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The Costs of Covering Mental Health and Substance Abuse Care at the Same Level as Medical Care in Private Insurance Plans

Roland Sturm

Presented to the Health Insurance Committee, National Conference of Insurance Legislators

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Preface

This document presents the written testimony of Roland Sturm, Ph.D., as submitted to the Health Insurance Committee, National Conference of Insurance Legislators on July 13, 2001, in Chicago, Illinois.

The Costs of Covering Mental Health and Substance Abuse Care at the Same Level as Medical Care in Private Insurance Plans

Testimony Presented to the Health Insurance Committee, National Conference of Insurance Legislators on July 13, 2001 in Chicago, Illinois

by
Roland Sturm, Ph.D.
RAND Health

I am a senior economist at RAND and director of economic and policy research in the UCLA/RAND Center on Managed Care. RAND is a nonprofit institution that helps improve policy and decisionmaking through research and analysis. This statement is based on research funded by the Robert Wood Johnson Foundation, the National Institute of Mental Health, and the National Institute on Drug Abuse. The opinions and conclusions expressed are mine and do not necessarily reflect those of RAND or the research sponsors.

My research has focused on costs and utilization patterns for mental health and substance abuse treatment in today's health care environment. New data are needed to inform policy decisions because the health care delivery system has changed dramatically. For most privately insured Americans, behavioral health (which includes mental health and substance abuse care) is now managed by specialized managed care companies. Treatment patterns have changed dramatically, and patterns criticized in the

past as excessively costly, such as prolonged hospitalization of children or automatic 28-day inpatient stays for substance abuse, are almost nonexistent.

These changes in how mental health and substance abuse treatment is delivered mean that legislation will have different consequences today than it would have had 20 years ago. However, estimates of the cost consequences of proposed legislation, including reports by the Congressional Research Service[1,2] and by the Substance Abuse and Mental Health Services Administration,[2,3] were based primarily on actuarial assumptions, which reflect utilization patterns from the 1970s and 1980s. Many of these assumptions do not reflect today's mental health or substance abuse treatment systems in the private sector.[4-7] None of the actuarial studies have incorporated the experience of employers that have implemented parity.

We have identified a number of employers that have adopted parity-level benefits and the following results are based on actual experience with parity. Our first studies focused on 24 plans that had no limits on mental health or substance abuse care, $10 copayments for outpatient visits, and $100 copayments for inpatient care. However, services were managed through a managed behavioral health organization. Providing unlimited mental health benefits in these plans resulted in about $45 per plan member per year of insurance payments to providers.[4] Unlimited substance abuse benefits alone accounted for about $5 per plan member per year.[7] To put these numbers into perspective, the additional costs of adding full parity benefits for mental health and

substance abuse to a plan that previously offered no such benefits is in the order of 3-4 percent of premium, based on a total annual health maintenance organization insurance premium of $1,500 per member. Adding parity-level substance abuse treatment to a plan that previously offered no substance abuse benefits is in the order of 0.3 percent. Expanding existing benefits in a plan would have a correspondingly smaller effect. Note that the numbers reflect payments to providers (the part counted as the medical loss ratio); administrative fees or insurance profits are in addition.

The Ohio State Employee Program has been one of the first parity-level employer-sponsored health plans, starting in 1991.[5] As the expansion to benefits was accompanied by a switch to managed care, there was an initial drop in costs. We have now followed the program for 10 years and the level of MH and SA services has remained constant up to the first quarter of 2001. Thus, there is no evidence of a cost explosion.

Two large West Coast employers have just implemented parity as of January 2001, which reflected a substantial increase in the generosity of plan benefits. Both plans have been managed by United Behavioral Health before and after the parity switch and there have been no other changes in management. For the first employer (over 20,000 covered lives), costs in the first quarter under parity were identical to the previous two quarters and slightly lower than in the prior year. For the second employer (over 50,000 covered lives), costs in the first quarter have been higher by about $1.50 per member per

month compared to prior quarters. Because this employer offers a relatively costly medical plan, this increase corresponds to less than 1% of premium.

Our results suggest that parity in employer-sponsored health plans is not very costly under comprehensively managed care, which is the standard arrangement in today's marketplace. The total costs of providing parity-level benefits is less than the increase of benefit expansion claimed by recent actuarial studies. There also is no support for excluding substance abuse from parity efforts because of cost reasons because decoupling mental health and substance abuse care in terms of benefits cannot save any meaningful amount. However, decoupling is likely to create difficulties in coordinating treatment and lead to less efficient care. Since a high proportion of individuals have both MH and SA problems, poor coordination of care is a significant concern.

