Insurance Benefits

# The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits


**U.S. Department of Health and Human Services**
Substance Abuse and Mental Health Services Admnistration
Center for Mental Health Services
Center for Substance Abuse Treatment

# The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits

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# EXECUTIVE SUMMARY

## *Background*

Health plans offered by employers typically provide less coverage for mental health and substance abuse (MH/SA) treatment than for general medical and surgical services. States and the federal government have begun to require that mental health and/or substance abuse treatment be covered in the same way as other medical care. This concept is known as "parity."

In 1996, Congress passed and President signed the Mental Health Parity Act. Effective January 1, 1998, this law requires that health plans provide the same annual and lifetime limits for mental health benefits as they do for other health care benefits. The act does not affect service limits, such as limits on outpatient visits, or cost sharing, such as deductibles. Nor does it apply to substance abuse benefits.

States have mandated parity, as well. By September 1997, 12 states had passed laws that, to various degrees, require parity in mental health and/or substance abuse benefits. Others have enacted legislation conforming to the federal mandate.

Opinion differs as to the costs and effects of parity mandates. This study was designed to address these issues by:

- summarizing the characteristics of state parity laws,
- conducting detailed case studies of five states with such laws,
- analyzing previous actuarial estimates of the costs of parity, and
- providing updated estimates of premium increases due to full and partial parity.

Following are the key findings of the study. Please see the full text for the specific context of each finding.

## *Key Findings*

- **Most State parity laws are limited in scope or application.** Few address substance abuse treatment, and many are limited to treatment for serious mental illnesses. Many exempt small employers or only apply to plans for government employees.

- **State parity laws have had a small effect on premiums.** Cost increases have been lowest in systems with tightly managed care and generous baseline benefits.

- **Employers have not attempted to avoid parity laws by becoming self-insured, and they do not tend to pass on the costs of parity to employees.** The low costs of adopting parity allows employers to keep employee health care contributions at the same level they were before parity.

- **Costs have not shifted from the public to the private sector.** Most people who receive publicly funded services are not privately insured.

- **Previous actuarial predictions of premium increases due to MH/SA parity ranged from 3.2 percent to 11.4 percent, primarily due to differences in their assumptions.** Some of these assumptions may have limited support. For instance, some estimates have assumed a cost shift from the public to the private sector as a result of a parity mandate. This study did not find support for this assumption, however.

- **Based on an updated actuarial model, full parity for mental health and substance abuse services is estimated to increase premiums by 3.6 percent, on average.** Mental health care accounts for most of this increase. Increases for mandates limited to parity in cost sharing or service limits will be lower (see table below).

- **Premium increases vary by type of plan.** Fee-for-service and preferred provider organizations would have a 5 percent premium increase. In contrast, health maintenance organizations that tightly manage care would have only a 0.6 percent premium increase.

- **Projected premium increases do not reflect potential market responses.** For example, employers might contract with more managed care firms to manage MH/SA benefits under a parity mandate. This employer response would result in lower premium increases.

- **Premium increases are greater for plans that are limited to children.** Under the Balanced Budget Act of 1997, states will receive block grant funds to fund health insurance for uninsured, low-income children. Including parity in these plans will likely increase premiums more than that for an equivalent plan for adults and families. However, these differences are minimal for services provided within health maintenance organizations.

## AVERAGE PREMIUM INCREASE DUE TO PARITY

| Type of Service | Parity in Cost Sharing | Parity in Service Limits | Full Parity |
|---|---|---|---|
| MH/SA | 0.4% | 1.2% | 3.6% |
| MH only | 0.3% | 1.1% | 3.4% |
| SA only | 0.1% | 0.03% | 0.2% |

# INTRODUCTION

Employment-based health insurance plans typically provide less coverage for mental health and substance abuse (MH/SA) services than for medical/surgical services. Some states and the federal government, and some employers, have begun to require that mental health and/or substance abuse treatment be covered in the same way as other medical care. This concept is known as "parity."

This report presents findings from a project conducted by Mathematica Policy Research, Inc. for the Substance Abuse and Mental Health Services Administration (SAMHSA) on the costs and effects of providing parity for MH/SA benefits. Primary funding for the report was provided by the Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT). Additional support was provided by other SAMHSA components, as part of the agency's managed care initiative.

This project sought to answer the following questions:

- Which states passed MH/SA parity laws? What are the provisions of the state parity laws?
- What are the effects of state parity laws on health insurance premiums, employers, insurers, and employees? How do employers and insurers respond to MH/SA parity laws?
- Why do existing actuarial predictions of health insurance premium increases due to parity differ so much?
- What are the predicted increases in health insurance premiums due to limited and comprehensive MH/SA parity benefit options?

To answer these questions, we conducted four analyses. First, we described and compared state parity laws (Heiser, et al., 1998). Second, we performed a case study analysis in five states that have parity laws to determine the early experiences of key stakeholders. We spoke with representatives from 47 organizations in the study states, including insurers, employers, employer associations, and insurance regulators (Hill, et al., 1998).

Third, we reviewed actuarial studies conducted in 1995 and 1996 of the costs of federal parity legislation (Sing and Hill, 1998b). Finally, we used an updated actuarial model to predict the costs of several full and partial parity benefit options (Sing and Hill, 1998a). The partial and full benefit options were developed with the help of a policy advisory panel that included representatives from the business community and from mental health, substance abuse, and managed care organizations in the public and private sectors (see Appendix C). The assumptions we used in the cost estimates were reviewed by an expert panel of actuaries and economists (see Appendix D).

This report is organized as follows. In chapter 1, we describe the policy context for the debate about parity and summarize federal and state parity laws. We present findings from the case study analysis in chapter 2. In chapter 3, we summarize previous actuarial studies of parity, and, in chapter 4, we present updated predictions of the premium increases for full and partial mental health and substance abuse parity.

# CHAPTER 1

# State Parity Laws

Since 1994, at least 40 states and the U.S. Congress have considered mental health and substance abuse (MH/SA) parity bills. Insurance regulation traditionally has been a state responsibility. The federal Mental Health Parity Act of 1996 imposed a national minimum benefit standard for mental health benefits on employer-sponsored health insurance for the first time.

## *Federal Parity Legislation*

In 1996, Senators Pete V. Domenici (R-NM) and Paul D. Wellstone (D-MN) proposed an amendment to S.1028, the Health Insurance Reform Act. This amendment would have required insurers to provide the same coverage for mental health and medical/surgical benefits. Actuaries predicted this amendment would raise health insurance costs by 3.2 percent to 8.7 percent (Bachman, 1996b; Rodgers, 1996).

In part because of fears about increased health insurance costs, the Domenici-Wellstone amendment did not pass. Instead, the federal government enacted the Mental Health Parity Act of 1996. This act requires that, starting January 1, 1998, insurers provide the same annual and lifetime spending limits for mental health benefits as they do for other health care benefits.

While this provision is a step toward parity for mental health care, it neither requires employers to provide mental health benefits, nor does it affect the terms and conditions of mental health coverage such as visits, days, and cost sharing. Furthermore, the provision exempts companies with 50 or fewer employees and companies for which the legislation results in increased costs of at least 1 percent. The Mental Health Parity Act does not apply to substance abuse benefits.

## *State Parity Mandates*

By the end of September 30, 1997, 12 states had enacted parity laws that require more generous MH/SA benefits than those provided for in the Mental Health Parity Act of 1996 (Heiser, et al., 1998). These 12 states are Arkansas, Colorado, Connecticut, Indiana, Maine, Maryland, Minnesota, New Hampshire, North Carolina, Rhode Island, Texas, and Vermont. Eleven states passed bills to comply with the Mental Health Parity Act of 1996. Other states passed laws that increase MH/SA benefits but do not require parity, but these are not discussed in this report.

The 12 state MH/SA parity laws differ significantly from each other in the (1) conditions covered, (2) specificity of parity, (3) minimum benefit requirements, (4) approved providers, (5) use of managed care, and (6) exemptions/populations covered (Table 1.1).

## TABLE 1.1

## CHARACTERISTICS OF MENTAL HEALTH AND SUBSTANCE ABUSE PARITY LEGISLATION BY STATE

| Characteristics of Legislation | State | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AR | CO | CT | IN | ME | MD | MN | NH | NC | RI | TX | VT |
| **CONDITIONS COVERED** | | | | | | | | | | | | |
| Definition of mental illness | | | | | | | | | | | | |
| Does not define mental illness (i.e., covers mental illness broadly) | | | | ✓ | | ✓ | ✓ | | | | | |
| Defines mental illness | ✓ | ✓ | ✓ | | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Covers only serious mental illness or "biologically based" mental illness | | ✓ | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | |
| Designates particular diagnoses | | ✓ | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | |
| Covers substance abuse | ✓ | | | | | ✓ | ✓ | | ✓ | | | ✓ |
| **SPECIFICITY OF PARITY** | | | | | | | | | | | | |
| Provides specific language about how MH/SA benefits may not differ from those for physical health | ✓ | | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ |
| **MINIMUM BENEFITS** | | | | | | | | | | | | |
| Specifies minimum benefit requirements | | | | | ✓ | ✓ | | | ✓ | | | |
| **APPROVED PROVIDERS** | | | | | | | | | | | | |
| Specifies providers who may offer services under the mandate | | | | | ✓ | | | | ✓ | | | ✓ |
| **MANAGED CARE** | | | | | | | | | | | | |
| Mentions managed care | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ |
| Contains medical necessity clauses | ✓ | | | | ✓ | ✓ | ✓[a] | | | ✓ | | |
| **EXEMPTIONS/POPULATIONS COVERED** | | | | | | | | | | | | |
| Only applies to government employees | | | | ✓ | | | | | ✓ | | ✓ | |
| Exempts small businesses | ✓ | | | | ✓ | ✓ | ✓[b] | | | | | |

[a]Minnesota enacted a definition of medical necessity in 1997. This definition will become effective on January 1, 1998.
[b]Small employers may choose an alternative benefit design without parity.

