, copayments, deductibles, annual and lifetime limits).
 - Comprehensive parity covers a broad range of mental health conditions, including substance abuse, with few or no restrictions.
- Mandate laws may or may not be parity laws. These laws require insurers or health insurance plans to do at least one of the following:
 - Provide some specified level of mental health coverage, or in cases when mental health insurance was already being provided, meet a minimum benefits level.
 - Offer the option of mental health coverage.
- Executive orders for mental health parity for government employees may be issued at the federal or state level.

Task Force Finding (August 2012)

The Community Preventive Services Task Force recommends mental health benefits legislation, particularly comprehensive parity legislation, based on sufficient evidence of effectiveness in improving financial protection and increasing appropriate utilization of mental health services for people with mental health conditions. There is also evidence that mental health benefits legislation is associated with increased access to care, increased diagnosis of mental health conditions, reduced prevalence of poor mental health and reduced suicide rates.

Evidence from a concurrent economic review indicated that mental health benefits expansion did not lead to any substantial increase in cost to health insurance plans, measured as a percentage of premiums.

Rationale

Basis of Finding

Despite the high prevalence of mental illness in the U.S. (Kessler et al., 2005), many affected people do not receive adequate mental health care (Messias et al., 2007). Several Institute of Medicine (IOM) reports have examined the impact of financial burden on utilization of health care (IOM, 2002; IOM, 2002b; IOM, 2003; IOM, 2010;), and determined that the cost of care is a major factor hindering access to care (IOM, 2010). More than half of American families reported limiting their medical care in the past year because of cost concerns, and nearly 20% reported serious financial problems due to medical bills and in some cases resulting in an inability to pay for food, heat, or housing (IOM, 2010). Furthermore, medical bills contributed to half of all personal bankruptcy filings (IOM, 2002; IOM, 2003). There is a strong association between health insurance plans that offer coverage for preventive and screening services, prescription drugs, and mental health care and the receipt of appropriate care (IOM, 2002b).

This review found evidence that mental health benefits legislation is associated with improved financial protection and increased appropriate utilization of mental health services for people with mental health conditions. Appropriate utilization includes, but is not limited to, mental health visits for people identified with a mental health need, visits rendered by mental health specialists, or care visits that are in line with evidence-based guidelines for mental health care. This review also found evidence associating mental health benefits legislation with increased access to care, increased diagnosis of mental health conditions, reduced prevalence of poor mental health, and reduced suicide rates.

The Task Force finding is based on evidence from a systematic review of 30 studies reported in 37 papers (search period 1965 - March 2011). Twenty eight studies examined the effects of state or federal mental health parity legislation or policies, and two studies examined the effects of state mandated coverage for mental health and substance abuse. Six of these studies examined the effects of comprehensive parity legislation or policies and generally found stronger effects for comprehensive parity legislation or policies versus those that were less comprehensive. This Task Force finding is considered sufficient rather than strong due to the limited number of studies on health outcomes and difficulties disentangling the effects of mental health benefits legislation and managed care, which became more prevalent in the U.S. during the same time period.

Applicability and Generalizability Issues

All studies were conducted in the U.S. and findings are applicable to people with private and public insurance. Few studies reported outcomes by subgroups that could be used in applicability assessment. Results from included studies indicate that effects for children (two studies) are similar to effects for adults for the outcome of financial protection. Subgroup analysis by region and by employer size shows no difference in the access to care outcome. None of the

studies reported outcomes by racial or ethnic minority groups. However, the body of evidence includes national samples that should be representative of all racial and ethnic groups.

One study reported evidence on effectiveness for low socioeconomic status (SES) populations for the appropriate utilization outcome and found that among Medicare enrollees 65 years of age and older, mental health benefits changes were most effective for people in the lowest income and education groups. Another study found state parity mandates to be most effective in increasing utilization of any mental health service for people in the lowest income group who work for small employers (<100 employees). The same study found that employees working for small employers were more likely to use mental health services after implementation of state parity mandates regardless of income. Information about employer size was also limited.

