

Mental Health and Substance Abuse Insurance Parity

Current Status of Mental Health Problems in New Hampshire, Effects of New Federal Legislation and Other States' Experiences

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EXECUTIVE SUMMARY

In our state, lack of access to mental health and substance care is a pressing issue. Over the last decade, New Hampshire (NH) residents have consistently reported high rates of alcohol and substance abuse in comparison to national averages, yet the state's efforts and infrastructure to deal with mental health and substance abuse issues continue to fall short of national standards. Furthermore, our research shows that the costs of mental illness, in NH as well as the U.S., are high and continuing to rise, rendering the issue of mental health coverage even more critical.

Last year, President George W. Bush signed into law the Emergency Economic Stabilization Act of 2008 (H.R. 1424), which included the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008. This legislation mandates that employers providing health insurance offer mental health and substance abuse benefits equitable to the medical and surgical treatment benefits they provide. This act, in combination with other recently passed legislation discussed in this report, may have a complex effect in NH, where thousands of small businesses, Medicaid subscribers, and the 16 percent of the population that is uninsured or self-insured may remain untouched by these new parity regulations.

As case studies of Maryland, Vermont, and Connecticut illustrate, comprehensive state-based parity legislation does not have detrimental effects, but neither does it greatly increase the number of needy people with access to care. For example, in Vermont six years after parity, comprehensive mental health insurance parity had not increased overall healthcare spending, nor had it significantly reduced the number of insured persons – two major concerns of opponents to parity. On the contrary, following the implementation of parity, spending in Vermont decreased, though possibly due to other factors, while access to and utilization of care improved slightly.

While it is difficult to determine how H.R. 1424 will impact NH until the regulations have been written by the relevant federal agencies, we conclude this report with an elaboration of such policy recommendations in NH as the expansion of Medicaid substance abuse coverage, the extension of parity laws to small businesses, the maintenance of funding for community mental health centers, and an education campaign to inform consumers of parity stipulations and the possible applications to their lives. We also suggest that further study be done on the many states with full or partial parity laws, to better understand how such laws change access to mental health and substance abuse treatment and whether the NH legislature should amend its parity laws.

1. MENTAL HEALTH AND SUBSTANCE ABUSE IN NEW HAMPSHIRE

1.1 Prevalence and Treatment of Mental Health and Substance Abuse in New Hampshire

A report by the Substance Abuse and Mental Health Services Administration from December 2008 outlines mental health and substance abuse in New Hampshire. Several findings differ from the national norm. Mental health illnesses are commonly defined using the diagnoses outlined in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV), published by the American Psychiatric Association.¹ The federal and state definitions recognize patients with a mental health disorder if they can be diagnosed based on the criteria listed in the DSM. New Hampshire residents, ages 12 to 17 and 18 to 25, are ranked among the highest in the country in terms of abuse or dependence on drugs or alcohol, according to DSM-IV criteria.² The level of abuse or dependence on alcohol has been among the highest in the nation for all age groups since 2002.³ Additionally, the number of New Hampshire residents seeking admission to either inpatient or outpatient treatment services has doubled between 1992 and 2006.⁴ Despite the increase in demand for services, the rate of residents with an unmet need for treatment, defined as those that meet the diagnostic criteria according to the DSM-IV for abuse or dependence on substances or alcohol but have not received treatment in the past year, is among the highest in the country.⁵

Evidence suggests that the mental health situation in New Hampshire is similar to that of the nation. Nationally, 26.2 percent of adults are afflicted with diagnosed mental illnesses every year.⁶ In the Center for Disease Control and Prevention's 2004 Behavioral Risk Factor Surveillance System Survey, 33.4 percent of those surveyed in New Hampshire reported poor mental health.⁷ Furthermore, in the 2006 National Alliance on Mental Illness report on America's care networks for the seriously mentally ill, New Hampshire's status was shown to have sharply declined in the last sixteen years, currently ranking thirty-sixth in the nation for overall mental health spending at \$151 million annually, or \$117.14 per capita.⁸ In comparison to Connecticut, a state with a strong mental health infrastructure, per capita spending was almost thirty percent lower. The 2009 report however gave New Hampshire a C, an entire letter grade up from 2006.⁹ The report cited such advances as the commission convened by the New Hampshire legislature to address weaknesses in the current system, and preventative programs to address serious mental illnesses.¹⁰ Areas of concern include the shortage of inpatient psychiatric beds and the lack of affordable housing for those with mental illnesses.¹¹ Furthermore, jail diversion programs are necessary to decrease the high number of people incarcerated with mental illnesses.¹²

The Center for New Hampshire Policy Studies points out that New Hampshire's aging population poses unique mental health issues for the state. The New Hampshire Office of Energy and Planning estimates NH's population over 65 will nearly double by the year 2030, with close to 40 percent of the population over 65 in some counties.¹³ An increased demand on NH's Medicaid program, among others, serving the elderly in mental health

illnesses will require NH to make appropriate steps to adequately serve its aging population.

1.2 Cost of Mental Health and Substance Abuse in New Hampshire

The costs of mental health services, which are often not covered thoroughly under insurance plans, are a frequent roadblock to treatment. In a study by the National Alliance on Mental Illness, of the people who reported having a mental illness and/or substance abuse problem without access to treatment, eighty percent listed cost as the reason for this lack of access.¹⁴ A report by the Surgeon General states that the “direct costs of mental health services in the United States in 1996 totaled \$69.0 billion.”¹⁵ In New Hampshire, the costs of treating attempted suicides and suicides alone in “acute care settings,” disregarding any preventative measures, is approximately \$6.2 million annually.¹⁶ Health care costs comprise sixteen percent of the nation’s gross domestic product, and mental health spending makes up only 6.2 percent of these costs.¹⁷ However, in calculating this figure, only direct costs, or the costs of treatment, are considered.

