



An Environmental Scan of the Impact of Parity

Practical Implications of the Paul Wellstone and
Pete Domenici Mental Health Parity and
Addiction Equity Act of 2008



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Background

Enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (2009 Parity Act) signals the “beginning of a new era, with new challenges” (Shern, Beronio, and Harbin, 2009). Private and public stakeholders in the mental health community are preparing for this important transition, which is taking place in the context of an uncertain economy and national health care reform. To inform the development of regulations governing the 2008 Parity Act, and assist both payers and providers in their response, Advocates for Human Potential (AHP), Inc., has produced a series of planning and implementation tools dedicated to Behavioral Health Parity. The following environmental scan, conducted in May of 2009 is the first in the series. It is based on a review of research, Federal and State experiences with parity, and key informant interviews with leaders in the private and public sectors.

Preliminary Review of Available Data

Background and History

Historically, insurance coverage for mental illnesses and substance use disorders (collectively referred to as behavioral health conditions) has been much more restrictive than that for any other illnesses. Employer-sponsored health plans typically have imposed higher out-of-pocket costs and limited both annual and lifetime visits and lengths of stay for treatment of behavioral health conditions. Though mental health advocates have long argued for parity of coverage, philosophical and financial factors have contributed to an ongoing dichotomy:

- Some prominent 17 century European philosophers—notably France’s Rene Descartes—viewed the “mind” as completely separate from the “body,” a belief that underlies much of Western medicine. As Shern et al. (2009) note, “These false distinctions discourage

people from seeking help and encourage health care payers and plans to limit coverage.”

- Mental illnesses were believed to be lifelong conditions with no hope for recovery.
- Insurers and health plans believed that offering coverage for behavioral health conditions on par with that for other illnesses would drive up the cost of health care; early research confirmed their assumptions (see below).
- Some opponents of parity argued that insurance regulation is a State, not a Federal, function.

Likewise, several factors influenced a push for parity at both the State and Federal level:

- A landmark 1999 report by the U.S. Surgeon General reported that people with mental illnesses can and do recover and that effective treatment is available (U.S. Department of Health and Human Services [HHS], 1999).
- With research supporting differential coverage, mental health benefits shrank in relation to benefits for other conditions during the late 1980s and early 1990s (Barry, Frank, and McGuire, 2006).
- Evaluations of parity at both the State and Federal level revealed little impact on overall health care costs (see below).
- Research revealed that people with serious mental illnesses die, on average, 25 years earlier than the general population. They die from treatable medical conditions caused by modifiable risk factors, including smoking, obesity, substance abuse, and inadequate access to medical care (Parks, Svendsen, Singer, and Foti, 2006).

Parity at the State level

Most legislative action on parity has occurred at the State level. The majority of activity in the 1970s and 1980s related to substance use disorders, specifically alcoholism. The first parity statutes requiring equal insurance coverage for mental and physical illnesses were enacted in

1991 in North Carolina and Texas. Today, 46 States have some type of insurance law that falls into one of the following three categories (National Conference of State Legislatures [NCSL], 2009; Robinson, Connolly, Witter, and Magaña, 2007):

- **Mandated offering:** Coverage that requires insurers to provide equal mental and physical health benefits if the insurers choose to offer coverage for behavioral health conditions. Mandated offering laws also may require that insured individuals have the option of coverage for behavioral health conditions, which they may accept or decline.
- **Mandated benefits:** Coverage that requires insurance for specific behavioral health conditions. These laws are not considered full parity because they allow discrepancies in the level of benefits provided for behavioral health and other conditions.
- **Parity:** Coverage that requires insurance for behavioral health conditions equal to insurance provided for physical health conditions. Some States, such as Vermont, provide coverage for all behavioral health conditions, including substance abuse. Others, such as California, limit coverage to serious mental illnesses and serious emotional disturbances.

Beginning in the early part of this decade, some States began to restrict the scope of existing laws, reacting in part to concerns that required benefits were increasing health insurance costs. A number of States have more than one law pertaining to mental health insurance coverage. Still others have used the Mental Health Parity Act of 1996 (see below) as the basis for their laws. As a result, the National Conference of State Legislatures notes, “Parity is a patchwork of Federal and State legislation, with all the complications that such a structure implies” (Wood, 2005).