## Conditions Covered

All state mandates require mental illness to be covered in the same way as other medical care. However, they differ in how this term is defined, and sometimes limit coverage to serious or biologically based illnesses. Coverage for substance abuse treatment may or may not be mandated.

In some states, mental illness is broadly defined, and substance abuse is also covered. In Maryland, Minnesota, and North Carolina, the mandates include all mental illnesses broadly defined, and they explicitly state that substance abuse is included. In Vermont, the mandate covers all mental illnesses listed in the *International Classification of Diseases Manual,* and the mandate explicitly includes substance abuse.

In Arkansas, the mandate includes all mental illnesses listed in either the *International Classification of Diseases Manual* or the *Diagnostic and Statistical Manual of Disorders*. The mandate does not include substance abuse (Health Policy Tracking Service, 1997). Arkansas did, however, pass legislation in the late 1980s requiring parity for substance abuse (Scott, Greenberg, and Pizarro, 1992). In Indiana, the mandate includes all mental illnesses, but explicitly *excludes* substance abuse.

In the remaining states, the mandates list particular mental illnesses that are covered. Specifically, in Colorado, Connecticut, Maine, New Hampshire, Rhode Island, and Texas, the mandates cover only serious or biologically based mental illnesses. The list of specific illnesses that must be covered includes bipolar mood disorder, major depressive disorder, schizophrenia, schizo-affective disorder, obsessive-compulsive disorder, panic disorder, autism, and paranoia/psychotic/delusional disorders (Table 1.2). Substance abuse is not covered by these state mandates (Health Policy Tracking Service, 1997).

## Specificity of Parity

The parity mandates in all 12 states require health plans to provide coverage for mental illnesses that is comparable to coverage provided for other illnesses. Some laws provide little more direction than that, leaving what is meant by "coverage" (for example, service limits, cost-sharing requirements, annual/lifetime spending limits) and "comparable" open to interpretation by the carrier. Others are more specific about ways in which benefits for mental and physical illnesses may not differ.

In Colorado, Connecticut, and New Hampshire, the mandates do not specify the ways in which mental health benefits must be equal to those for physical illness. For example, in Colorado and New Hampshire, the laws simply state that health plans shall provide coverage for mental illness that is no less extensive than the coverage provided for any other physical illness.

## TABLE 1.2

## SERIOUS/BIOLOGICALLY BASED MENTAL ILLNESSES SPECIFIED IN PARITY LEGISLATION

| Serious Mental Illnesses/ Biologically Based Disorders | States | | | | | |
|---|---|---|---|---|---|---|
| | CO | CT | ME | NH | RI | TX |
| Bipolar mood disorder | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Major depressive disorder | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Obsessive-compulsive disorder | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Panic disorder | ✓ | ✓ | ✓ | ✓ | | |
| Paranoia/psychotic/delusional disorder | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Pervasive developmental disorder/autism | | ✓ | ✓ | ✓ | | |
| Schizo-affective disorder | ✓ | ✓ | | ✓ | ✓ | ✓ |
| Schizophrenia | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

In the other nine states, the legislation contains more specific language about how the benefits for mental illness may not differ from those for physical illness. For example, the laws assert that benefit and service limits must be at least as generous for mental illnesses as for other illnesses. However, the mandates vary in the level of detail provided.

In Indiana, for example, a health insurance contract "may not permit *treatment limitations or financial requirements* on the coverage of services for mental illness if similar limitations or requirements are not imposed on coverage of services for other conditions." Whereas Indiana refers to "limitations and requirements," Arkansas elaborates on this area by defining financial requirements as including "co-payments, deductibles, out-of-network charges, out-of-pocket contributions or fees, annual limits, lifetime aggregate limits imposed on individual patients, and other patient cost-sharing amounts." Some states also require minimum mental health benefits, as described below.

## Minimum Benefit Requirements

Mental health parity does not prevent insurers from providing a low level of benefits for mental illness by lowering the level of benefits provided for physical illness. To ensure that people with mental illness get a minimum acceptable level of care, three states (Maryland, North Carolina, and Maine) designate specific services that must be provided for mental illness, independent of the services provided for other illnesses. Though carriers may need to offer more services, if necessary, to achieve parity with other illnesses, they may not offer fewer services than specified by the laws.

Maryland mandates a minimum benefit package in which there can be no annual limit on outpatient visits. Outpatient visits must be covered at a level of at least 80 percent for the first 5 visits, 65 percent for the next 25 visits, and 50 percent for any other visits. The law further states that a minimum of 60 partial inpatient days must be covered.

North Carolina and Maine specify that certain care for mental illness is "necessary" and must be provided regardless of provisions for other illnesses. These two states do not specify the level at which such services must be provided, however. North Carolina's law states that "allowable institutional and professional charges for inpatient psychiatric care, outpatient psychotherapy, intensive outpatient crisis management, partial hospitalization, and residential care and treatment" are necessary and must therefore be covered. Maine's legislation says that "at a minimum, inpatient, day treatment, and outpatient services must be provided."

## Approved Providers

In three states--North Carolina, Maine, and Vermont--only specific providers identified by the law can offer services covered under the mandate. In all likelihood, the states did this to protect patients by ensuring that their diagnosis and treatment would be provided, or at least

supervised, by qualified mental health providers, and to protect insurers by lessening the chances that they would have to reimburse unnecessary or inappropriate care.

For example, the Maine legislation defines "provider" to include licensed physicians, accredited public hospitals or psychiatric hospitals, and community agencies licensed at the comprehensive service level by the Department of Mental Health and Mental Retardation. The mandate further states that services offered by these providers must be supervised by a psychiatrist or licensed psychologist. It also specifies that mental illnesses must be diagnosed by a licensed allopathic or osteopathic physician or psychologist.[1]

## Managed Care

Mandates in nine states mention managed care, primarily to state that managed care plans are included as health insurers covered by the mental health parity requirements, or that mental health benefits covered by the parity law may be delivered in a managed care system. Four states--Arkansas, Maine, Maryland, and Rhode Island--address the managed care concept of medical necessity by stating explicitly that medical necessity determinations are not prohibited. Arkansas, for example, defines medical necessity and does not prohibit plans from applying medical necessity determinations. Maine's mandate states that when determining medical necessity, providers must use the same criteria for medical treatment of mental illness as for medical treatment of physical illness.

North Carolina's mandate, which only covers the insurance plan for government employees, is relatively specific about managed care. It states that the benefits provided "shall be subject to a managed, individualized care component" that includes inpatient utilization reviews, readmission and length-of-stay reviews, and a network of qualified providers. Furthermore, care received outside the network is subject to an additional coinsurance rate of 20 percent above the general coinsurance rate in the package.

In Minnesota, the regulations specify criteria for exempting managed care plans and for determining which services are subject to parity. In some cases, the services covered differ for managed care and indemnity plans. For example, among large groups, only managed care plans are required to provide both inpatient and outpatient coverage (Blewett, 1997).

## Exemptions/Populations Covered

Government employees are the only population affected by the legislation in Indiana, North Carolina, and Texas. Three other states--Arkansas, Maine, and Maryland--exempt small businesses from the parity provisions. The law in Arkansas does not apply to individual plans or

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[1]The original parity legislation in Maine was amended in 1996 to include psychologists among those who can diagnose the mental illnesses covered. Prior to that amendment, only illnesses diagnosed by licensed allopathic or osteopathic physicians were covered.

to employers with 50 or fewer employees as long as they offer the parity provisions as an option. The law also does not cover state employees and health benefit plans if provisions would result in a cost increase of 1.5 percent or more. Maryland exempts small employers with 2 to 50 employees, and Maine exempts small employers with 20 or fewer employees.

In all states, Medicare and Medicaid, federal employee health insurance plans, and employer self-insured plans, which are not regulated by state health insurance laws, are automatically exempt. Private employers who are self-insured are exempt from state health insurance laws under the federal Employee Retirement Income Security Act of 1974 (ERISA). But unlike the state laws, the federal Mental Health Parity Act of 1996 does apply to self-insured plans.

# CHAPTER 2

# Case Studies

Mental health and substance abuse (MH/SA) parity may affect insurers, employers, state agencies, and consumers. We used case study methods to more fully understand the effects of parity from the perspectives of these groups.

Case study analyses of parity describe informants' judgments about the effects of parity and provide information more quickly than statistical analyses. But unlike statistical analyses, they cannot be used to estimate the costs of parity or provide the percentage of organizations that are affected. Statistical studies require detailed health expenditure data before and after parity is implemented. In addition, for comparison purposes, statistical studies require health expenditure data from employers that have implemented parity and those who have not. To date, published statistical studies of the insurers' or employers' experiences with parity are limited (National Advisory Mental Health Council, 1997).

## *Study Methods*

To explore the effects of MH/SA parity on key stakeholders, we conducted case studies in 5 of the 12 states that have parity laws. We wanted each state to have at least one year of experience with parity. Therefore, we chose the four states that required parity in coverage for private-sector employees on or before 1995 (Maryland, Minnesota, New Hampshire, and Rhode Island), and Texas, which is one of two states with a law applying to coverage for public employees. In addition, we contacted five employers who voluntarily adopted parity for MH/SA insurance benefits, and two agreed to participate in our study.