It is harder to quantify the effects of mental health issues than physical health issues, because many of the costs of mental health issues are indirect, such as “reduced labor supply, public income support payments, reduced educational attainment, and costs associated with other consequences such as incarceration or homelessness.”¹⁸ Studies show that serious mental illness causes \$193.2 billion in lost earnings annually in the form of lowered productivity in the workplace as well as personal and sick days taken due to symptoms of serious mental illness.¹⁹ One projection estimated that the combination of health care costs, lost earnings, and disability benefits result in an economic cost of \$317 billion annually.²⁰ This figure is rather conservative, as the door-to-door survey did not reach hospitalized and incarcerated individuals, nor did it consider co-morbidity, that is, the affliction with two or more disorders contemporaneously, or homelessness. In fact, among homeless citizens, sixty-six percent report substance use and/or mental health problems, and 20 to 25 percent meet criteria for serious mental illnesses.²¹ These figures indicate the substantial cost of mental illness on society, both at a national and a state level.

1.3 H.R. 1424: Paul Wellstone Mental Health and Addiction Equity Act of 2008

After it passed through Congress, President George W. Bush signed into law H.R. 1424, the Emergency Economic Stabilization Act Of 2008 on October 3, 2008.²² Congress included the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 in the Stabilization Act. The mental health parity piece of the law amends sections of the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC).²³ The act mandates that health insurance providers offer the same level of benefits for mental health and substance abuse treatment as they do for medical and surgical treatment.²⁴ This applies to treatment from out-of-network providers as well.²⁵ While insurance

providers are not mandated to offer mental health and substance abuse benefits, if they choose to do so they must follow this regulation. The act leaves to insurance companies the determination of what constitutes a mental health or substance abuse issue, in accordance with any existing federal or state laws.²⁶ Insurance companies must write regulations for parity by October 3, 2009, and plans must comply with these regulations beginning in the subsequent plan year. (For many plans this will be on January 1, 2010.)²⁷

The act includes the small employer exemption, which allows employers with fewer than 50 employees in the previous year to disregard the act.²⁸ Insurance plans can additionally seek an exemption if, in the first year of parity, their total costs (the cost of mental health and substance abuse treatment in addition to that of medical and surgical treatment) rise more than two percent or more than one percent in any year thereafter.²⁹ Plans must, however, wait at least six months before they are eligible to apply for exemptions.³⁰ Additionally, plans are not mandated to carry mental health and substance abuse benefits and may choose to drop them altogether. In this situation parity does not apply. Furthermore, those Americans who enroll in individual health insurance plans are not guaranteed parity under the new law.³¹ The plan was intended to set a national “floor” for parity and was not intended to preempt any existing laws. Thus, states that currently have parity laws stronger than the federal law will not be affected.³²

The specifics of which mental health treatments the legislation covers will be determined by federal regulators at the Department of the Treasury, the Department of Health and Human Services, and the Department of Labor.³³ These regulations must be in place by October 3, 2009, for the law to take effect on January 1, 2010. The law states that health insurance companies must supply to patients the criteria used to determine which treatments are “medically necessary” for mental health disorders.³⁴ Additionally, they must reveal to patients the reason for any denial of a claim for mental health treatment.³⁵ Most likely the criteria will be based on the DSM-IV, which is the standard resource for such definitions. While the original legislation included a provision that health insurance companies cover treatment costs for all diagnoses in the DSM-IV, this was later abandoned during Congressional negotiations.³⁶ Specific regulations have yet to be developed for the cost-exemption provisions that allow insurance companies with exorbitant costs in the first year of parity to opt out of the requirements.

The Congressional Budget Office (CBO) anticipates the cost of H.R. 1424 after it goes into effect will be the greatest for the federal government because of the decrease in taxable wages.³⁷ According to estimates, premiums on group health insurance plans will rise by about 0.4 percent and those on Medicaid plans will rise by about 0.2 percent.³⁸ As the higher cost of health insurance is deducted from compensation and benefits, the government will cope with a decrease in taxable wages.³⁹ The CBO estimates a loss of \$1.1 billion in tax revenue between 2008 and 2012, and a loss of \$3.1 billion in tax revenue between 2008 and 2017, including the loss from Social Security payroll taxes.⁴⁰ In addition, the increased spending on Medicaid is estimated to cost \$310 million between 2008 and 2012, and \$820 million between 2008 and 2017.⁴¹ While the act merely prohibits states from enforcing laws that counteract the new federal regulations,

according to the CBO there should be no significant costs for state or local governments.⁴² However, governments that purchase health insurance through private companies may face higher premiums passed onto them as the buyers of the additional coverage.⁴³ The impact will be similarly felt in the private sector. As previously stated, the direct cost of implementing parity in services provided by health plans is 0.4 percent of current premiums.⁴⁴ The CBO estimates these direct costs translate to a rise from \$1.3 billion in 2008 to \$3.0 billion in 2012.⁴⁵

1.4 Impact on New Hampshire

According to a senior public health analyst at the Substance Abuse and Mental Health Services Administration (SAMHSA), the law will improve coverage for over 113 million Americans.⁴⁶ The increase in access to needed treatment will help legitimize mental health disorders by placing them on par with physical illness. By reducing the barriers to mental health care the law is partly reducing the stigma surrounding seeking treatment.

Once the Department of the Treasury, the Department of Health and Human Services, and the Department of Labor draft federal regulations, the impact on New Hampshire's insurance providers will become clearer. Specific regulations are necessary to answer such disputed issues as what constitutes parity between the co-pay for mental health treatment and physical health treatment. They also need to specify the steps insurance providers can take to opt out of parity requirements, and the oversight of such providers. A timeline for this process has yet to be made public.

