Department of the Public Advocate

Mental Health Insurance Parity White Paper

(Updated 5/4/07)

"Mental health must be seen for what it is – a public health issue, no different than other medical disorders. For New Jersey to reduce the burden of mental illness, to improve housing, to improve access to care and to achieve urgently needed public education about mental illnesses and mental health, stigma must no longer be tolerated…New Jersey should mandate full mental health parity for all state regulated plans."

Governor's Task Force on Mental Health Final Report, March 31, 2005

Importance of Parity

The Department of the Public Advocate, and its Division of Mental Health Advocacy, strongly supports mental health parity legislation. While there are many issues that the Division of Mental Health will be working on over the next few years, the Department felt it was critical to make clear its strong belief that all individuals should be treated equally, whether they have mental or physical health concerns. It is not acceptable that individuals should endure mental illnesses or receive limited treatment for these real, treatable diseases when they would not be subjected to such neglect in the treatment of their physical complaints.

Allowing disparate treatment for individuals with mental illnesses is discriminatory. People with mental illnesses are routinely stigmatized in our society in ways that would not be tolerated if the individual had a physical health condition rather than a mental health condition. However, because mental health issues are marginalized and because mental health consumers do not always recognize the importance of advocacy or have the resources to contest unjust practices, this discrimination continues. Such stigmatization against people with mental illnesses makes it easier to treat their illnesses differently.

Mandating coverage for biologically based mental illnesses, while not offering coverage for other illnesses and addictions, creates the very real possibility that mental health treatment will fail. Individuals may gain a measure of relief from symptoms, but treating only some aspects of the person's illness is not medically effective, cost effective or humane, and will not be lasting.

Background

On the Federal level, Congress enacted the Mental Health Parity Act in 1996. While important, this was only a first step toward ensuring equal coverage between mental health and general health benefits. The 1996 Act applied only to

employers with 50 or more employees and required that if those employers provided health insurance coverage for biologically based mental illnesses the coverage must be equal to that offered for physical illnesses. They could not impose restrictions such as annual visit or dollar limits on such care, unless such limits also applied to physical illnesses.

This mandate did little to address the problems faced by millions of people in accessing appropriate mental health treatment. In the Surgeon General's Report on Mental Health in 1999, Surgeon General David Satcher observed: "Concerns about the cost of care – concerns made worse by the disparity in insurance coverage for mental disorders – are among the foremost reasons why people do not seek needed mental health care." While some states have addressed this issue, little has been achieved since 1996 in the fight for insurance parity.

Health insurance plans typically limit the amount of coverage for treatment of mental health conditions, if such conditions are covered at all. Mental health insurance parity means insurers who provide coverage for mental health conditions may not place limits on that coverage that are any greater than the limits on coverage for physical illnesses. Parity is not a mandate. It only defines the level of coverage that must be offered <u>if coverage for mental health issues is offered at all</u>. Parity can describe different levels of coverage:

- <u>Full mental health insurance parity</u> requires that those employers who offer mental health insurance coverage must provide coverage for all mental health conditions, not merely those that are biologically based, but allows for some exceptions.
- <u>Comprehensive health insurance parity</u> requires employers who offer mental health insurance coverage to provide coverage for all mental health and substance abuse conditions at the same levels at which they cover general physical illnesses, with no exceptions.

New Jersey enacted a limited parity law in 1999. Under the state's <u>partial mental health insurance parity</u> statute, insurers who cover mental illnesses need only cover those mental illnesses deemed to be biologically based. The statute does not require parity for coverage of a broad spectrum of behavioral health problems, including addictions and eating disorders, even when these illnesses co-occur with biologically based diseases. For example, an individual who suffers from severe depression, typically accepted as a biologically based disease, may self-medicate (that is, use a non-prescribed substance such as alcohol or another drug to alleviate symptoms) in order to decrease or dull his feelings of depression. Under the current statute, this individual could be treated for his depression, but could be refused treatment or receive only limited treatment for his alcohol abuse, thus rendering his mental health treatment ineffective.

The primary basis for opposition to parity laws is that they are too costly, but this has not proven to be true in states which enacted comprehensive or full parity laws. In 2001, the Congressional Budget Office estimated that the increased cost to employers as a result of full parity would be less than 1%. Studies of parity laws in Connecticut, Vermont, and Minnesota have shown this to be true.

This small cost increase represents the cost of moving from no requirement concerning mental health coverage to full parity. Because New Jersey already requires partial parity, however, the cost to employers here would be far less than one percent. When Texas reformed its partial parity law to require full parity under its state health benefits plan, the state saw a significant decrease in medical costs.