Data Quality Issues

Of the 30 studies, 11 included a comparison group (both time series and other designs with concurrent comparison groups), nine were interrupted time series or retrospective cohort studies, and ten were simple time series, before/after, or post-only designs. The most common limitations for the body of evidence included:

- Difficulty disentangling the effects of managed care from those of mental health benefits legislation. Managed care, especially the behavioral health carve-out technique, was often implemented simultaneously, or to a higher degree, following expansion of mental health benefits. Most study authors did not, or were unable to, report effects for managed care and benefit expansions separately.
- Incomplete information about utilization Many studies that reported effects on utilization, either outpatient or inpatient, did not include enough information to evaluate the appropriateness of the utilization (e.g., the type of healthcare provider, patient need for mental health care, or whether care met evidence-based guidelines).
- Potential data dependency. Several of the included studies assessed the effects of the same mental health benefits legislation in the same states. As a result, there was the potential for data dependency across studies in the review (i.e., the same people or populations were represented more than once in the body of evidence).
- Potential bias in data collection method. The body of evidence consists of two types of data: survey data, which relies on self-report and is subject to recall bias, and claims data, which may underreport use of mental health services.
- Differing classification of state mandates. Most authors that used data from multiple states classified states into two categories of 'parity' and 'no or weak parity', or into three categories of 'strong', 'medium' and 'weak' parity laws for their analyses. While many authors relied on the National Conference of State Legislatures (Cauchi, Landess & Thangasamy, 2011) to classify state mandates, others used alternative sources or classified laws themselves based on the interpretation of individual state statutes. As a result, some of the states were categorized differently in this review.
- Challenges controlling for exemptions. Few studies of state mandate legislation controlled for the 1974 Employee Retirement Income Security Act (ERISA), which exempts self-insured employers (typically large employers with >500 employees) from state mandates. Similarly, no studies of the 1996 MHPA federal law controlled for small employers or group health plans that were exempt from the legislation. Failure to control for these exemptions could lead to potential underestimates of the effects of mental health benefits legislation.

Other Benefits and Harms

Additional benefits from mental health benefits legislation could include reductions in the utilization of other health services. This phenomenon is known as an "offset effect," (McGuire & Montgomery, 1982; Mechanic, 1978) and can be

expected due to the interrelationship between mental health and physical health. Another possible benefit would be a decrease in insurance coverage-related discrimination and stigma for mental illnesses, a problem that has been noted by the National Institute of Mental Health (McGuire & Montgomery, 1982).

Possible harms of mental health benefits legislation include "moral hazard", which is the tendency for enrollees in healthcare plans with reduced out-of-pocket expenses to use services at a higher rate than those with higher out-of-pocket expenses, resulting in the potential for over-utilization (Frank, Koyanagi & McGuire, 1994). Another possible harm is "adverse selection", which is the tendency of people with poorer health to enroll in insurance plans that offer more benefits, resulting in a higher risk pool for those health plans (Frank, Koyanagi & McGuire, 1994). However, no studies in this review reported evidence of moral hazard, and only one study (Branstrom & Cuffel, 2004) reported adverse selection for a subgroup of study participants.

Some researchers have suggested that employers may drop mental health coverage to circumvent mental health benefits legislation. Claxton and colleagues (Claxton et al., 2010) found that, nationally, 5% of employers dropped mental health coverage, but only 2% reported doing so as a result of the 2008 MHPAEA law. Similarly, the GAO 2011 Mental Health and Substance Abuse Report (U.S. Government Accountability Office, 2011) found that approximately 2% of employers discontinued coverage of both mental health and substance use or substance use disorders alone for the 2010 plan year.

Economic Evidence

The primary focus of the economic review was to determine the impact of mental health benefits expansion on cost to health insurance plans. The economic review includes 14 studies (search period 1965 - March, 2011). Of these, 11 studies provided evidence on plan cost impacts and 3 provided evidence on other economic effects.

Costs reported in the studies were first translated to annual cost per member and the change in this variable was then expressed as the percentage of average annual premium for single all-health coverage during the period. For this purpose, historical statistics for premiums associated with employer-provided health insurance coverage were drawn from secondary sources (Kaiser Family Foundation & Health Research & Educational Trust, 2012) since premiums associated with the plans were not reported in the studies.

Cost Impacts: Four studies about the Federal Employees Health Benefits (FEHB) plan, two studies of state mandates, and five studies of individual employers provided direct evidence on cost impacts due to benefits expansion.

Three of the four studies assessing cost impacts of the 1999 FEHB mental health benefits expansion found decreases from 0.02% to 1.34% in cost per member across multiple plans, expressed as percent of the study year premiums. Only one plan in one study experienced an increase of 0.23% as a percent of premium. The fourth study from the 1967 expansion found some increase in cost but the increase was substantially due to adverse selection and occurred during a period prior to advent of managed care.