The relatively high number of small businesses in the state could leave many employees without mental health parity under the small employer exemption. The Small Business Association estimates that New Hampshire has about 145,900 small businesses.⁴⁷ In 2004, 56.5 percent (311,500 people) of the non-farm labor in the state was employed by a small business.⁴⁸ However, the SBA defines a small business as one that has fewer than 500 employees whereas the exemption found in H.R. 1424 is for businesses with fewer than 50 employees.⁴⁹ We were unable to determine exactly how many businesses will be affected by the provision. Additional mental health benefits are projected by the CBO to raise premiums, though in a large, self-insured company the costs can be spread out more easily than in small companies.⁵⁰ Contrary to earlier versions of the bill, the final legislation did not contain an exemption for companies that self-insure. It is possible some mid-sized companies may choose to drop mental health coverage altogether rather than raise the coverage level up to that of benefits for mental health.⁵¹

Research on the impact of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Federal Employee Health Benefits Program (FEHBP) has found that mental health parity laws in the past have not been associated with a large increase in costs.⁵² State level research has also not shown significant increases in health care spending in the wake of mental health parity legislation. For more information, see Section 3.

1.5 H.R. 6331 Medicare Improvements for Patients and Providers Act of 2008

On July 15, 2008 H.R. 6331 Medicare Improvement for Patients and Providers Act of 2008 became law.⁵³ The law repeals the reduction in physician reimbursements and will increase reimbursements in 2009.⁵⁴ Additionally, it expands eligibility for low-income benefits and provides financial incentives for paperless medical records.⁵⁵ Most importantly for our research, Congress included a provision for mental health parity, which will be phased in over the next six years.⁵⁶ The co-pay for outpatient mental health treatment will be reduced from 50 percent to 20 percent to match the rate for other Medicare outpatient treatment.⁵⁷

The Congressional Budget Office anticipates the cost of H.R. 6331 will simultaneously increase and decrease direct spending.⁵⁸ The net impact of the legislation will be a \$100 million reduction in deficits over 2008-2013 and a reduction less than \$50 million over 2008-2013.⁵⁹ The increased spending on physician reimbursements will be offset primarily by reductions to the funding of Medicare Advantage (MA) plans.⁶⁰

2. MENTAL HEALTH INSURANCE IN NEW HAMPSHIRE

As Table 1 indicates, the majority of New Hampshire residents (65 percent) have employer-based health insurance. Medicare is the second largest health care provider, covering 13 percent of residents.

2.1 Employer Coverage

Employer coverage, which accounts for 65 percent of health insurance coverage in New Hampshire, consists of various forms of health insurance plans that include: health maintenance organizations (HMOs), preferred provider organizations (PPOs), point of service (POS), and indemnity.⁶¹ NH has five state-licensed insurance companies: Anthem Health Plans, CIGNA Health Care of New Hampshire, Connecticut General Life Insurance Company, Harvard Pilgrim Health Care of New England, and Matthew Thornton Health Plans, Inc.⁶² Most citizens covered under employer-based health care plans have mental health and substance abuse benefits included in their plan.

Examining health insurance plans offered by Harvard Pilgrim Health Care (HPHC), one of NH's most popular employer-based health care providers, demonstrates some detailed examples of what is available to NH residents. HMO mental health coverage with the HPHC can range from *Premier HMO 10 (3w)* to *Best Buy HMO 2000 w/coin insurance (C2)*.⁶³ Coverage plan HMO 3w, for example, provides mental health services such as inpatient care at no charge, with a maximum of sixty days per calendar year, drug and alcohol rehabilitation limited to thirty days per calendar year, among many other mental health benefits provided with a \$10 copayment.⁶⁴ Under the HMO C2 plan, however, a patient is limited to thirty inpatient days in a calendar year, and gives \$20 copayments for drug and alcohol rehabilitation.⁶⁵

2.2 Parity Consequences for Employment-Based Insurance

It is very unlikely that the cost of employment-based insurance will significantly increase in 2010 as a result of parity legislation. Some insurance experts have speculated that many employers will stop providing mental health insurance once the Mental Health Parity and Addiction Act is passed in 2010. A 2008 Forum for Health Economics & Policy Report concludes there is “no evidence that full mental health parity mandates would increase the number of insured, or that employers decreased their contribution to health insurance premiums.”⁶⁶ The report also finds, “no evidence that labor market composition changed due to parity regulations or that the costs of the mandates have been pushed on employees in the form of lower wages.”⁶⁷ Proposed parity legislation, therefore, should have a minimal impact on the level of care in employer-based health insurance.

2.3 Individual Coverage

Mandated parity coverage will not apply to individual health insurance.⁶⁸ Five percent of New Hampshire residents opt for individual health insurance coverage.⁶⁹ Because mental health parity regulations do not apply, many mental health benefits that might be included in ‘standard’ employer-based group plans are not available in individual plans. Sometimes individual health insurance consumers have the option to pay extra for coverage of additional services like substance abuse therapy. This extra coverage is referred to as an optional rider, and is both costly and more difficult to obtain.⁷⁰

2.4 Medicare

Basic inpatient services are available under Medicare Part A coverage (hospital insurance), which is provided to citizens with Social Security Plans. Outpatient health care is provided under Medicare Part B, which requires patients to enroll by paying monthly premiums. Medicare Part B covers most outpatient care but it must be determined to be medically necessary or listed as a preventive service. In July 2008, Congress passed the Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331).⁷¹ This bill will establish mental health parity within the Medicare system by 2014. Co-payments for mental health outpatient treatment will go down from 50 percent to 20 percent over the next five years. The amount patients will have to pay for mental health treatment will step down gradually: 45 percent in 2010 and 2011, 40 percent in 2012, 35 percent in 2013, and 20 percent in 2014 and beyond.⁷²

2.4.1 Medicare and Substance Abuse Coverage

Medicare will cover substance abuse treatment in both inpatient and outpatient settings if: you receive services from a Medicare-participating provider or facility; your doctor states that the services are medically necessary; and your doctor sets up your plan of treatment.⁷³