From May through July 1997, we contacted 47 organizations in the study states, including insurers, employers, employer associations, and public officials, such as representatives from the state departments of mental health and substance abuse. We also spoke with provider associations, such as state psychiatric associations, and consumer and family advocates. Informants from the 5 states included representatives from 9 insurers, 6 employers and unions, 3 associations of small employers, 18 public agencies, 6 provider associations, and 5 consumer and family advocacy groups.

We spoke with more organizations in states with broader laws. These included 18 organizations in Minnesota, 13 in Maryland, 8 in Rhode Island, 6 in New Hampshire, and 2 in Texas. We did not contact any insurers in New Hampshire because Lewin (1997) had recently done so. Finally, we spoke with benefits staff from the two employers that voluntarily adopted parity. Some of the information shared with us is confidential. We therefore keep the organizations and individuals that participated in this study anonymous.

# *Study Findings*

## Impact of Parity on Premiums

We asked 20 insurers, employers, and insurance regulators about the effects of parity on MH/SA expenditures and premiums. We spoke with at least one insurer, employer, or regulator in each study state and many in Minnesota. All nine of the insurers in our case studies used managed care for MH/SA treatment services. In the discussion below, we emphasize the reports from the most knowledgeable informants.

For two reasons, many informants could not say exactly if, or by how much, parity raised MH/SA costs or service use. First, data on the subject were sometimes confidential. Second, because MH/SA expenditures are generally a small portion of a health insurer's total premium, many insurers do not allocate resources to collect these data. According to William M. Mercer (1997), MH/SA expenditures constitute about 4 percent to 7 percent of total health care expenditures in a highly managed preferred provider organization (PPO) plan.

Even when changes in MH/SA expenditures were known, informants reported that other factors, such as competition, could have larger effects on premiums than parity. These other factors made it difficult to precisely determine the role of parity.

Informants knew the trends in total premiums, but most relied on their judgment and experience to decide whether any change in premiums was due to MH/SA parity laws. Informants provided more detailed information on the MH/SA expenditures or utilization for only six plans. Given the small number of informants and the variable quality of the information they provided, our answers to the research questions are qualitative, rather than precise.

**Most insurers, especially managed care plans, experienced small increases in total premiums.** Most, but not all, insurers in Maryland, Minnesota, New Hampshire, and Rhode Island reported small increases in total premiums due to MH/SA parity laws. Representatives from two managed care companies in Maryland stated that premiums increased by 1 percent or less due to the 1995 MH/SA parity law. After this initial increase, total premiums generally "leveled out."

However, the two Maryland managed care plans had different experiences with MH/SA inpatient and outpatient expenditures and service use. While one plan observed a "slight" increase in outpatient service use by enrollees as a result of parity, the second reported a "significant" increase in the use of outpatient and partial hospitalization services. Inpatient MH/SA hospital use rose for enrollees in the first plan but dropped slightly for enrollees in the second. Hospital use was measured by the number of days per thousand enrollees.

For the Maryland insurer with the largest increase in outpatient care, expenditures increased by 22 percent during the first 6 to 8 months after parity was implemented. Because MH/SA expenditures represent about 5 percent of total health care costs, the total premium increase due to parity was just over 1 percent. However, this informant told us that a 22 percent increase in MH/SA expenditures is a large increase in MH/SA costs.

In Minnesota, informants said that after the 1995 MH/SA parity law was enacted, health care premiums did not increase or did so by only a few percentage points. Relying on their judgment and experience, six informants said they believed that premium increases due to parity were small. Two of these informants quantified premium increases as 1 percent or 2 percent. These findings are similar to those reported by Koyanagi (1996) and Blewett (1997).

In New Hampshire, informants used data on total premium increases along with their judgment and experience to assess the increase in premiums due to the parity law. These informants estimated that the state's 1995 serious mental illness (SMI) requirement led to premium increases of 5 percent or less. These findings are consistent with the findings from the Lewin Group (1997).

Informants in Rhode Island generally did not attribute premium increases to the newly established parity for SMI benefits. The increases they did mention were very minor. One informant from a managed care company observed no impact on costs but noted that it may take some time for the law to have an effect. Since the law was passed, no enrollees in this company's plan have used more than 90 days of inpatient care, which is the minimum benefit under the law.

Another Rhode Island managed care company with information based on health expenditure data observed a premium increase of less than 1 percent. One informant said that the state's SMI parity law did not lead to large premium increases because it covers only medication visits and hospitalization.

**Expenditures for MH/SA treatment dropped if managed care was introduced at the same time as parity**. The SMI parity mandate for state employees in Texas became effective in September 1992. At that time, a managed behavioral health care plan replaced the fee-for-service (FFS) plan that had been offered to state employees. State employees could enroll in this managed care plan offered by Blue Cross/Blue Shield of Texas or in one of several HMOs.

From 1992 to 1995, the cost of MH/SA care for state employees enrolled in the Blue Cross/Blue Shield plan dropped by 47.9 percent (National Advisory Mental Health Council,

1997). By 1995, all claims for SMI amounted to about $2.40 per member per month. This is equal to about 1.5 percent of all claims costs.[2] HMO data were unavailable.

Of the two employers that voluntarily adopted parity for MH/SA services, one had extremely high MH/SA costs in a FFS plan before offering parity. To contain costs, the company decided to offer employees a managed care plan with mental health parity, in part to make the plan more attractive to employees who were opposed to managed care. Costs for MH/SA care fell dramatically because of the increased utilization management.

Employers who did not have such high costs before parity likely would not realize comparable cost savings, our informant noted. These findings and those from Texas are consistent with findings of another case study conducted by William M. Mercer, an employee benefits consulting firm, which found that two employers that implemented parity lowered their MH/SA expenditures by using managed care firms (Mercer, 1997).

## Reasons Why Premium Increases Were Small

Case study informants identified two main reasons for the small total premium increases after MH/SA parity laws were passed. First, as mentioned, managed care played a key role in containing expected cost increases. Second, parity represented only a small increase in MH/SA benefits for some states.

**Managed care and competition constrained premium increases.** Managed care played a role in containing expected cost increases after MH/SA parity laws were passed. As noted above, MH/SA treatment dropped dramatically for employers who introduced managed care for MH/SA services when parity was adopted.

In Maryland and Minnesota, informants noted that MH/SA care was moderately to tightly managed before parity. This resulted in either no premium increase or an increase of a few percentage points or less. Several informants said that competition in the health care market in Minnesota also constrained premium increases. For example, a purchaser changed health plans because premiums rose by 2 percent. (Informants said the increase was not due to the parity law.) According to one informant, some health plans in Minnesota had been heavily discounting their premiums. However, insurers might have more heavily discounted premiums if the state had not mandated parity.

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[2]These costs are based on data in a letter from Sheila W. Beckett, Executive Director, Employees Retirement System of Texas, to Texas Rep. Garnett Coleman, February 27, 1997.

**Some states already required broad MH/SA coverage, or they legislated limited parity.** Parity resulted in only a small increase in MH/SA benefits in New Hampshire and Rhode Island, in part because the 1995 laws apply to a small number of people (those with SMI), and New Hampshire had generous benefits before parity was implemented.

In New Hampshire, our informants explained, the 1995 parity law applies only to people who have serious mental illnesses, who represent a very small percentage of the population. Less than 3 percent of U.S. adults have serious mental illnesses (National Advisory Mental Health Council, 1993). In addition, case study informants told us that few people with serious mental illnesses work for large employers that have health insurance plans. In Rhode Island, the new law applies only to medical treatment for serious mental illnesses.

Further, two informants noted that New Hampshire had passed MH/SA mandates as early as 1975. At that time, the state required group insurers and HMOs to provide mental health hospital services on the same basis as services for other illnesses under major medical care. The law also required group insurers and HMOs to cover at least 15 hours of outpatient treatment after two visits (The Lewin Group, 1997).

## Impact on Employers and Insurers

MH/SA parity laws increase the incentive for insurers and employers to minimize the cost of MH/SA treatment. They may reduce these costs in three main ways. First, employers can offer coverage through managed care rather than FFS plans. Second, they can drop insurance coverage or become self-insured. State parity laws do not apply to self-insured employers. Finally, they can pass on the costs of parity to employees by raising employee contributions to health insurance or by paying lower wages.

**Employers and insurers used managed care to contain costs.** Parity was related to increased enrollment in managed MH/SA care plans and tighter utilization management for MH/SA treatment. Public employers in Texas and one employer who voluntarily adopted parity replaced their FFS MH/SA plans with managed behavioral plans. In addition, some informants reported that parity increased the intensity of utilization management.

In New Hampshire, managed care plans responded to parity by tightening the criteria they use to determine medical necessity. Some insurers in New Hampshire reported expanding their case management protocols for SMI (The Lewin Group, 1997). The managed care market was already strong in Minnesota, Maryland, and Rhode Island, so informants did not report much increase in managed care in those states.

**Employers did not become self-insured or decide to pass on the full cost of parity to employees.** None of the insurers or associations of small employers in our study identified MH/SA parity laws as a main consideration in a decision to self-insure. However, they may have

made the decision for other reasons. For example, in Minnesota, some employers decided to self-insure to avoid a 2 percent premium tax.