Currently, eleven states have full or comprehensive parity laws that require all private insurance plans to cover all mental health and substance abuse disorders.[1] New Jersey is among 25 states that have limited parity statutes, which requires that biologically based mental illnesses [BBMI] be covered on a basis equal to that of physical illnesses, but allows for exceptions for addictions, eating disorders, and other illnesses and disorders that may not be recognized as biologically based.

Employers may, of course, offer insurance plans which cover non-biologically based illnesses, and some employers do that. Some of the health plans offered to employees of the State of New Jersey do offer some additional coverage, but arbitrary annual and lifetime limits are imposed. [2]

The High Cost of Untreated Mental Illness vs. the Low Cost of Parity

Beyond the humane costs associated with allowing those with an illness to continue to suffer, untreated mental illness is also very expensive. While opponents criticize mental health parity as too costly, in reality the lack of parity costs far more than the 1% increase in premiums that employers and other insurance payers have experienced. Health plans which place high financial barriers to mental health treatment also have higher rates of more costly long-term disability claims than do plans which provide easier access to mental health care[3].

Vermont is widely acknowledged to have the most comprehensive parity legislation in the nation. Since 1997, the cost to the state for mental health treatment has increased by 0.1% of the total healthcare budget while state workers report much greater satisfaction with their health plans[4].

Additional savings associated with parity come about as people are treated earlier, more aggressively, and by the appropriate provider. A well known study published by the National Institute on Drug Abuse [NIDA] in 1986 showed that cardiologists prescribe certain anti-anxiety medications more than any other

group of specialists. Further study by NIDA indicates that anti-anxiety medication may not be needed when other therapies which treat the underlying anxiety, rather than just the resulting symptoms, are used. Parity would allow individuals to access their healthcare from an appropriate specialist, so that their illness is treated, rather than just ensuring that its symptoms are controlled.

Decreases in healthcare costs are even greater when mental health coverage is in a managed care system. For example, Texas enacted a partial parity law in 1991, and saw a 48% decrease in the cost of mental health care within managed care plans. In 1997, the State legislature in Texas enacted an even stronger parity law.

There is no data to suggest that parity results in large cost increases. In fact, such a cost increase has not been experienced in any state that has adopted full parity, and Federal employee health insurance data showed an increase in cost of only 0.1% over five years under full parity, as compared with no parity provision. Some states, notably North Carolina and Texas, even showed a decrease in overall insurance costs when mental health parity was enacted[5]. The cause of this decrease in insurance costs is thought to be two-fold: people received treatment earlier in their illness, when treatment was less costly and typically did not require hospitalization, and they were able to get appropriate treatment from the appropriate provider, rather than having a primary care physician or other healthcare professional treat their mental health issues in a haphazard fashion. PriceWaterhouseCoopers (then Coopers & Lybrand) prepared an actuarial report in 1999 noting that, under the original Domenici-Wellstone bill requiring full parity, Americans would have enjoyed an overall .5% decrease in the cost of mental health coverage up to that point.

Studies from the National Institute of Mental Health (2000) and PriceWaterhouseCoopers Consulting (2002) indicate that workers' complaints about physical issues and time out from work and medical bills associated with these complaints also decrease when parity is enacted. The World Health Organization's most recent report on mental health in December, 2005 supports these findings as well.

When the cost of mental health parity is compared to the cost of lost productivity and absenteeism, parity is cost effective and practical. In 1999, the Surgeon General's Report stated that it costs employers in the United States $70 billion annually *not* to have mental health parity, primarily in the form of increased absenteeism and lost productivity. The International Labor Organization [ILO] prepared a policy paper in 2000, assessing the "price tag" of mental illness. When both direct costs (hospitalizations and medications, for example) and indirect costs (such as lost wages of family members who provide care) are considered, the ILO estimated the cost of mental illness at more than $80 billion annually. The ILO study also asserted that "The cost impact of health insurance parity for mental illnesses has proved minimal."

Corporate Leaders Conclude Parity is Smart Business

Some employers have long recognized that mental health insurance parity has important benefits for the workforce. William Mercer, Inc., a human resources consulting firm, conducted a survey of businesses in 1998, finding that 70% of respondents saw mental health parity as a reasonable national policy goal. In 1993, the National Advisory Mental Health Council estimated the cost of providing equal physical health coverage and mental health coverage for all Americans at $6.5 billion. However, it further estimated the savings for general medical services and other indirect costs associated with a lack of mental health coverage at $8.7 billion, showing a net decrease in healthcare dollars spent of $2.2 billion. While the cost would be greater today, the savings would be greater as well.