2.5 Medicaid

Medicaid is the largest payer for mental health services, providing access to care for 58 million adults and children in the United States.⁷⁴ Six percent of New Hampshire (NH) residents are covered through the State's Medicaid program (see Table 2).⁷⁵ Parity legislation will not affect the mental health treatment of Medicaid patients in NH. That said, recent Medicaid budget cuts initiated by the state government might affect mental health services provided to Medicaid patients. The State of New Hampshire cut Medicaid reimbursement by two percent on December 1, 2008.⁷⁶ For community mental health clinics, such as West Central Behavioral Health (WCBH), this cut threatens their clinics' ability to continue to provide services to indigent residents. Medicaid insures approximately 72 percent of WCBH patients.⁷⁷

2.5.1 Medicaid and Substance Abuse Coverage

Medicaid currently does not cover substance abuse treatment. Therefore, a Medicaid provider can only give substance abuse treatment to a patient who has been diagnosed with another mental health illness. A New Hampshire resident between the ages of 18 and 60 years old currently does not receive Medicaid-reimbursed treatment if they only require treatment for substance abuse.⁷⁸ The need for substance abuse treatment among Medicaid enrollees is significant and in some cases significantly higher than those with private coverage; one out of every five Medicaid hospital days is attributable to substance abuse.⁷⁹ There are ten community mental health agencies in New Hampshire, including West Central Behavioral Health (WCBH). These clinics receive minimal funding to cover substance abuse for indigent patients. The WCBH organization, for example, operates on a \$64,000 annual budget for substance abuse. In March 2009, the state made a 9.6 percent reduction to substance abuse treatment spending.⁸⁰

2.5.2 Problems with Medicaid and Parity

States cannot reimburse for any services provided by an institution (characterized as any institution with more than 16 beds) that treats 'mental diseases', such as mental retardation or chronic mental illness.⁸¹ This law has prevented New Hampshire from providing residential substance abuse treatment for its Medicaid patients.⁸²

2.5.3 Recommendations

At a minimum, New Hampshire should provide inpatient detoxification and substance abuse outpatient services (that are billed as physician services), to record the level of substance abuse treatment in NH and provide mental health insurance accordingly.⁸³ Considering the need of substance abuse treatment among Medicaid enrollees and the high rates of statewide substance abuse, it seems as though the state should consider covering Medicaid treatment services.

2.6 Children's Health Insurance Program (CHIP) and NH Healthy Kids

Half of all Medicaid enrollees nationwide (26 million) are children.⁸⁴ New Hampshire Healthy Kids (NHHK) is a non-profit organization that administers the CHIP program and other low-cost insurance options for children and teens in New Hampshire.⁸⁵ In New Hampshire through NHHK, low-income children may qualify for Medicaid or CHIP through one of three programs: the “Healthy Kids Program” that serves children from birth to age 18 with incomes up to the federal poverty level (FPL); “Healthy Kids Gold”, that serves infants to age one in families with income between 185 percent and 300 percent of FPL; and “Healthy Kids Silver”, that provides coverage for uninsured children ages one through 18 in families with incomes between 185 percent and 300 percent of FPL, where the family must pay premiums between \$25 and \$135 depending on income level and family size.⁸⁶ NHHK also administers Healthy Kids Buy-In to provide unsubsidized coverage for children who do not qualify for Gold or Silver, and includes private managed care, health care, and dental coverage.

All beneficiaries have mental health and substance abuse services included in their coverage through a fee-for-service system.⁸⁷ CHIP programs cover a maximum of 15 days per calendar year of mental health inpatient services provided in psychiatric or general hospitals, inpatient substance abuse services for medical detoxification, as well as outpatient mental health and substance abuse services limited to 20 visits per calendar year.⁸⁸ In NH 12 percent of children privately insured under 18 had an indication of a mental health issue, while 25 percent of children in the Medicaid population under 18 had an indication of mental illness (See Figures 1 and 2).⁸⁹

On February 4, 2009 President Obama signed into law H.R. 2, Children's Health Insurance Program (CHIP) Reauthorization Act of 2009.⁹⁰ This law mandates that private CHIP plans provide mental health benefits equivalent to those offered for medical and surgical treatment.⁹¹ An additional 4 million children will also be eligible for CHIP coverage under the new legislation.⁹²

2.7 Other Public Forms of Health care Coverage

One percent of New Hampshire citizens are covered by “other public” forms of health care. The New Hampshire Health Plan (NHHP), which is a state high-risk insurance pool, is available for citizens who do not qualify for any other private health insurance plan and is “intended to be the insurer of the last resort in New Hampshire”.⁹³ The NHHP, however, does not mention any specific mental health coverage benefits in the outline of its plan.

2.8 Options for the Uninsured

Uninsured citizens, including 17,000 uninsured children in NH, have several options to receive mental health care, but will remain unaffected by the federal parity law.⁹⁴ The National Mental Health Information Center lists community-based resources, pastoral

counseling, self-help groups, Social Security programs, and Public Assistance (such as Medicaid, and Medicare) as resources for New Hampshire residents. Many of these resources are problematic to use on a frequent basis for citizens who need intensive treatment. Community-based resources, for example, often require a citizen to have a private insurance plan or be a recipient of formal public assistance. Social Security programs similarly are difficult to use, as the programs require a citizen to have a documented disability.⁹⁵ Furthermore, uninsured residents with severe mental illnesses pay the most for their services because all treatment is funded out-of-pocket.⁹⁶ High out-of-pocket costs decrease a resident's likelihood of seeking and sustaining their treatment. Most hospitals and some health care organizations provide charity care to uninsured patients who demonstrate an inability to pay for services.⁹⁷ Generally, acute care is more likely to be provided free of charge, because indigent patients are less likely to pursue preventive services without knowing in advance that they will receive charitable services.