None of the employers we spoke with mentioned changing employee contributions to reflect changes in MH/SA benefits. For example, two employers continued to use the same premium contribution formula, so employees paid the same percentage of their health insurance costs. A few informants said that the low costs of adopting the law might be responsible for the lack of employer response. In addition, employers may have decided to keep employee contributions the same in order to sustain employee morale and good will.

In Minnesota, small employers may offer their employees a basic benefit plan instead of a plan that provides full MH/SA parity. A case study participant told us that most small employers, however, chose a plan subject to the state laws because the total costs are about the same. Under Rhode Island's Small Employer Health Insurance Availability Act, employers with fewer than 50 employees may purchase a standard or economy benefit plan with less extensive coverage than full parity. However, an informant told us that these benefit packages are so limited that employers never purchase them. Instead, they choose coverage subject to the law.

**Most employers did not collect and analyze data to measure changes in productivity or employee absenteeism due to parity**. It could be argued that employees who use the additional MH/SA benefits may function better in the workplace and become more productive. Employers would benefit from less absenteeism and lower employee turnover. However, case study informants thought that parity did not affect productivity, or they did not know whether it did.

Two informants said that MH/SA parity had no effect on employee absenteeism or turnover. Several informants told us that because productivity is difficult to measure, they could not determine the extent to which more generous MH/SA benefits increased productivity. One informant credited increased productivity to the company's employee assistance plan.

These findings are consistent with those of William M. Mercer (1997), which conducted a telephone survey of benefit managers at 24 companies. Of the six companies that provided the most comprehensive MH/SA coverage, none had measured changes in productivity or absenteeism due to MH/SA parity.

## Impact on Public MH/SA Expenditures

State and local governments traditionally have financed a substantial portion of MH/SA services. Some actuaries have assumed that MH/SA parity laws would shift the provision of MH/SA care from the public to the private sector (Bachman, 1996b; Rodgers, 1996).

This reasoning is based on two assumptions. The first assumption is that before parity was legislated, the public sector was financing MH/SA care for people who were privately insured but whose benefits did not cover necessary MH/SA services. Under parity, these people should be able to bill their private insurers for more MH/SA care instead of using publicly funded services. The second assumption is that parity mandates must increase the amount or type of services that private insurers cover. Neither of these assumptions was borne out by our study.

**Nearly all case study informants reported they had seen no changes in state spending on MH/SA as a result of parity.** These informants included state program officials from Maryland, Minnesota, New Hampshire, and Rhode Island, as well as insurers, MH/SA provider associations, and consumer advocates. Furthermore, detailed expenditure data from New Hampshire's public mental health system show no evidence of a decline in public mental health expenditures resulting from parity.

Our informants gave two key reasons why parity did not seem to affect public MH/SA expenditures. First, publicly financed MH/SA services are provided primarily to people who have serious mental illnesses or severe substance abuse disorders. Because most of these individuals are unable to work or can work only part-time, they have no access to private insurance. Therefore, they are not affected by parity.

Second, the public system finances many services that private insurers do not cover, even under parity, because they are not considered medically necessary. Such services include psychosocial services (such as psychosocial rehabilitation and life-skills training) and services requested by a third party (such as court-ordered services). People needing these services must seek care from publicly financed providers.

In addition, ERISA and small employer exemptions reduce the number of people affected by parity laws. State MH/SA parity laws do not affect most people in employer-sponsored health plans because they are enrolled in a self-funded plan (exempt under ERISA), or because they are in a small employer plan (exempt from the state law).

More specifically, we found that state MH/SA parity laws affect only about 30 percent of people with health insurance in Maryland, Minnesota, and Rhode Island (Lipson and De Sa, undated; Maryland Insurance Administration, undated). Informants in New Hampshire had no data or estimates on the number of people enrolled in self-funded plans.

In Maryland, Minnesota, and Rhode Island, small employers are exempt from MH/SA parity laws. Under the Maryland Health Care and Insurance Reform Act of 1993, all insurance contracts sold to employers who have 2 to 50 employees eligible for coverage must provide the benefits required in a standard comprehensive benefit plan. This small group policy limits inpatient MH/SA hospital days to 25 per person per year. As we noted above, small employers in Minnesota and Rhode Island have not used the small employer exemptions in those states.

# CHAPTER 3

# Actuarial Assumptions

This chapter begins with a discussion of some of the key components of the studies conducted during 1996 that estimated the increase in premiums due to mandates requiring parity in mental health and substance abuse (MH/SA) insurance coverage. Previous actuarial predictions of premium increases due to MH/SA parity varied widely, primarily due to differences in their assumptions. We also discuss the assumptions underlying the updated model we used to make our cost estimates, which are discussed in chapter 4.

## *Previous Actuarial Studies of Parity*

In 1996, four actuarial studies predicted the increase in health insurance premiums that would have resulted had the Domenici-Wellstone amendment to S.1028 passed. (The Domenici-Wellstone amendment would have required full parity for mental health benefits.) These predictions varied widely. They ranged from 3.2 percent by Coopers and Lybrand (Bachman, 1996b) to 8.7 percent by Price Waterhouse (Rodgers, 1996). Milliman and Robertson, Inc. predicted a 3.9 percent premium increase (Melek and Pyenson, 1996a). The Congressional Budget Office (CBO, 1996) predicted a 4.0 percent increase.

Four other actuarial studies were conducted in 1996. Two studies estimated the increase in premiums for S.298, which would have mandated parity for serious mental illnesses (SMI) only. This bill also did not pass. These estimates ranged from 2.5 percent (Melek and Pyenson, 1996b) to 11.4 percent (Watson Wyatt Worldwide, 1996). Two other studies estimated the increase in premiums due to the Mental Health Parity Act of 1996. These estimates were similar--0.4 percent (Lemieux, 1996) and 0.3 percent (Bachman, 1996a).

## Assumptions Underlying the Previous Studies

Differences in the estimates of the costs of different parity proposals are largely the result of differences in the assumptions underlying the models used in the studies (Sing and Hill, 1998). These actuarial models include the components discussed below. The studies are summarized in Table 3.1.

**Diagnoses**. The text of the mental health parity provision to S.1028 (the mental health parity proposal) did not indicate whether "mental health" referred to mental health services only, or to both mental health and substance abuse services. Consequently, some studies included all MH/SA diagnoses in the parity mandate, and some included only mental health, excluding substance abuse. S.298, the SMI parity proposal, applied only to SMI diagnoses such as

## TABLE 3.1

## ACTUARIAL COST STUDIES ESTIMATING THE EFFECTS OF EXPANDED MH/SA INSURANCE BENEFITS

| Legislation Analyzed | Study | Organization for Which the Analysis was Conducted | Estimated Increase in Premiums Due to Mandate |
|---|---|---|---|
| S.1028 | Congressional Budget Office (May 13, 1996) | U.S. Congress | 5.3 percent for indemnity plans<br>4.0 percent for a composite of indemnity and managed care plans |
| | Coopers and Lybrand LLP (April 1996) | American Psychological Association | 3.2 percent |
| | Milliman and Robertson, Inc. (April 12, 1996) | The Coalition for Fairness in Mental Illness Coverage[a] | 3.9 percent for mental illness and substance abuse<br>3.2 percent for mental illness (excluding substance abuse) |
| | Price Waterhouse (May 1996) | Association of Private Pension and Welfare Plans<br>Business Roundtable<br>ERISA Industry Committee<br>National Association of Manufacturers | 8.7 percent for composite of fee-for-service, PPO, POS, and HMO plans |
| S.298 | Watson Wyatt Worldwide (March 1996)[b] | Association of Private Pension and Welfare Plans | 8.4 percent for lower demand response<br>11.4 percent for prudent demand response |
| | Milliman and Robertson, Inc. (April 11, 1996) | Coalition for Fairness in Mental Illness Coverage[a] | 2.5 percent |
| S.2031 | Congressional Budget Office (September 1996) | U.S. Congress | 0.4 percent initially<br>0.16 percent after employer responses |
| | Coopers and Lybrand LLP (September 1996) | American Psychological Association | 0.3 percent for indemnity plans<br>0.12 percent for composite of fee-for-service, PPO, POS, and HMO plans |

[a]The Coalition for Fairness in Mental Illness Coverage represents the National Alliance for the Mentally Ill, the National Mental Health Association, the American Managed Behavioral Healthcare Association, the American Psychiatric Association, and the National Association of Psychiatric Health Systems.

[b]The Watson Wyatt Worldwide estimates were made for all mental health diagnoses, not just SMI diagnoses.

schizophrenia, manic depressive disorder, and major depression. However, one study estimating the costs of S.298 included all mental health diagnoses instead of only SMI diagnoses.[3]

**Health care delivery system.** This component indicates the distribution of enrollees in fee-for-service (FFS), preferred provider organization (PPO), point-of-service (POS), and health maintenance organization (HMO) plans. Most studies estimated the premium increase for a composite of these plans. These composite studies specified a separate set of assumptions for, and computed the impact in, each delivery system. The impact in each delivery system was then weighted and summed with the weighted impacts of the other delivery systems to estimate an aggregate impact. Two studies estimated the premium increase for a PPO plan.

**The impact of managed care.** The impact of managed care indicates the effect of utilization management activities on health expenses. The studies generally characterized FFS plans as loosely managed delivery systems (with little control of health expenses), PPO/POS plans as moderately managed systems (with moderate control of expenses), and HMOs as tightly-managed systems (with firm control of expenses). However, one study assumed that POS plans were also tightly managed.