According to the Social Security Administration, the leading cause of disability in the United States is untreated clinical depression. However, clinical depression is a very treatable disease, particularly in its early stages. By providing parity now, New Jersey residents with untreated mental illnesses will not have to wait until their illness becomes so serious as to cause disability. Earlier treatment will prevent the need for more costly services later, including the disability of the worker and the cost of hospitalization.

More employers now recognize that parity will benefit their employees, as well as their profitability. Among employers who self-insure, McDonnell-Douglas saw absenteeism drop 44% for employees who received appropriate treatment, and saw a savings of $4.4 million in medical claims among workers who were treated for mental health and substance abuse disorders.

Delta Airlines is a large company with thousands of employees that provides mental health insurance parity. In testimony in May, 2002 a Delta official noted:

> "*The important message from large employers like Delta is that in the last decade we have introduced and implemented generous mental health and substance abuse benefits for our employees not in response to legislative mandate but because it improves our corporate bottom line."*

Stanford Alexander, Chairman of Weingarten Realty Investors, testified before the U.S. Congress Subcommittee on Employer-Employee Relations in 2002. He said:

> *"With support and good health insurance, I know that people who might otherwise suffer in isolation and self-doubt, who might lose jobs, who might lose families, will be better able to seek help and benefit from modern medication and supportive service. With such treatment, they can remain on the job, they can avert crisis, and they can get the support they need to maintain their lives in a stable and productive way."*

William Sheehan, the President and CEO of Torrmetal Corporation, a small company in Ohio gave testimony before the Senate Insurance, Commerce, and Labor Committee in September, 2005, stating:

> *"The impact of untreated mental illness in the workplace is costly to all employers, but small employers are particularly hard hit. Each employee in a small business is an integral part of the workplace. If an employee suffers from mental illness and cannot afford the necessary treatment, the entire company suffers. If we were able to offer these employees the same level of treatment for mental illnesses as they get for medical or surgical needs, they could get better and return to work. Better yet, adequate treatment may prevent employees from losing time at work."*

From these examples, it is apparent that mental health insurance parity is viewed as advantageous by both employers and employees.

Other Reasons for Cost Savings

The most expensive illnesses to treat are typically those which are biologically based, which are already covered under New Jersey's limited parity law. The federal Substance Abuse & Mental Health Services Administration [SAMHSA] estimated in 1998 that those with biologically based illnesses account for 90% of the cost increases associated with parity. New Jersey's current partial parity law already requires equal coverage for those individuals, further undermining arguments that moving to comprehensive parity would be too costly. Parity will not result in higher costs, nor will it result in an increase of costly hospital stays. No other state or private sector employer has reported such a result, and there is no basis for the contention that New Jersey would experience these results.

There is concern that enacting parity would result in increased costs for New Jersey's State Health Benefits Plan [SHBP]. In 2001, the federal government implemented parity through the Federal Employees Health Benefits Program, which covers members of Congress as well as other federal workers and their dependents. A five-year study conducted by the Department of Health and Human Services found that there was "little or no increase in total mental health or substance abuse spending" as a result of parity.[6] Over the five year period ending in December 2006, Federal health insurance costs increased by 13%, while full coverage for parity and substance abuse increased costs only 0.1% over the same five year period.

A cost estimate by the Division of Pensions and Benefits in the Department of the Treasury estimates an increase of only 0.5 % in costs to the SHBP if full parity is enacted. The Office of Legislative Services concurred with this estimate.[7]

A comprehensive parity statute could also result in a significant decrease in charity care costs incurred by hospitals for both mental health and addictions.

For those individuals who are insured and are treated for mental health and substance abuse issues, their treatment would be paid for by their insurer, rather than through limited charity care funds provided from the state treasury. By making certain that insurance companies pay their share of healthcare costs, the cost to the State and the individual is mitigated and any cost to the State Health Benefits Plan would likely be partially offset.

For calendar year 2005, New Jersey hospitals requested over $87 million dollars in charity care funds from DHSS for mental health and addictions. By enacting parity, hospitals which offer mental health and addictions treatment would be better able to recoup funds from insurers, rather than having to request funds from an overburdened state charity care system.

A one-day survey conducted in February 2007 by the Department of the Public Advocate found that 14% of the patients in hospital short-term psychiatric care facilities throughout the State had private insurance plans provided through their employer or a family member's employer. If these insurance plans offered mental health coverage, only biologically based illnesses would fulfill current coverage requirements. Those patients who suffer from non-biologically based illnesses, but nonetheless needed treatment, would then be faced with paying a hospital bill on their own or requesting charity care. If they did neither, the hospital could include these unpaid charges when requesting state charity care aid. Hospitals could avoid requesting some charity care funds if those patients' insurers were required to pay for the cost of their treatment. This could result in a significant decrease in requests for charity care

Within the mental health community, there is concern that soldiers returning to New Jersey will use the public mental health system rather than the Veterans Administration system for mental health treatment. Because mental illness is so stigmatizing, many military personnel do not want a record of this kind of treatment in their military file. However, under current parity laws, even for those with mental health coverage, there would be no statutory requirement that they be provided with coverage for post-traumatic stress disorder [PTSD] or addictions, which are two issues for which military personnel most often seek treatment.