3. STATE MENTAL HEALTH AND SUBSTANCE ABUSE PARITY LEGISLATION

To date, 42 states have enacted some form of mental health parity, although the laws differ greatly in their stringency and depth of coverage (see Table 3). Five states require what is considered full parity. Many other states have limited parity, exempting small businesses and only requiring insurance parity for a limited set of specified diagnoses, such as "severe mental illnesses." These laws do not protect children and adults whose illnesses can be disabling, such as multiple personality disorders, anorexia nervosa and bulimia, post-traumatic stress syndrome, and substance abuse disorders. Children with serious emotional disturbances are also often excluded.⁹⁸

Vermont (passed in 1997), Maryland (1994), Connecticut (1999), Minnesota (1995), and Oregon (2005) have adopted the most comprehensive parity laws. These laws require that health insurers set the same deductibles, co-payments, annual expense caps and annual visit limits for mental health patients as for patients with physical health conditions.⁹⁹

Researchers have undertaken few comprehensive quantitative analyses of state mental health parity laws, either comparatively or for a single state. One notable exception is Vermont – the Mental Health Information Center, a nonpartisan think tank devoted to health policy issues, conducted a comprehensive survey of the effects of the state's parity legislation. The study found that the legislation had minor effects on access to care, costs or scope of coverage.¹⁰⁰ Another study, investigating multiple states that have strict mental health insurance parity laws, found that those laws had not harmed the labor market, which was a major fear of some legislators who opposed them.¹⁰¹

3.1 Vermont's Experience with Mental Health and Substance Abuse (MHSA) Parity

In 1998, Vermont passed legislation requiring full parity for both mental health and substance abuse services and extending the requirement to private insurance plans. The law eliminates separate and unequal deductibles and out-of-pocket costs for mental health

and substance abuse services. It requires a single deductible and the same out-of-pocket co-payments or co-insurance for mental health and substance abuse services and all other covered health services. It also removes separate yearly and lifetime visit limits and dollar spending maximums.¹⁰²

In 2003, the Mental Health Information Center (MHIC) conducted a study examining how implementation of parity in Vermont affected major stakeholders: employers, health plans, providers, and consumers. They found that while some aspects of the law were beneficial for patients, others had minimal impact and sometimes complicated the health care process. Overall, their findings indicate that the law had prompted only minor changes in mental health and substance abuse treatment availability for Vermont citizens.

The researchers concluded that:

- Employers did not stop providing insurance when they had to provide parity;
- People used mental health services more;
- People used substance abuse services less;
- Cost-sharing burden decreased for patients; and
- Overall spending decreased.

Much of the analysis focused on two health plans - Kaiser/Community Health Plan (Kaiser/CHP) and Blue Cross Blue Shield of Vermont (BCBSVT) - which together covered almost 80 percent of Vermont's privately insured population in 1998. One important aspect of the Vermont case study to bear in mind is that the parity legislation was implemented almost concurrently with a switch among many Vermont providers to managed care health systems.¹⁰³ Therefore, some of the fluctuation in costs, expenditures, and frequency of usage may have resulted from the switch to managed care programs, instead of the parity legislation. Additionally, findings from this study reflect experiences during the first two to three years of parity in Vermont. It is possible that a longer study period might yield different results.

3.1.1 Parity Did Not Cause Employers to Drop Coverage or Switch to Self Insurance Products

The possibility that employers might cease to provide insurance because of the cost of mental health parity was a major concern voiced by the law's opponents. However, the study indicated that most Vermont employers did not stop providing health insurance as a benefit to employees after parity became a requirement. Of employers who offered insurance coverage when parity went into effect on January 1, 1998, just 0.3 percent (accounting for 0.07 percent of Vermont employees) reported dropping that benefit because of parity requirements.¹⁰⁴

A substantial number of employers did choose to self-insure, or use company funds to pay their employees medical costs instead of contracting to a private insurer. Companies

that did this could have avoided having to provide parity, as the laws did not apply to companies that self-insured. From 1998 to 2001, about four percent of Vermont employers (accounting for about eight percent of Vermont employees) switched one or more of their health plans to a self-insured product. However, only three percent of those who had switched, or less than an eighth of a percent of all Vermont employers (0.12 percent) said that the parity requirements were a factor in their decision.¹⁰⁵

3.1.2 Access to Outpatient Mental Health Services Improved with Parity; Access to Inpatient or Partial Treatment Declined

The likelihood of obtaining mental health services not related to substance abuse rose by between 18 and 24 percent in the two health plans as a result of parity. The average number of outpatient visits per user increased as well. Thus, parity improved access to and intensity of outpatient mental health services among many health plan members in Vermont.¹⁰⁶

However, access to inpatient or partial treatment fell sharply, especially among Kaiser/CHP members. There was a 32 percent lower likelihood of obtaining inpatient mental health treatment following parity. The study mentioned that this could have been because Kaiser/CHP instituted a new program to increase the use of intensive outpatient care as an alternative to temporary hospitalization.¹⁰⁷

3.1.3 Access to Substance Abuse Treatment Was More Limited After Parity

The likelihood of inpatient substance abuse treatment was much lower after the implementation of parity. With Kaiser/CHP it decreased by 51 percent lower and with BCBSVT it decreased by 34 percent. The study noted that though BCBSVT members did experience an increase in the duration of inpatient care, this was quite probably because those who did end up hospitalized were being treated for much more severe addictions.¹⁰⁸

The study did not draw any conclusions about why this might have occurred. It is possible an external factor decreased patients' willingness to seek treatment, but had they sought it, they might have found that it had become more easily accessible. Also, rates of drug abuse and arrests in Vermont rose during the years the study was conducted.¹⁰⁹ So, while the number of patients who needed treatment did not decline, it's possible that many people that would seek treatment were being sent to prison, and therefore losing their employer-provided insurance.