**Pre-parity MH/SA benefit package.** Some studies estimated the increase in premiums for a "typical" pre-parity MH/SA benefit package, and others estimated the increase for a "leaner" pre-parity MH/SA benefit package that required larger out-of-pocket costs for enrollees using the same level of services. Some of the leaner packages specified a 50 percent inpatient MH/SA coinsurance, instead of the typical 80 percent coinsurance.

**Induced demand.** This component incorporates the models' assumption about *consumer response* to a change in the price of MH/SA services. When MH/SA insurance coverage is expanded, the price of these services to plan enrollees declines, since there may be higher covered service limits and lower enrollee cost sharing. The induced demand effect indicates the degree to which consumers increase their use of MH/SA services in response to a decline in the price of these services. The assumptions for the increase in health plan expenses due to induced demand ranged from 5 percent to 69 percent.

**Reduced utilization management for MH/SA services.** Parity could require plans to manage medical/surgical and MH/SA treatment to the same extent. One study assumed that most insurance plans more stringently manage MH/SA treatment than medical/surgical care. That study also assumed that these plans would, therefore, reduce their management of MH/SA treatment to comply with the parity legislation. The other studies did not make these assumptions. None of the federal or state MH/SA parity laws that were passed on or before 1995 mandated and enforced parity with respect to utilization management.

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[3]The Watson Wyatt Worldwide estimates include all mental illness treatment (Hay/Huggins Company, Inc. 1997c).

**Shift from public-sector to private-sector provision.** State and local governments finance a substantial portion of MH/SA services. Most of the studies assumed that expanding private coverage of MH/SA services would have no effect on the amount of services provided in the public sector, or that these effects would not be relevant to their premium estimates. Two studies, however, assumed that a substantial shift would occur.

## Different Assumptions in Two Key Areas

The actuarial studies of the Domenici-Wellstone amendment (S.1028) had widely different assumptions in two important areas. These areas are (1) the impact of managed care, and (2) whether parity results in a shift from public-sector to private-sector service provision.

**The impact of managed care.** Utilization management is key to constraining health care costs. The highest estimate of premium increases due to parity, 8.7 percent by Price Waterhouse (Rodgers, 1996), and the lowest estimate, 3.2 percent by Coopers and Lybrand (Bachman, 1996a), illustrate the different assumptions about managed care.

Coopers and Lybrand assumed that 50 percent of consumers would be in an HMO or POS plan, and that both of these plans are tightly managed. However, POS plans are typically classified as being moderately managed because they cover services provided by non-network providers, while HMOs do not. This suggests that instead of 50 percent, less than 30 percent of enrollees in 1996 would have been in tightly managed plans (Jensen, et al., 1997; Miller and Luft, 1994).

Unlike the other models, the Price Waterhouse model assumes that parity applies to utilization management, which will result in *less* management of MH/SA services. The model assumes that before parity, MH/SA services are more tightly managed than medical surgical services. Consequently, the model assumes that the amount of utilization management for MH/SA services in FFS, PPO, and POS plans would drop after parity, leading to an increase in expenditures. Although a law could require parity with respect to utilization management, to date no state or federal law has mandated and enforced such a requirement. Therefore, this assumption currently is not very realistic.

**A shift from the public to the private sector.** Some of the models assume that parity in employment-based insurance will cause a shift in the provision of MH/SA services from the public sector to the private sector. In other words, they assume that if the private sector provides more MH/SA coverage, consumers may use less publicly financed services and more MH/SA services paid for by private insurance.

In particular, Price Waterhouse assumed that this shift would raise FFS mental health expenditures by 50 percent and PPO/POS mental health expenditures by 21 percent (Rodgers, 1996). This is the second reason their predictions are higher than the other studies. No quantitative research has examined such shifts as a result of parity mandates, and we did not find any evidence of such a shift in the case study findings presented in chapter 2.

## *Actuarial Study for This Report*

Based on this analysis of previous studies, our own case study findings, a review of the research to date, and input from this project's expert panel of actuaries and economists (see Appendix D), we made the actuarial assumptions described below. A majority of the expert panel members who commented on the assumptions agreed that the model's assumptions were reasonable.[4] The panel includes representatives from three of the five organizations that produced actuarial estimates for federal parity legislation in 1996.

### Assumptions Underlying the Updated Study

**Baseline benefit packages.** The baseline benefit packages for FFS, PPO, POS, and HMO plans represent typical packages that reflect the Mental Health Parity Act of 1996. In other words, for each type of plan, the baseline benefit package is the one that has the highest percentage of enrollees (the statistical "mode"). It is also the one in which the benefit maximum for mental health services equals the benefit maximum for medical/surgical services.

**Induced demand.** As noted earlier, the induced demand effect indicates the degree to which consumers increase their use of MH/SA services in response to a decline in the price of these services. Our assumptions about induced demand are based on findings from the RAND Health Insurance Experiment, which examined the effects of various cost-sharing arrangements on the use of health services and on the health status of individuals (Manning, et al., 1989). We assume a slightly lower response from people enrolled in HMOs. This assumption was suggested by two expert panel members.

**Amount of utilization management.** For medical/surgical services, the model assumes that FFS plans are lightly managed, PPO and POS plans are moderately managed, and HMOs are tightly managed. For MH/SA services, we assume more aggressive management. For FFS, PPO, and POS plans, we assume that, on average, the management of MH/SA benefits leads to a 25 percent reduction in costs compared to no management. For HMOs, we assume that MH/SA services are provided by behavioral carve-out plans that aggressively manage care and yield large cost savings.

**Administrative costs.** Our assumptions about administrative costs are based on a 1994 HayGroup study for the CRS (Hay/Huggins Company, Inc., 1997a). We assume that HMOs have higher administrative costs, especially for their MH/SA services.

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[4]In October 1997, we asked all expert panel members for their comments on the initial assumptions. Only one panel member did not respond. In November 1997, a draft of Sing and Hill (1998a) was sent to panel members to see if they had any additional comments on any of the model assumptions.

**Shift of MH/SA service delivery from the public to the private sector.** We assume that parity does not shift the provision of MH/SA services from the public sector to the private sector. This assumption is based on case study findings described in the previous chapter.

**Family demographics.** Based on data from the Current Population Survey, the model assumes that 84 percent of employees with family coverage have a covered spouse and that there are 1.22 children per family. The model also assumes that spouses have expenditures that are 1.08 times higher than those of employees.

# CHAPTER 4

# Cost Estimates

One main goal of this study was to project the costs of providing parity for mental health and substance abuse (MH/SA) insurance benefits. We did this by using an actuarial model to predict the premium increases for three benefit options. One option gives full parity, and the other two give partial parity, for MS/SA benefits. Information about the relative costs of parity options can be used by employers and benefit managers who want to assess the tradeoffs between offering full or partial parity for MH/SA benefits.

In this chapter, we present the three parity benefit options we developed and discuss the updated actuarial model we used to determine our cost estimates of premium increases for families. We also determine increases in premiums for child health plans with parity that states may develop as a result of the Balanced Budget Act of 1997. Finally, we offer some caveats for interpreting the results.

## *Options for Providing Parity in MH/SA Insurance Benefits*

The three benefit options we analyzed in this study were developed in consultation with this project's policy advisory panel. The panel included representatives from the business community and from mental health, substance abuse, and managed care organizations in the public and private sectors (see Appendix C).

We estimated premium increases for one full and two partial MH/SA parity benefit options. In this study, "full parity" means that insurance benefits for any group of MH/SA diagnoses must be the same as insurance benefits for medical/surgical diagnoses with respect to three areas--cost sharing (such as copayment or coinsurance amounts), service limits (such as the number of outpatient visits or inpatient hospital days), and annual or lifetime spending limits (such as annual or lifetime benefit maximums).

Partial parity means that benefits for MH/SA diagnoses must be the same as benefits for medical/surgical diagnoses in two of the three areas listed above. One of the partial parity options requires parity with respect to cost sharing and spending limits. The other requires parity with respect to service limits and spending limits. Both partial parity options comply with the Mental Health Parity Act of 1996, since they require parity with respect to spending limits.

The costs of each full and partial parity option are predicted for the following diagnosis groups and plans:

- three diagnosis groups for families (all MH/SA diagnoses, MH diagnoses only, SA diagnoses only); and all MH/SA diagnoses for children only; and
- four plan types (FFS, PPO, POS, and HMO).

The baseline (initial), partial parity, and full parity MH/SA benefit options for a FFS plan are listed in Table 4.1. Full parity plans are listed in Table 4.2. For each plan type, the full parity benefit options have unlimited MH/SA inpatient days and outpatient visits. The cost- sharing requirements are the same as the cost-sharing requirements for medical/surgical benefits for the typical plan. For FFS plans, the cost-sharing requirement for covered services under the full parity option includes a 20 percent coinsurance payment for inpatient and outpatient services.

The typical plan was determined based on a review of the literature (O'Grady, 1996; KPMG Peat Marwick, 1997). In addition, our expert of actuaries and economists reviewed our assumptions about the benefit packages.

## *Method for Estimating Costs*

We used actuarial cost models developed by the HayGroup to estimate the costs of the full and partial parity benefit options. The model in our study improves on models in previous actuarial studies in several ways. First, it was recently revised by the HayGroup. This revised version includes expense data from managed behavioral health care companies, separate expense data for substance abuse services, and separate data on MH/SA expenses for children. Earlier versions of the HayGroup model did not include these features.