Conclusion

Enacting legislation that mandates mental health insurance parity will slightly increase costs to all insurance payers who currently offer insurance for mental health and substance abuse issues. Parity legislation will not affect those insurers who do not offer such coverage, as this legislation does not mandate that such coverage be offered.

Requirements that insurance companies pay for mammograms allow more women to receive early intervention for breast cancer, when treatment is most

successful. Couples who otherwise could not conceive children gratefully benefit from mandates requiring fertility treatments. New mothers in New Jersey's hospitals benefit from requirements that they have a minimal inpatient stay, and that they receive information about postpartum depression. Clearly, these mandates are worthwhile.

The Governor's Task Force on Mental Health studied the issue of mental health parity and supported it because it will help ensure that New Jersey's residents receive the care they need. Current legislation which requires coverage only for mental health problems that are accepted as biologically based is inadequate because it allows too many people to continue suffering. Providing mental health insurance parity is an investment that is necessary and deserved.

Governor Corzine has a longstanding history of supporting mental health parity. While serving in the United States Senate, he co-sponsored S.543, the Mental Health Equitable Treatment Act of 2001, as well as S.486, the Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003. As a candidate for Governor in 2005, then-Senator Corzine characterized himself as "an ardent supporter of legislative efforts to ensure mental health parity."[7] He declared:

> *"Today, in America, two-thirds of our citizens with mental illness do not have access to mental health services despite the fact that many have health insurance. Those who do have access to mental health benefits often have to pay higher costs for care, have limited access to specialists, and face other obstacles to mental health services."*[8]

Comprehensive mental health insurance parity must be enacted in order to ensure that residents and workers in New Jersey will have the opportunity to avail themselves of necessary, appropriate health services. To separate mental health and physical health issues, and to provide inequitable coverage, perpetuates unnecessary suffering and sanctions discrimination against a group of people who have been victims of discrimination for far too long.

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[1] A National Mental Health Association survey of state mental health insurance parity laws in September 2005 showed that five states (Connecticut, Maryland, Minnesota, Vermont, and Oregon) have comprehensive parity laws which allow for no exemptions to cover mental health and substance abuse disorders under private insurance plans. Six other states – Indiana, Kentucky, Maine, New Mexico, Rhode Island, and Washington – have enacted full parity laws which allow for some exemptions in limited circumstances.

[2] New Jersey Department of the Treasury, Division of Pensions and Benefits.

[3] Disability Management, Employee Health and Fringe Benefits, and Long-Term Disability Claims for Mental Disorders: An Empirical Exploration, Salkever, Goldman, Purushothaman, and Shinogle. April 2000.

[4]*Effects of the Vermont Mental Health and Substance Abuse Parity Law* SAMHSA 2003

[5] *The Costs of Mental Health Parity,* Steve Melek. The Society of Actuaries, Schaumberg, IL. March, 2005.

[6] US Department of Health & Human Services, 2006.

[7]The cost estimate of S544 prepared by the Treasury in 2005, with which OLS concurred, estimated the bill would increase costs by 0.5 percent, or $7.5 million for the State and $7.8 million for local SHBP participants, for a total increased cost of $15.3 million. The local SHBP participants included five counties, 302 school districts, 311 municipalities, 23 charter schools and 286 authorities, commissions and state autonomous agencies. Fiscal Notes to S807 and A2512 on June 22, 2006 and July 3, 2006, respectively, prepared by the Division of Pensions and Benefits, and with which the Office of Legislative Services concurred, again estimated that the bill would increase costs by 0.5 percent, and estimated the dollar amounts at $1.6 million for the State and $2.9 million for local SHBP participants, for a total of $4.5 million. No more recent formal estimates have been provided, but the Department of Treasury has indicated that the discrepancy is the result of an error made in calculating the 2006 fiscal estimates. Both estimates, however, indicate costs would increase by 0.5 percent.

[7]This is Senator Corzine's response to the Mental Health Association in New Jersey's Blueprint for Change. October 2005. Available at www.mhanj.org.

[8]This is Senator Corzine's response to the Mental Health Association in New Jersey's Blueprint for Change. October 2005. Available at www.mhanj.org.