One of the two studies that assessed the impact of state mandates evaluated the impact of Vermont's law during the period 1996-1999 and estimated that cost per member decreased by 0.29% of premiums. The other study evaluated four plans under the Oregon law for the period 2005-2008 and found that cost per beneficiary increased in all the plans, with the largest increase at 0.60% in terms of premiums in the period.

Of the five cost studies of individual employers who expanded benefits voluntarily or in response to administrative rule, two found that cost per member decreased as a percentage of period premium by 0.61% and 7.31%, and one study

found no change in cost. Two remaining studies reported increases as a percentage of period premiums, one at 0.29% and another at 1.04%.

In summary, of the ten studies based on data from 1990 onwards, five showed decreases in annual cost per member. For one study, there was no change in annual cost per member. Of the four remaining studies, two showed an increase in annual cost per member to be less than 0.3% and the other two an increase of 0.6% and 1.04%, respectively. The decreases in cost following an expansion of benefits may be due to simultaneous implementation of managed care.

Other Economic Effects: Of the three studies that examined other economic effects, one found no unfavorable effects of mental health benefits expansion on rates of employment, wage rates, the business share of premiums, or the percentage of the working population covered by insurance. Another found that states with a larger number of health mandates had a lower probability of ownership of businesses with more than one employee. The remaining study found a significant reduction in suicide rates as a result of state mandates, and estimated the cost per averted suicide to range from \$1.3 million to \$3.1 million.

Considerations for Implementation

- Mental health benefits legislation does not address the shortage of mental health providers (Thomas et al., 2009) and inpatient beds (Torrey et al., 2008) that are concerns in some areas of the country. Such shortages constrain access to mental health services and place a ceiling on the potential increases in appropriate utilization of mental health services.
- Low public awareness of state and federal laws by both employers and employees may result in employers failing to comply with laws and employees underusing services (Lake et al., 2002). Also, when no clear definition of covered services is legislated, individual health plans can decide which treatments and services are covered (Lake et al., 2002). This may limit coverage to evidence-based treatment or services, which may restrict the availability of promising therapies still under investigation (California Department of Mental Health, 2005).
- There are often exemptions in mental health benefits legislation that affect implementation in certain groups. Larger employers tend to self-insure and are therefore exempt from insurance-related state mandate laws due to the 1974 ERISA Act. In addition, the 1996 MHPA and 2008 MHPAEA laws exempt employers with fewer than 50 employees and group health plans that demonstrate a resulting overall cost increase of 2% annually. While employers may voluntarily follow state laws, these exemptions may affect the potential reach of mental health benefits legislation.

Evidence Gaps

- There is limited research investigating the effects of mental health benefits legislation on mental health outcomes. Specifically, studies are needed to assess effects on morbidity (reduction of symptoms, relapse prevention, remission and recovery), mortality and quality of life.
- Further research is needed to clarify the role of mental health benefits legislation in reducing health-related disparities and improving mental health outcomes among important population subgroups (e.g., low SES groups, racial and ethnic minorities and individuals diagnosed with different types of mental illness).
- There is limited evidence for those covered by public health insurance (e.g., Medicaid and Medicare). Further research is needed in these populations to confirm the effectiveness of mental health benefits legislation in improving mental health.
- Evaluations of the effects of the most recent federal legislation, the 2008 MHPAEA, are needed as this law contains more requirements for parity than the earlier 1996 MHPA.

- Evaluations of long-term (more than three years) effects of mental health benefits legislation are needed.
- Researchers reported a utilization outcome that often combined measures of inpatient and outpatient utilization. The desired direction for these types of utilization differs with various patient conditions; reporting them separately will better indicate that patients are receiving appropriate care. Another challenge in mental health is the determination of whether care provided is evidence-based or guideline-concordant. In addition, most studies reporting any utilization lacked measures of appropriateness of use, such as descriptions of provider type and patient need for mental health care.

Economic Review Evidence Gaps

- Future economic research needs to adequately allow for concurrent effects of general and medical care inflation rates, innovations in pharmaceuticals, changes in prescription patterns, and secular trends in the diagnosis and treatment of mental illnesses and substance abuse.
- Very few studies evaluated the effects of mental health benefits expansion on business decisions related to employment and their consequences. Plausible consequences could include effects on the unemployment rate, salaries, and the offer of health benefits as part of a compensation package. This is especially important where the laws apply differently across employers of different sizes, as was the case for the laws and mandates included in both the effectiveness and economic reviews.

The data presented here are preliminary and are subject to change as the systematic review goes through the scientific peer review process.

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Disclaimer

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