Second, the assumptions we used to estimate the premium increases, as defined in chapter 3, were reviewed by this project's expert panel of actuaries and economists. Many of our initial assumptions were revised according to their comments. Third, our assumptions incorporate new data and case study findings that were not available in 1996. Finally, we produced separate estimates for a wider range of benefit options, diagnosis groups, and health plan types than previous studies. The updated actuarial model and assumptions are described more fully in Sing and Hill (1998a).

### The Estimation Process

The estimation process is as follows. The models predict premiums for health plans by using data on the benefit packages of the full and partial parity benefit options. These data include information on covered services, service limits, and cost-sharing arrangements. The model then builds in assumptions about administrative costs, the level of utilization management, and patients' responses to changes in their out-of-pocket costs.

The cost of each parity benefit option is the difference between the predicted premium for that option and the estimated premium for a "baseline plan." In this study, a baseline plan is a typical health plan covering medical/surgical and MH/SA services. For each plan type, it is the benefit package that has the most enrollees (the statistical mode). For example, a typical FFS plan covers 30 days of inpatient care and 20 outpatient visits for MH/SA services (O'Grady, 1996). In comparison, a full parity FFS plan would cover unlimited inpatient days and outpatient visits for MH/SA services.

**TABLE 4.1**

**PARTIAL AND FULL PARITY BENEFIT OPTIONS FOR A FEE-FOR-SERVICE PLAN**

| MH/SA Service | Baseline Benefits (Typical FFS Benefits) | Partial Parity | | Full Parity |
|---|---|---|---|---|
| | | Parity in Service Limits | Parity in Cost Sharing | |
| Inpatient Hospital | 30 days<br>20% coinsurance | Unlimited days<br>Days 1-30: 20% coinsurance<br>More than 30 days: 50% coinsurance | 30 days<br>20% coinsurance | Unlimited days<br>20% coinsurance |
| Outpatient | 20 visits<br>50% coinsurance | Unlimited visits<br>50% coinsurance | 20 visits<br>20% coinsurance | Unlimited visits<br>20% coinsurance |

## TABLE 4.2

## FULL PARITY BENEFIT OPTIONS

| MH/SA Service | Fee-For-Service | PPO | | POS | | HMO |
|---|---|---|---|---|---|---|
| | | In-Network | Out-of-Network | In-Network | Out-of-Network | |
| Inpatient Hospital | Unlimited days 20% coinsurance | Unlimited days 10% coinsurance | Unlimited days 30% coinsurance | Unlimited days fully covered | Unlimited days 20% coinsurance | Unlimited days covered in full |
| Outpatient Services | Unlimited visits 20% coinsurance | Unlimited visits 10% coinsurance | Unlimited visits 30% coinsurance | Unlimited visits $10 copayment | Unlimited visits 20% coinsurance | Unlimited visits $10 copayment |

Appendix B illustrates how to compute the premium increase due to a benefit option with increased MH/SA insurance benefits. The new premium is the sum of the baseline MH/SA and medical/surgical expenditures plus the increase in MH/SA expenditures. The percentage premium increase is the difference between the new premium and the baseline premium, divided by the baseline premium. A large percentage change in MH/SA expenditures causes a small change in premiums, because MH/SA expenditures account for only a small part of premiums (4 percent to 6 percent of the expense data in the HayGroup model, depending on the type of health care plan).

## The HayGroup Actuarial Model

The HayGroup actuarial model has been used extensively to study the effects of proposed policies for the federal government. Earlier versions of this model were developed under contract with the Congressional Research Service (CRS). These versions were used to predict the costs of the Mental Health Parity Act of 1996 and the Domenici-Wellstone amendment to the Health Insurance Reform Act of 1996. The model was recently updated in consultation with the National Institute of Mental Health. The updated model includes data from managed behavioral health plans, separate expense data for children, and substance abuse data (Hay/Huggins Company, Inc., 1997b).

Sturm (1997) recently criticized an older version of the HayGroup model. He believes that the model overstates the costs of parity because it does not adequately account for managed care in the delivery of MH/SA services. This criticism is no longer relevant since the revised model includes data and assumptions for managed behavioral health plans.

**Assumptions about PPO and POS plan network use and provider discounts.** The HayGroup actuarial model is adjusted to incorporate three features of PPO and POS plans. These features are (1) network provider discounts, (2) coverage for in-network and out-of-network services, and (3) the effects of utilization management by POS gatekeepers.

Enrollees in PPO and POS plans pay lower out-of-pocket costs when they use network providers. These lower costs encourage enrollees to use these providers. Enrollees in PPOs can self-refer to any provider they wish to see. However, many enrollees in POS plans are assigned to a primary care network provider called a "gatekeeper." The gatekeeper must authorize all in-network service use (Jensen, et al., 1997). Providers in PPO and POS networks agree to charge a discounted price for the services they provide to PPO and POS plan enrollees.

For PPO and POS plans, the HayGroup model assumes that 70 percent of care is given by network providers. The model also assumes that the plan receives a 15 percent discount from network providers. For POS plans only, the model assumes that the use of in-network services is further reduced by 12 percent due to services denied by gatekeepers. The model assumes that POS out-of-network service use increases by 15 percent. This is based on the assumption that some POS plan enrollees will seek treatment out of network (and pay a higher coinsurance rate) when the gatekeeper denies in-network care.

**Types of MH/SA treatment.** The model does not *separately* compute expenditures for psychotherapeutic drugs, intensive nonresidential care, and SMI. This is because usable expense data for these services are not available. However, expenses for intensive nonresidential care services and partial hospitalization are included in the model's inpatient and outpatient expense data.

## *Estimated Premium Increases for Families*

The model predicts that *full parity for all MH/SA diagnoses will raise family premiums for a composite of plans by 3.6 percent* (Table 4.3). By "composite" we mean a weighted average of fee-for-service (FFS), preferred provider organization (PPO), point-of-service (POS), and health maintenance organization (HMO) plans. Mental health care accounts for most of this increase (3.4 percent).

Although MH/SA expenditures would increase by 75 percent, the premium increase is 3.6 percent because MH/SA expenditures are only 4 percent to 6 percent of health expenditures at baseline, depending on the type of plan. Premium increases are the largest for FFS plans and PPOs (5.0 and 5.1 percent).[5] Premium increases are lower for tightly managed HMOs (0.6 percent) (Table 4.4).

Our tables do not report separate estimates for the parity options for serious mental illnesses (SMI), since the model cannot compute premium increases for changes in these benefits. However, a very "rough" estimate for SMI parity options can be obtained by pro-rating the predicted cost increases for the mental health parity options.

One way to do this is to use findings from two studies conducted by Milliman and Robertson, Inc. One study (Melek and Pyenson, 1996b) estimated that parity for SMI, as defined in S.298 (which did not pass), would increase premiums by 2.5 percent. The other study (Melek and Pyenson, 1996a) estimated that parity in benefits for all mental health diagnoses would increase premiums by 2.8 percent.

These studies suggest that expenses for SMI represent 89 percent of the increase in expenditures for all mental health diagnoses due to parity, since 2.5 percent is 89 percent of 2.8 percent. Therefore, to get a rough estimate of the increase in premiums due to parity for SMI, we can assume that the premium increase for SMI parity is 89 percent of the premium increase for mental health parity.

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[5]Total premiums rise slightly more in PPO plans than in FFS plans because MH/SA expenditures are a larger proportion of the PPO premium (4.3 percent) than of the FFS premium (3.9 percent).

## TABLE 4.3

## AVERAGE PREMIUM INCREASES AGGREGATED ACROSS PLAN TYPES

| MH/SA Diagnoses | Average Premium Increase | | |
|---|---|---|---|
| | Parity in Cost Sharing | Parity in Service Limits | Full Parity |
| MH/SA | 0.4 | 1.2 | 3.6 |
| MH only | 0.3 | 1.1 | 3.4 |
| SA only | 0.1 | 0.03 | 0.2 |

NOTES:

1. The premium increases for FFS, PPO, POS, and HMO plans were aggregated by assuming the following distribution of enrollees among plan types:

| | |
|---|---|
| FFS | 20% |
| PPO | 30% |
| POS | 20% |
| HMO | 30% |

2. The table indicates increases in family premiums. Family premiums are computed from the individual adult and child premiums using the following formula:

   Family premium = (1 + .84 * 1.08)*adult premium + 1.22* child premium

   This formula assumes that 84 percent of employees are married, the cost of coverage for the spouse is 1.08 times more than the cost for the employee, and that there are 1.22 children per family on average. The demographic assumptions are based on data from the Current Population Survey. The cost of coverage for a spouse relative to the employee is based on data for a typical plan (Hay/Huggins Company, Inc., 1997a).