3.1.4 Spending for Covered Mental Health and Substance Abuse Services Declined After Parity

Overall, insurance companies' mental health and substance abuse spending fell between 8 and 18 percent after parity was implemented, even though parity raised limits on use of care. Mental health and substance abuse service spending rose slightly for BCBSVT and

declined for Kaiser/CHP.¹¹⁰ This decline in total costs could have been related to the decline in use of substance abuse services, which as discussed above, might not have been related to parity.

3.1.5 Consumers Paid a Smaller Share of Total Spending for Covered Mental Health and Substance Abuse Treatment after Parity

After parity, employees who sought mental health and substance abuse treatment paid for a smaller percentage of it – one of the main goals of parity legislation. For example, in BCBSVT plans, employees went from paying 27 percent to paying 16 percent of their total costs for covered mental health and substance abuse services.¹¹¹

3.1.6 Managed Care was an important factor in controlling costs

Vermont health insurers implemented managed care programs around the same time that they passed the parity legislation. According to the study, insurance companies felt that the use of managed care made parity affordable, because it shifted decision making from patients to the companies, enabling them to choose what to supply.¹¹² Vermont parity legislation did not affect the design of managed care– insurance companies, not patients or doctors, still have final say as to what type of mental health treatment constitutes a medical necessity.

3.1.7 Awareness of parity was relatively low among consumers

According to the study, beneficiaries were unaware of parity and their newly expanded mental health and substance abuse benefits, which insurance providers, employers, employees and health care professionals agreed could have limited the policy's impact. The stakeholders surveyed felt that a proactive education campaign about parity should have been undertaken, arguing that such a campaign could have helped consumers and providers utilize the law effectively.¹¹³

3.2 Connecticut's Experience with MHSA Parity

Connecticut's parity legislation requires insurers to provide benefits for most mental or nervous conditions, though, like in Vermont, it allows insurers to determine benefits based on medical necessity. Some Connecticut public figures, stakeholders and mental health advocates have said that this renders the law ineffective. An editorial in the *Hartford Courant* dubbed their law a “big disappointment.”¹¹⁴

Few studies have been done to quantify the effects, positive or negative, of this legislation. Tom Kirk, Commissioner of Mental Health and Addiction Services for Connecticut told *Medscape* magazine that access to care has "sharply improved" since Connecticut's parity law was enacted eight years ago.¹¹⁵ "Despite the stigma that still exists in accessing mental health care, we are probably doing better than other states," Kirk said.¹¹⁶

3.3 Maryland's Experience with MHSA Parity

Maryland's comprehensive parity legislation for mental health and substance abuse issues was the first of its kind, enacted in 1994. The law requires non-discriminatory coverage for any person with a mental illness, emotional disorder, or drug or alcohol abuse problem. Companies are required to provide inpatient coverage for mental health and substance abuse treatment to the same degree that they provide inpatient coverage for physical illnesses, which includes at least 60 days of inpatient care, 60 days for partial hospitalization, outpatient medication management (the number of visits equal to visits for physical illnesses), psychotherapy with no annual limitations, and graduated co-payments based upon the number of outpatient visits.¹¹⁷

Though no comprehensive study has been done of the Maryland parity laws, it does not seem to have changed drastically mental health and substance abuse care accessibility. According to the National Institute of Mental Health, The first year that Maryland's parity law was in effect, one managed care company saw a small increase in costs; costs fell back the second year to the pre-parity level.¹¹⁸ Another Maryland company reported increased costs of less than one percent. By the third year, premiums in Maryland actually decreased slightly.¹¹⁹

3.4 Comprehensive Effects of These Laws on the Labor Market and Suicide Rates

In one of the few studies that assessed the effects of mental health parity on a state's general welfare, Atilla Cseh of Valdosta State University investigated whether states that enacted parity legislation saw changes in employer provided health insurance coverage and changes in the probability of full-time employment, working hours, and wages for a sample of private workers.¹²⁰ The study found no concerning consequences. Overall, employers did not stop providing coverage, wages and hours did not decrease, and jobs did not decrease in availability because of prohibitive parity costs.¹²¹ These were some of the major areas that opponents of parity legislation were concerned the laws would impact.

In addition, a 2007 study from the University of California at Santa Barbara examined how varying strengths of state level mental health insurance parity legislation changed state suicide rates. The study included a variety of states, each with different parity legislation and different levels of mental health disease prevalence, focusing particularly on states that had transitioned from no or limited parity laws to strong or comprehensive parity laws, and controlling for factors such as prior trends in suicide rates or changing population. Researchers concluded that ten to fifteen years after comprehensive laws requiring insurance coverage to include mental health benefits at parity with physical health benefits were passed states, the suicide rate of individuals in a "working age group" (34-64 year olds) decreased by five percent.¹²² Younger adults and senior citizens did not see results that were statistically significant. That age group is logically the most likely to be affected by mental health insurance parity legislation, because they are more likely than young adults or senior citizens to have strong employer-provided health

insurance coverage, which is the insurance category targeted by parity. For a summary of this information see Table 3.

4. CONCLUSION AND RECOMMENDATIONS

Legislators considering mental health parity legislation must understand its limits. Studies indicate, as described previously, that there are no serious short-term adverse effects of implementing parity, and parity does seem to have slightly increased some people's access to affordable mental health and substance abuse treatment. However, parity does not affect anyone without health insurance who suffers from mental health and substance abuse issues. Furthermore, it is likely that individuals with more severe mental health and substance abuse problems are also less likely to have jobs, particularly jobs that offer health insurance benefits. Therefore, even the most stringent parity legislation would not fix the problems the uninsured face with accessing mental health and substance abuse treatment.