While we found no evidence that employer costs could rise by several percent with parity, our results do not apply to unmanaged indemnity plans and may only hold for large employers, but not for individuals or for small groups buying insurance. Our data also reflect a fairly "typical" employed population. Some industries may attract higher than average rates of substance abusers; industries with a predominantly younger female labor force may see higher rates of mental health care.

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The Costs of Covering Mental Health Care at the Same Level as Medical Care

Roland Sturm, Ph.D.

Director, Economic and Policy Research
UCLA / RAND Center on Managed Care
for Psychiatric Disorders

The Problem

- Insurance benefits for mental health care are:
  - Limited
  - Decreasing
  - Not at parity with benefits for medical care
- Sick individuals exceed coverage and are shifted into public system

Why Is There Not Parity?

- Fear that parity would bring an explosive increase in health care costs
- Belief that money would be spent on ineffective therapies
  - Could approach fraud and abuse in some cases
- Belief that mental health conditions are personal problems, not "real" diseases
- Vicious cycle: employers offering better benefits in isolation attract "bad risks", regulation can break this inefficient cycle

What Has Changed?

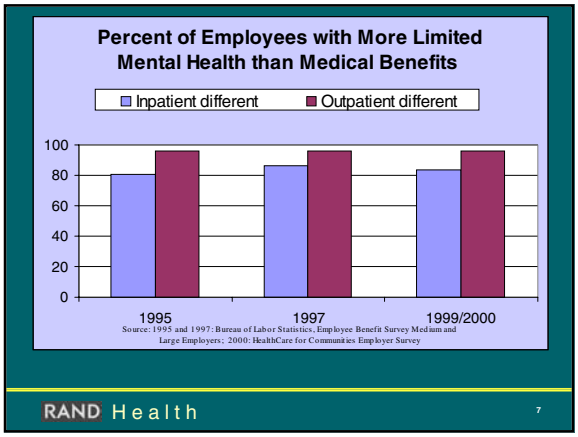
- Many psychiatric diseases are now known to have biological causes and treatments
- Newer and effective treatments
- More people are coming under managed care, which contains costs
  - most mental health care is managed by specialized organizations ("carve-outs")
  - carve-outs already have more than 170 million members (according to industry numbers)
  - very different from medical care

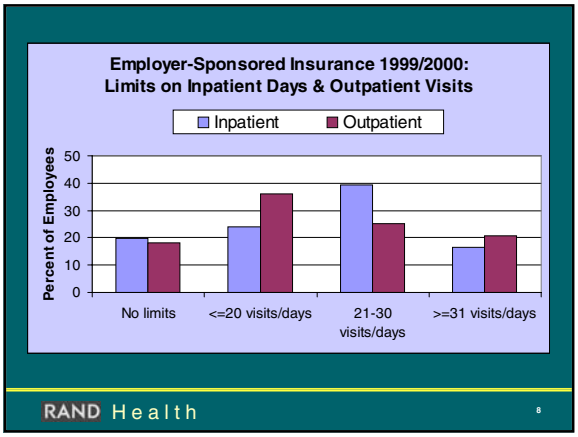
Questions to Be Answered

- Benefits in employer-sponsored plans in 2000: Is there a role for parity legislation?
- What are the costs of unlimited behavioral health care under managed care to employers?
- How has parity and managed care affected mental health care costs? Case studies of several large employers who implemented parity

Question 1: How Have MH Benefits Improved?

- We conducted new national survey of employer-sponsored mental health insurance
- No noticeable change between 1995 and 2000:
  - Only about 1 in 5 individuals with employer-sponsored mental health insurance has no day/visit limits in 1999/2000.
  - Coverage limits are very low: More than half of all plan members are covered for 20 or fewer outpatient visits and about 60% for 30 or fewer inpatient days.



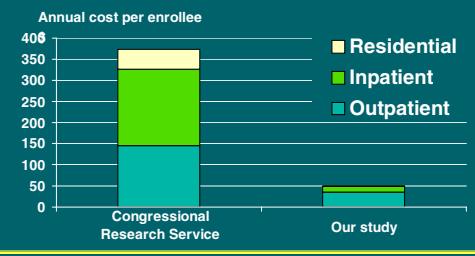


Question 2: What are the Costs of Parity under Managed Care?