3. Premium increases do not necessarily add up within columns due to rounding.

## TABLE 4.4

## PERCENTAGE INCREASES IN TOTAL PREMIUMS BY DIAGNOSIS AND PLAN TYPE

| Diagnosis | Percentage Increase in MH/SA Expenses | | | Percentage Increase in Total Family Premium | | |
|---|---|---|---|---|---|---|
| | Parity in Cost Sharing | Parity in Service Limits | Full Parity | Parity in Cost Sharing | Parity in Service Limits | Full Parity |
| **FFS** | | | | | | |
| MH/SA | 15.4 | 41.7 | 126.8 | 0.5 | 1.4 | 5.0 |
| MH only | 13.5 | 40.5 | 119.8 | 0.4 | 1.3 | 4.8 |
| SA only | 1.9 | 1.2 | 7.0 | 0.1 | 0.05 | 0.3 |
| **PPO** | | | | | | |
| MH/SA | 17.0 | 40.0 | 117.7 | 0.6 | 1.5 | 5.1 |
| MH only | 14.8 | 38.7 | 111.4 | 0.5 | 1.4 | 4.8 |
| SA only | 2.2 | 1.3 | 6.3 | 0.1 | 0.1 | 0.3 |
| **POS** | | | | | | |
| MH/SA | 0.2 | 33.9 | 64.6 | 0.00 | 1.7 | 3.5 |
| MH only | 0.2 | 33.4 | 63.1 | 0.00 | 1.7 | 3.4 |
| SA only | 0.00 | 0.4 | 1.6 | 0.00 | 0.02 | 0.1 |
| **HMO** | | | | | | |
| MH/SA | 6.1 | 3.7 | 11.6 | 0.3 | 0.2 | 0.6 |
| MH only | 5.5 | 3.7 | 10.9 | 0.3 | 0.2 | 0.6 |
| SA only | 0.6 | 0.00 | 0.7 | 0.03 | 0.00 | 0.04 |

NOTE: Premium increases do not necessarily add up within columns due to rounding.

**Parity for substance abuse benefits.** Full parity for substance abuse would increase expenditures on substance abuse care by about 26 percent (not shown), but the total premium for the composite plan would increase by 0.2 percent. This premium increase is low relative to the premium increase for all mental health diagnoses for two reasons.

First, and most importantly, few people would use expanded benefits. Consumers of long-term substance abuse treatment are rare in the privately insured population, because few are employed. For employed people who do receive substance abuse treatment, few require long-term care. Wesson (1995) reports that most detoxification patients do not need inpatient or residential treatment. Furthermore, inpatient treatments are short-term, so that 30 days per year of inpatient substance abuse benefits are reasonable.

Second, our projections use a baseline plan with more generous substance abuse benefits than the typical plan. We assume that the lifetime benefit maximum for *both* mental health and substance abuse treatment is $50,000 for the typical plan before parity. This implies that the lifetime benefit maximum for substance abuse services *only* for the typical plan is *less than $50,000* (by the amount of the mental health benefits used).

Under the Mental Health Parity Act of 1996, the lifetime benefit maximum for mental health treatment is $1 million, but no benefit maximum is specified for substance abuse services. For purposes of this study, we assume that there is a $50,000 lifetime benefit maximum for substance abuse services. Therefore, the benefit maximum for substance abuse treatment under the act is greater than the benefit maximum for substance abuse treatment before the act.

**Partial parity options.** The premium increases predicted by the model for the partial parity options as defined in this study are much lower. For all MH/SA diagnoses, the composite premium increases are 0.4 percent or less if there is parity in cost sharing. If there is parity in service limits, the composite premium increases are 1.2 percent or less.

The partial parity premium increases are higher when there is parity for service limits compared with parity for cost sharing because there is a greater increase in benefits when there is parity for service limits. Specifically, for most plan types, parity for service limits increases the number of covered inpatient hospital days from 30 days to 365 days and increases the number of covered outpatient visits from 20 visits to an unlimited number of visits.

In contrast, when there is parity for cost sharing, there is generally no change (or a relatively small change) in the out-of-pocket expenses for inpatient care because the typical health plan already offers parity with respect to inpatient cost sharing. For outpatient visits, there is a decrease in the FFS coinsurance rate of 50 percent to 20 percent, and a decrease in the HMO copayment amount from $20 to $10.

## *Estimated Premium Increases for Child Health Plans*

Under the Balanced Budget Act of 1997, states will receive block grants to fund health insurance for uninsured, low-income children (Mann and Guyer, 1997). States may either expand Medicaid eligibility and provide full Medicaid benefits for uninsured children, or they may establish or expand a separate state program for children.

Estimating the costs of parity in this program is difficult for two reasons. First, we do not know what the baseline benefit packages are. States that do not expand Medicaid may use any of three standard benefits packages or a package that is actuarially equivalent to one of these. Second, we do not know the prevalence of MH/SA disorders among the covered children. States have great latitude in choosing which children are covered. Within the scope of this project, we could not fully address the costs of parity for these programs for uninsured children, but we make predictions that are likely to be conservative estimates of the true costs of parity for separate state programs for children. Our estimates are not relevant for Medicaid expansions.

We produced actuarial estimates of the costs of full and partial parity for all MH/SA diagnoses for currently insured children of employees of medium and large employers (Table 4.3). The premiums are estimates of the average costs of coverage for one child. Unlike employer-sponsored insurance, the premiums do not include any costs for covering adults.

We estimate that full parity for child health plans would increase MH/SA expenditures for currently insured children with FFS coverage by 158.9 percent and the total premiums by 7.0 percent. In contrast, full parity for children's MH/SA benefits in a tightly managed HMO would increase premiums by 0.8 percent. We do not present a composite premium, because we do not know what types of delivery systems states might use for their block grant programs.

The estimated increases in MH/SA expenses and premiums for children are greater than the estimates for families shown in Table 4.1 because MH/SA expenses account for a greater portion of children's premiums. Data on children's MH/SA expenses indicate that children use such services at a much lower rate than adults, but children who use MH/SA services have, on average, higher expenditures than adults (Sturm, 1997; Grazier and G'Sell Associates, 1997).

The estimates in Table 4.5, which are based on data for children who are currently privately insured, are likely to be lower than the actual costs of parity for uninsured children. If states provide insurance coverage to currently uninsured children, these children are likely to use more MH/SA services than those who are currently insured. For example, Frank, et al. (1994) estimate that, if the uninsured population (adults and children) were given insurance coverage, the number using MH/SA treatment services would be 0 percent to 5 percent higher than the currently insured population.

However, the costs of covering uninsured *children* are uncertain, especially because states may choose to cover only some uninsured children. In addition, the state may establish a program with more or less generous medical/surgical benefits than those typical of medium and large employers, depending on how the state applies the benefit standards law.

## TABLE 4.5

## INCREASES IN CHILDREN'S MH/SA EXPENDITURES AND PREMIUMS FOR FULL PARITY BY PLAN TYPE

| Plan Type | Percentage Increase in MH/SA Expenses | | | Percentage Increase in Total Child's Premium | | |
|---|---|---|---|---|---|---|
| | Parity in Cost Sharing | Parity in Service Limits | Full Parity | Parity in Cost Sharing | Parity in Service Limits | Full Parity |
| FFS | 14.4 | 56.3 | 158.9 | 0.5 | 2.2 | 7.0 |
| PPO | 15.6 | 53.2 | 143.7 | 0.7 | 2.3 | 7.0 |
| POS | 0.3 | 38.0 | 81.3 | 0.00 | 2.2 | 4.9 |
| HMO | 6.0 | 3.5 | 11.2 | 0.4 | 0.2 | 0.8 |

NOTE: Estimates based on privately insured children, using typical benefit packages of medium and large employers. The premiums are estimates of the average costs of coverage for one child. Estimates do not adjust for likely greater service use among uninsured children or differences between private insurance benefits and those of health block grant programs for children.

## *Interpreting the Estimates*

Readers should keep several features of the model and our assumptions in mind when interpreting the predicted premium increases. First, this model (and other actuarial models) does not account for employer responses to parity mandates. Employers could respond to an anticipated premium increase due to a parity mandate by increasing employee contributions, dropping health insurance coverage, dropping or reducing coverage for MH/SA services, reducing other benefits, or increasing management of MH/SA services. These responses would lead to a lower premium increase than that estimated by this model. Therefore, our estimates indicate only the *initial* premium increase due to parity.

Second, these estimates are made with a baseline benefit package that is more generous than those used in previous actuarial estimates. Our baseline benefit package for each plan has a $1 million lifetime spending limit for mental health services, which reflects the Mental Health Parity Act of 1996. However, the baseline packages for previous actuarial estimates have a much lower lifetime spending limit for MH/SA services (such as $50,000). If our baseline packages had this lower limit, our projected premium increase for a composite of plans would be 4.2 percent instead of 3.6 percent.

Third, these estimates are based on the characteristics of a typical health plan for each plan type. But among each plan type there is great diversity in benefit and management levels.

Fourth, in this study we estimated premium increases for family coverage. Many previous studies estimated premium increases for single adults. This model predicts lower premium increases for single adults than for families. According to the model, full parity in MH/SA benefits for single adults would raise premiums for the composite plan by 3.1 percent (as opposed to 3.6 percent for families). For FFS plans, the model estimates a 4.3 percent premium increase for single adults, compared to 5.0 percent for families.

The adult-only premium increase for expanded MH/SA benefits is lower than the estimate for family coverage because the relative cost of MH/SA coverage for children in this model is higher than the relative cost of non-MH/SA benefit coverage. For non-MH/SA benefits, the revised HayGroup model assumes that the relative cost of children to adults is 58 percent (i.e., for every $100 in adult costs, children cost $58). For MH/SA benefits, the relative costs of children to adults is about 68 percent.

# CONCLUSION

Our study attempts to answer several key questions concerning the provision of full or partial parity in MH/SA benefits. By conducting an analysis of state MH/SA parity laws and case studies in five states, we found the following:

- Most state parity laws are limited in scope or application.
- State parity laws have had a small effect on premiums.
- Employers have not attempted to avoid parity laws by becoming self-insured, and they do not tend to pass on the costs of parity to employees.
- Costs for MH/SA services have not shifted from the public to the private sector.

Previous actuarial predictions of premium increases due to MH/SA parity varied widely, primarily due to differences in their assumptions. We determined that some of these assumptions may have limited support. For example, some estimates have assumed a cost shift from the public to the private sector as a result of a parity mandate. Our study did not find support for this assumption, however.