In the current economic climate, implementing a program that might increase costs a small amount to small businesses and to taxpayers in the form of forfeited taxes or increased Medicare spending is generally unpopular. However, as C.P. Rydell pointed out in a report for the Office of National Drug Control Policy, "Every dollar invested in substance abuse treatment saves taxpayers \$7.46 in societal costs (crime, violence, loss of productivity, etc.). With some outpatient treatment programs, total savings can exceed costs by a ratio of 12:1."¹²³ Loss of productivity created by mental illness is especially relevant to our economic recovery and should be weighed accordingly when considering parity and other mental health care legislation. If someone suffers from mental health and substance abuse issues, they may lose their job or perform their job with decreased efficiency and reliability. An increase in access to mental health care could prevent such situations, which have a negative impact on the individual, their family and the business, as well as New Hampshire's economic productivity and tax revenues.

It is currently unclear what specific changes the recent federal legislation will cause in New Hampshire until the federal agencies finalize their regulations. It is also unclear, given the lack of relevant studies, what long term effects state level parity laws have had, and how the varying stringencies of parity laws have affected their efficiency (see Table 3). Further quantitative analysis of these issues is needed.

However, our analysis demonstrates that some of the aspects of mental health insurance parity that New Hampshire lacks might be beneficial to its residents. For example, NH only provides parity for severe mental health disorders. Not only does the state law exclude common mental health problems, but also substance abuse, since federal laws do not classify substance abuse disorders as 'severe.' All mental health disorders are included in the federal legislation, so the benefits should accrue to NH without action of the state legislature. Given the significant costs of sustained substance abuse on a population, and the lack of detrimental effects of comprehensive parity in other states, achieving increased substance abuse treatment should lead to more effective mental

health coverage. Perhaps a productive move would be to contemplate removing the small business exemption, present in the federal legislation, from New Hampshire's parity laws. Many small businesses provide health insurances, and as studies showed, parity did not cause them grievous financial harm. However, as this might be a challenging political issue, a clause could be included that said that any small business demonstrating financial danger if they provide parity could be exempt.

Our research has led us to four recommendations. First, we recommend that NH expands Medicaid substance abuse coverage for those over the age of 18. As it is written, substance abuse treatment can only be obtained when co-morbidity is present. This requires the afflicted individual to first obtain a mental illness diagnosis before access to substance abuse treatment is granted. Given that, as we stated earlier, 20 percent of Medicaid hospital stays are attributable to substance abuse, this is a gap worthy of being addressed.

Second, it is important that NH maintains funding of the 10 community mental health centers, which provide much of the state's mental health care. These centers are particularly important to the lower-income population and those on Medicaid. Underfunding at these sites would severely limit their capacity to continue serving New Hampshire residents.

It is also essential that NH addresses the needs of NH's aging population, which is growing as the baby-boomer generation heads into retirement. With age come unique mental illnesses and challenges. Increasing accessibility to treatment for the elderly is worthy of consideration in the coming years.

Finally, we recommend that the state implements an education campaign to complement any federal or state level parity legislation. The goals of this campaign would be to decrease mental health stigmatization and increase a resident's likelihood of seeking treatment. As we saw with other states that have enacted full mental health insurance parity laws, misunderstandings about the coverage and a general lack of knowledge about mental health illness limit utilization of important services. The most effective parity legislation is that which residents are familiar with, and such an educational effort could help push New Hampshire forward in terms of mental health and substance abuse care.

TABLES AND FIGURES

Table 1. Health Insurance Coverage of New Hampshire’s Population (2006-2007).

	NH percent	US percent
Employer	65 percent	53 percent
Individual	5 percent	5 percent
Medicaid	6 percent	13 percent
Medicare	13 percent	12 percent
Other Public	1 percent	1 percent
Uninsured	11 percent	15 percent

Source: <http://www.statehealthfacts.org/profileind.jsp?ind=125&cat=3&rgn=31>

TABLE 2 – New Hampshire Total Expenditures For Mental Health Services For Medicaid Enrolled Adults Age 10 and Up By Provider Type (Services For Mental Retardation NOT included)

Provider Type	Total Expenditures	Service Count	Total Individuals	Average Cost per Adult	Average Cost per Service	Average Number of Services per Adult
Mental Health Clinic	\$56,919,439	504,986	10,551	\$5,395	\$113	48
Nursing Home – General	\$50,188,586	20,021	1,546	\$32,464	\$2,507	13
Nursing Home - County	\$26,390,323	8,592	878	\$30,057	\$3,071	10
Home and Community Based Care	\$14,751,524	258,807	2,961	\$4,982	\$57	87
Distinct Part. Unit - Rehabilitation	\$4,943,381	1,215	813	\$6,080	\$4,069	1
General Hospital	\$1,389,974	4,458	1,908	\$728	\$312	2
Psychologist	\$1,244,827	20,653	2,013	\$618	\$60	10
School Health Services	\$1,020,968	11,771	208	\$4,908	\$87	57
Adult Medical Day Care	\$908,332	21,744	235	\$3,865	\$42	93
Medical Services Clinic	\$852,724	40,835	391	\$2,181	\$21	104
Physician- Group	\$802,954	24,266	6,191	\$130	\$33	4
Mental Hospital	\$758,041	139	85	\$8,918	\$5,454	2
Private Non-Medical Institution for Children	\$645,024	356	25	\$25,801	\$1,812	14
DCYF Services	\$331,981	411	15	\$22,132	\$808	27
Rural Health Clinic	\$256,258	2,678	1,055	\$243	\$96	3
Home Health Agency	\$242,834	4,464	158	\$1,537	\$54	28
Planned Parenthood Clinic	\$227,443	350	159	\$1,430	\$650	2
Ambulance Service – Wheelchair	\$135,241	2,048	587	\$230	\$66	3
Advanced Registered Nurse Practitioner	\$98,901	2,245	368	\$269	\$44	6
Physician - Individual	\$74,852	1,909	509	\$147	\$39	4