- Data from 24 managed care plans starting in 1995 (about 140,000 persons)
- No deductibles or limits on any type of mental health or substance abuse service
- Copayments $10 per outpatient visit, $100 per inpatient admission
- But care is managed and requires
  - Prior authorization, case manager review, network use

How Much Did Full-Parity Benefits Cost?

- A lot less than estimated by CRS in 1996
- *Total* costs less than SAMHSA estimate of *increase* when switching from limited to parity benefits



Why This Discrepancy?

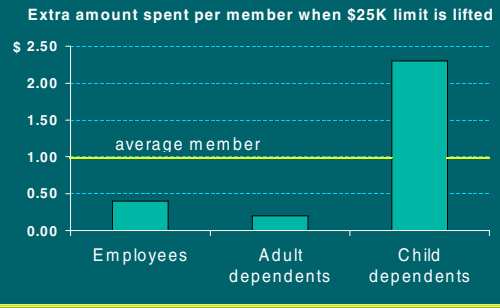
- No new data in CRS simulations compared to actual claims data in our analysis
- CRS and SAMHSA models based on utilization patterns from 70s and 80s and medical cost inflation
- But dramatic change in practice patterns, even in unmanaged plans
- CRS assumed all care is unmanaged, SAMHSA assumes medical and behavioral health management is the same
- Assumptions inconsistent with today's environment

What Are the Implications of Removing Coverage Limits?

Predicted annual cost per member as function of annual limit

Removing $25k annual limit raises total insurance payments by about $1 per member per year.

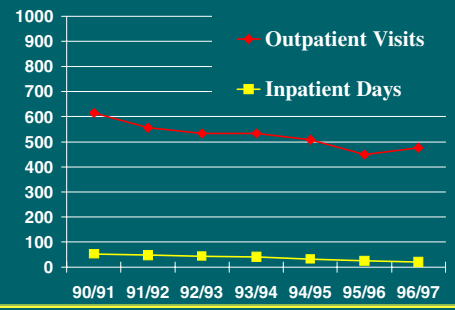
Most of the Extra Money Is Spent on Children



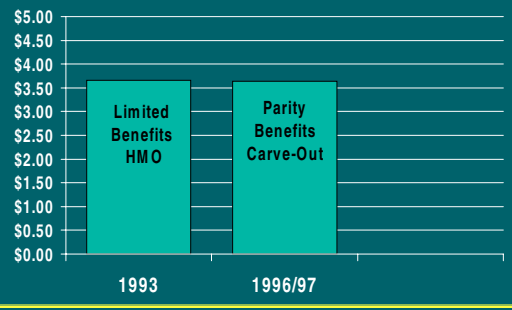
3. Case Studies of Employers: Ohio State Employee Program

- Switch to full parity in 1991 for members in Indemnity (FFS) medical plan, in 1995 for all members, including members in HMOs
- Administration "carved-out" to managed behavioral health organization
- Costs for services were contained for multi-year follow-up period

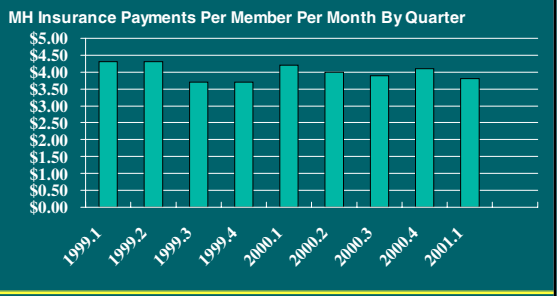
Utilization Did Not Explode Under Parity – Members in Indemnity (FFS) Medical Plan



Costs Before and After Parity – Members in Managed Care Medical Plans



Costs Remained Stable – Even After 10 Years

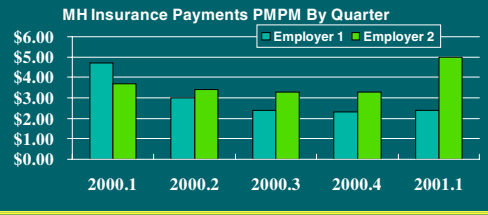


Comparing Ohio Experience to SAMHSA Predictions

- SAMHSA's predicted cost *increase* of expanding benefits higher than total cost of parity benefits.
- Bias partly due to the incorrect assumption that medical plan and behavioral health plans are identical, but managed care much more prevalent in behavioral health
- However, lack of new data in SAMHSA model likely to overestimate costs for less managed behavioral health plans as well