Finally, using an updated model and actuarial assumptions, we estimate that *full parity for mental health and substance abuse services will increase premiums by 3.6 percent, on average.* Premium increases are lower for plans that more tightly manage care, and they are greater for plans that are limited to children.

For more information on the individual studies that comprise this summary report, see the four background reports we produced: *Parity Study Background Report #1: State Parity Laws* (Heiser, et al., 1998); *Parity Study Background Report #2: Case Studies* (Hill, et al., 1998); *Parity Study Background Report #3: Actuarial Assumptions* (Sing and Hill, 1998b); and *Parity Study Background Report #4: Cost Estimates* (Sing and Hill, 1998a).

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# APPENDIX A

# Glossary

# GLOSSARY

| | |
|---|---|
| Baseline Benefit Package | For each type of health plan, the typical benefit package is the benefit package that has the highest percentage of enrollees (the statistical "mode.") Also referred to as the typical benefit package. |
| Benefit Package | Services covered by a health insurance plan and the financial terms of such coverage. These include including cost sharing, limitations on the amounts of services, and annual or lifetime spending limits. |
| Coinsurance | A type of cost sharing where the insured party and insurer share payment of the approved charge for covered services in a specified ratio after payment of the deductible. Most fee-for-service plans require a 20 percent coinsurance for covered inpatient and outpatient medical/surgical services. |
| Copayment | A type of cost sharing where the insured party is responsible for paying a fixed dollar amount per covered service. For example, an HMO could require a $10 copayment for every visit to a network physician. |
| Cost sharing | A health insurance policy provision that requires the insured party to pay a portion of the costs of covered services. Deductibles, coinsurance, and copayment are types of cost sharing. |
| Coverage Decision | A decision by a health plan whether to pay for or provide a medical service for particular clinical conditions. |
| Deductible | A type of cost sharing where the insured party pays a specified amount of approved charges for covered medical services before the insurer will assume liability for all or part of the remaining covered services. |
| ERISA | The Employee Retirement Income Security Act of 1974 (ERISA). Health plans that are self-insured are exempt from state regulation under ERISA. |
| FFS | Fee-for-service. A type of health care plan where health care providers are paid for individual medical services rendered. |
| Gatekeeper | A primary care physician in a managed care plan (such as an HMO or POS plan) who oversees the care of enrollees in the plan. |
| HayGroup | The HayGroup is a firm that conducts actuarial analysis. |

| | |
|---|---|
| HMO | Health maintenance organization. A type of managed care plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Services are furnished through a network of providers (such as physicians and hospitals). |
| Health Plan | An organization that acts as insurer for an enrolled population. Types of health plans include fee-for-service (FFS), preferred provider organization (PPO), point-of-service (POS), and health maintenance organization (HMO). |
| Managed Care | A system of health care delivery where the health plan attempts to control or coordinate the use of health services by enrolled members to contain health care expenditures and/or improve quality. Types of managed care plans include HMOs, point-of-service (POS) plans, and preferred provider organizations (PPOs). |
| POS | Point-of-service. Point-of-service plans are managed care plans that cover both in-network and out-of-network services. To encourage use of network providers, patient out-of-pocket costs are higher when non-network providers are used. POS plans generally manage in-network services more tightly than PPOs manage services because POS plans use gatekeepers. |
| PPO | Preferred provider organization. A PPO is a managed care plan that contracts with providers to furnish services to plan enrollees. PPO providers are paid according to a discounted fee schedule. Enrollees pay lower out-of-pocket costs when they use network ("preferred") providers. However, services they receive from non-network providers are also covered. Enrollees pay higher out-of-pocket costs when they use non-network providers for covered services. |
| Premium | The amount an insurer charges for a health insurance policy. The premium amount is computed to pay for the expected costs of all health insurance expenses. Health insurance expenses include medical/surgical services, MH/SA services, and administrative costs and profits. |
| Primary Care Physician | Primary care physicians generally include physicians with the following specialties: general practice, family practice, internal medicine, obstetrics/gynecology, and pediatrics. |

| | |
|---|---|
| SAMHSA | Substance Abuse and Mental Health Services Administration. SAMHSA is a government agency. Its responsibilities include conducting evaluations and other activities to improve prevention and treatment of mental health and substance abuse disorders. |
| SMI | Serious mental illness. The National Advisory Mental Health Council defines serious mental illness to include disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, manic depressive disorder, and autism, as well as severe forms of other disorders such as major depression, panic disorder, and obsessive compulsive disorder. |
| Self-insured Health Plan | Employer-provided health insurance in which the employer, rather than an insurer, is at risk for its employees' medical expenses. |
| Service Limits | Limits on the amount of services covered by a health plan. For example, a health plan can limit the number of covered outpatient visits or inpatient hospital days. |
| Typical Benefit Package | For each type of health plan, the typical benefit package is the benefit package that has the highest percentage of enrollees (the statistical "mode.") Also referred to as the baseline benefit package. |
| Utilization Review | The review of services delivered by a health care provider or supplier to determine whether those services were medically necessary. |
| William M. Mercer | William M. Mercer is an employee benefits consulting firm. |

# APPENDIX B

## Calculating the Premium Increase

# Calculating the Premium Increase

**Baseline Premium** =
baseline medical/surgical expenditures +
baseline MH/SA expenditures

⬇

**Increasing Coverage for MH/SA Services**
➜ increase in MH/SA service use
➜ increase in MH/SA expenditures

⬇

**New Premium** =
increase in MH/SA expenditures +
baseline medical/surgical expenditures +
baseline MH/SA expenditures

⬇

**Percentage Premium Increase** =

$$\frac{\text{new premium - baseline premium}}{\text{baseline premium}} \times 100$$

⬇

***Example:***

If: baseline medical/surgical expenditure = $95
baseline MH/SA expenditure = $5
baseline premium = $100
increase in MH/SA service use = $1

Then: new premium = $101
percentage premium increase is 1%

Note: The total premium increases by 1 percent, and MH/SA expenditures increase by 20 percent.

# APPENDIX C

## Policy Advisory Panel Members

# Policy Advisory Panel Members

| | |
|---|---|
| **James Baxendale**<br>Deputy Director[a]<br>National Association of State Alcohol and Drug Abuse Directors (NASADAD) | **Carmella Bocchino**<br>Vice President, Medical Affairs Department<br>American Association of Health Plans (AAHP) |
| **Gregory Bloss**<br>Public Health Analyst<br>National Institute on Alcohol Abuse and Alcoholism (NIAAA) | **Sharon Canner**<br>Vice President of Human Resources Policy<br>National Association of Manufacturers (NAM) |
| **William Cartwright**<br>Economist, Division of Clinical and Services Research<br>National Institute on Drug Abuse (NIDA) | **Michael Faenza**<br>Executive Director<br>National Mental Health Association (NMHA) |
| **Kevin Hennessy**<br>Management Analyst<br>Assistant Secretary for Planning and Evaluation (ASPE) | **Tom Hoyer**<br>Director, Office of Chronic Care and Insurance Policy<br>Health Care Financing Administration (HCFA) |
| **Anthony Knettel**<br>Director of Health Policy<br>ERISA Industry Committee (ERIC) | **Michael Malloy**<br>Director, Campaign to End Discrimination<br>National Alliance for the Mentally Ill (NAMI) |
| **Craig Obey**<br>Executive Director[b]<br>National Association of State Mental Health Program Directors (NASMHPD) | **Darrel Regier**<br>Director, Division of Epidemiology and Services Research<br>National Institute of Mental Health (NIMH) |
| **Hila Richardson**<br>Deputy Director for Medical Research and Practice Policy[c]<br>National Center on Addiction and Substance Abuse (CASA) | **E. Clarke Ross**<br>Executive Director<br>American Managed Behavioral Health Care Association (AMBHA) |
| **Gwen Rubinstein**<br>Deputy Director of National Policy<br>Legal Action Center | **Tom Wildsmith**<br>Policy Research Actuary<br>Health Insurance Association of America (HIAA) |

[a]No longer with the organization.
[b]Jennifer Urff has replaced Craig Obey at NASMHPD
[c]Patrick Johnson has replaced Hila Richardson at CASA.

# APPENDIX D

## Expert Panel Members

# Expert Panel Members

| | |
|---|---|
| **Linda Bilheimer**<br>Deputy Associate Director for Health<br>Congressional Budget Office (CBO) | **Wayne Ferguson**<br>Actuary<br>Health Care Financing Administration (HCFA) |
| **Richard Frank**<br>Professor of Health Economics<br>Harvard Medical School | **Jonathan Gruber**<br>Associate Professor of Economics<br>Massachusetts Institute of Technology |
| **Ed Hustead**<br>Executive Vice President<br>The HayGroup | **Mike O'Grady**[a]<br>Analyst<br>Medicare Payment Advisory Commission |
| **Roland McDevitt**<br>Senior Consultant<br>Watson Wyatt Worldwide | **David McKusick**<br>Senior Actuary<br>Actuarial Research Corporation |
| **Stephen Melek**<br>Consulting Actuary<br>Milliman and Robertson, Inc. | **Darrel Regier**<br>Director, Division of Epidemiology and Services Research<br>National Institute of Mental Health (NIMH) |

[a]Mike O'Grady previously worked at the Congressional Research Service (CRS).

SAMHSA

Substance Abuse and
Mental Health
Services Administration

CMHS

Center for
Mental Health Services

CSAT

Center for
Substance Abuse Treatment

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