Source: NH Policy Studies Report, “Mental Health and Adults: Aging Will Drive System”

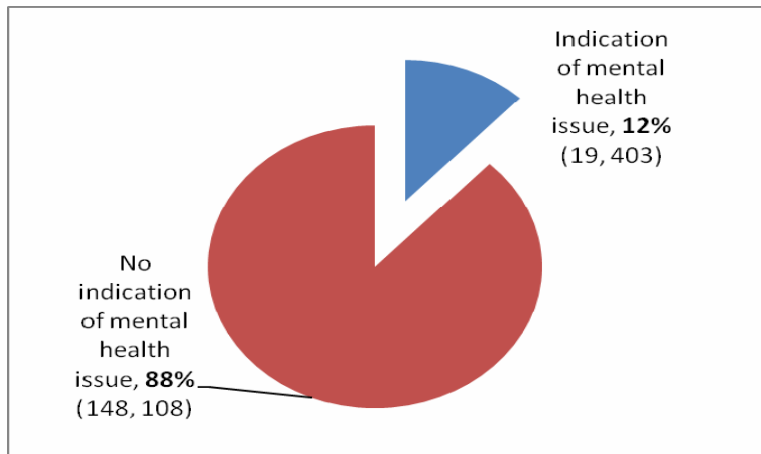


Figure 1. Population of Children in NH <=18 Privately Insured with an Indication of Mental Health Illness

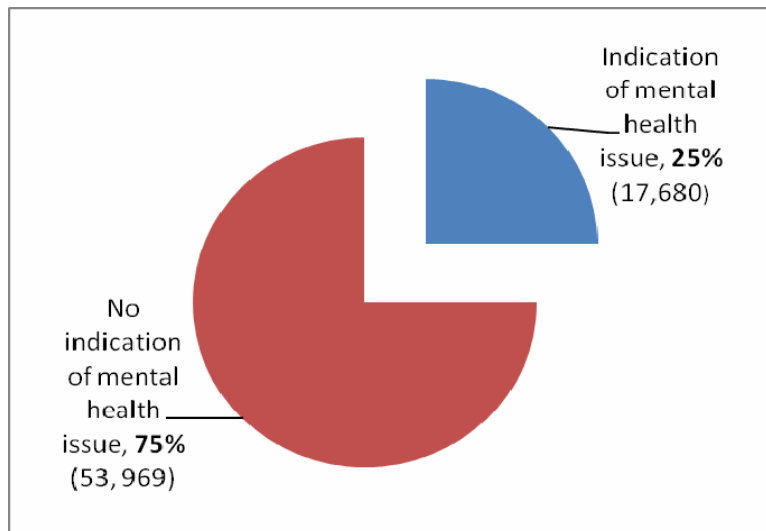


Figure 2. Mental Illness in the Medicaid Population in NH <=18 (2005 Medicaid Incurred Data)

Table 3 – State Mental health and Substance Abuse Parity Legislation

Full Parity <i>applies to all mental health and substance abuse disorders under private insurance plans. No exemptions.</i>	Partial <i>Not quite comprehensive parity due to certain exemptions and/or limitations. Often exclude substance abuse.</i>	Limited Parity <i>applies only to select groups such as those with severe mental illness (SMI) (biological, debilitating, i.e.: schizophrenia) or state & local employees, or only protects against certain types of discrimination. Often limits the size of employer businesses required to provide parity.</i>	Recommendation <i>Non-binding recommendation to provide parity.</i>	No Law
<p>Connecticut 1999 Maryland 1994 Minnesota 1995 Vermont 1997 Oregon 2005 <i>*Will not take effect until 2007</i></p>	<p>Indiana 1999/2001/2003 Includes substance abuse; 50 employees exemption; 4 percent cost increase cap</p> <p>Kentucky 2000 50 employees exemption; includes substance abuse</p> <p>Maine 1995/2004 20 employees exemption; includes substance abuse (Except V-Codes)</p>	<p>Arizona 1997/2001 Mirrors 1996 federal law; 50 employees exemption; 1 percent cost increase cap; parity for state employees Arkansas 1997/2001 50 employee exemption; 1.5 percent cost increase cap; excludes state employees; parity in SCHIP California 1999 SMI and children with serious emotional disorders only Colorado 1997 and Delaware 1998/2001 SMI only; include substance abuse Hawaii 2004 SMI only; 25 employee exemption; include substance abuse treatment. Illinois 2001 Iowa 2005 South Dakota 1998 Texas 1997 South Carolina 2000/2005 SMI only; 50 employees exemption Louisiana 1999 SMI only; includes children Massachusetts 2000 SMI only; 50 employees exemption; includes children & co-occurring disorders Missouri 2004 Limits out-of-pocket expenses Montana 1999 and Nebraska 1999 SMI only; 15 employees exemption New Hampshire 1994/2002 and Nevada 1999 SMI only; Limits out-of-pocket expenses; 25 employees exemption New Jersey 1999/2002 SMI only North Carolina 1991/1997 1991: Comprehensive parity for state & local employees/1997: mirrors federal law; 50 employees exemption; 1 percent cost increase cap Oklahoma 1999 SMI only; 50 employees exemption; 2 percent cost increase cap Tennessee 1998 25 employees exemption; 1 percent cost increase cap; excludes copayments, coinsurance and deductibles Utah 2000 Limits out-of-pocket expenses; 50 employees exemption Virginia 2004 SMI only; includes substance abuse; 25 employees exemption West Virginia 2004 SMI only; 2004 repealed alcohol coverage; 1 or 2 percent cost-increase cap</p>	<p>Alabama Alaska D.C. Florida Georgia Kansas Michigan Mississippi Ohio Pennsylvania New York North Dakota Wisconsin</p>	<p>Idaho Wyoming</p>

Source (information, not chart): http://www1.nmha.org/state/parity/state_parity.cfm

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