Recent Case Studies: Two West Coast Employers

- Switched to MH parity January 2001
- First employer covers over 20,000 in variety of medical plans
- Second employer covers over 60,000 in PPO medical plan
- All MH Care is managed by UBH



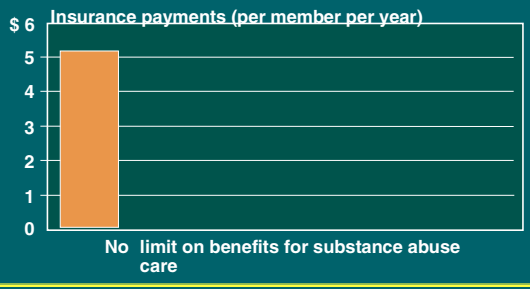
Even increase for employer B less than ¼ of SAMHSA prediction

- Random variation or other changes over time dominate effect of benefit changes
- Employer A's MH payments currently lower than previously, despite no changes in management
- Employer B's MH payments currently about $1.50 pm higher than in 2000
- But increase is less than 1% of total health premium
- No evidence that parity could cause increases of 3-4% in health premium.

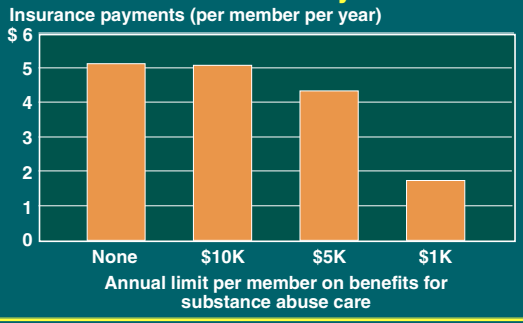
An Aside: Parity for Substance Abuse Treatment?

- SA often excluded in MH parity bills
- Could be inefficient: dual problem common among severely mentally ill
- SA costs are about 1/8 of MH costs, with correspondingly smaller parity effect
- However, social consequences of untreated SA may be especially costly
  - medical costs (alcoholism common among employees)
  - externalities

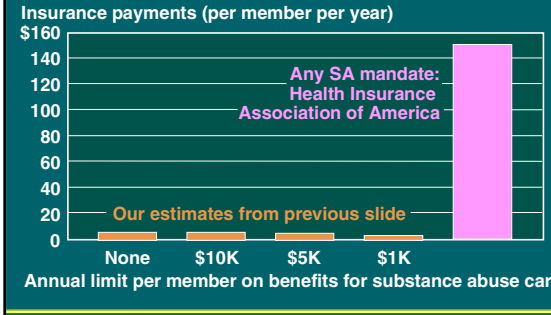
Few Employees Use SA Care => Total Costs Are Not Very High Under Unlimited Benefits



. . . So Increasing or Removing Limits Affects Costs Very Little



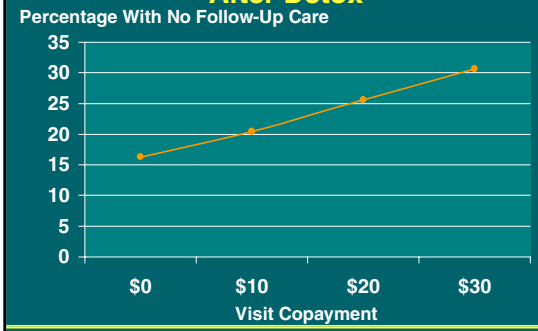
. . . And Much Less than Has Been Predicted



Parity Benefits Improve Quality of Care

- Lack of follow-up after detox major quality of care problem
- "Cycling" in and out of detox has led employers to impose limits on number of treatments
- But reduced copays increases follow-up and may avoid some of the repeat inpatient episodes

Copayments Affect Follow-Up Rates After Detox



Summary

- Evidence from actual employer experiences show that full parity benefits for MH and SA have negligible cost consequences
- Actuarial predictions overestimate costs by a factor of 4 to 8 (or even more), compared to actual experience
- Even the worst experience corresponds to less than 1% of total health premium