Parity at the Federal level

Two major developments mark the history of parity at the Federal level. The first relates to the Federal Employees Health Benefits (FEHB) Program, which first began offering parity in the late 1960s. However, in the mid 1970s, when more flexibility in benefit design was permitted, coverage for behavioral health conditions began to erode. From 1980 to 1997, the share of total claims accounted for by mental health and substance abuse claims declined from 7.8 percent to 1.9 percent, a trend

that mirrored behavioral health coverage in the larger health care market (HHS, 2004).

A renewed call for parity by President Bill Clinton resulted in changes to the FEHB Program beginning in 2001. Covered services include “clinically proven treatment” for mental illnesses and substance use conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association, 1994). Providers are encouraged to manage the care process by developing treatment plans, applying medical necessity criteria, employing utilization management methods, and creating networks of providers, among other techniques. Parity benefits may be limited to in-network providers only (HHS, 2004).

The second major development at the Federal level was passage in 1996 of the Mental Health Parity Act, the first Federal parity legislation. Implemented in 1998, this legislation focused on only one aspect of the difference in mental health insurance coverage—catastrophic benefits. It prohibited using lifetime and annual limits on coverage for mental health care that were different from general medical care (HHS, 2004).

Advocates felt the 1996 Parity Act was a first step in ending discriminatory insurance coverage, but they argued it did not go far enough. They noted that parity provisions did not apply to other forms of benefit limits, such as per-episode limits on length of stay or visits, copayments, or deductibles and that substance abuse was not covered by the legislation. The 2008 Parity Act attempts to correct some of the earlier legislation’s shortcomings.

Research Findings

There have been two significant waves of research into mental health parity. As Barry et al. (2006) note, studies conducted in the early and mid 1990s used actuarial estimates to determine the effect of prices on demand for ambulatory mental health care. They produced widely disparate estimates, ranging from a 1 percent to an 11 percent increase in total premiums due to parity, with the Congressional Budget Office (CBO) estimating a 4 percent increase.

The second generation of research in the late 1990s studied parity for mental health coverage in the context of managed care. These studies incorporated managed care effects into actuarial models using cost data from the FEHB, State parity experiences, the managed behavioral health care industry, and private employers. Barry et al. (2006) report, “After updating its estimation methods to incorporate managed care effects, the CBO scored comprehensive parity as raising group health insurance premiums by an average of 0.9 percent.” An increase of 1 percent or less as a result of implementing parity is a fairly consistent finding across the FEHB, State statutes, and private employers. Other findings include:

- Few, if any, plans leave a program to avoid parity and employers do not drop coverage (HHS, 2004; Rosenbach et al., 2003; Sing, Hill, Smolkin, and Heiser, 1998). A recent survey by the Partnership for Workplace Mental Health (2009) found that the majority of employers surveyed do not plan to drop coverage for mental health or substance abuse treatment.
- Access to and use of mental health and substance abuse services may increase consistent with long-term trends (HHS, 2004).
- Health plans are likely to enter into carve-out arrangements to manage care (HHS, 2004).
- Managed care controls costs; spending on mental health and substance abuse may fall under parity in plans not previously subject to managed care controls (Zuvekas, Regier, Rae, Rupp, and Narrow, 2002; Varmus, 1998).
- Managed care also may reduce access and use for some services and beneficiaries; parity increases offerings while managed care limits usage (Barry et al., 2006; Goldman et al., 2006; Wood, 2005; Rosenbach et al., 2003).
- Costs do not shift from the public to the private sector (Sing and Hill, 2001).
- Consumers’ out-of-pocket spending may decline substantially (for example, in Vermont, among people with serious mental disorders,

the proportion of individuals spending more than \$1,000 out of pocket annually was reduced by more than 50 percent) (HHS, 2004; Rosenbach et al., 2003).

- Quality of mental health and substance abuse services is unchanged (HHS, 2004).
- Parity in substance abuse treatment benefits may ease pressure on State budgets by reducing health, corrections, and welfare costs and increasing the number of people entering treatment (Gillo, Goplerud, and Williams, 2003).
- Providers and consumers often are unaware of new parity regulations and their impact (HHS, 2004; Rosenbach et al., 2003; Lake, Sasser, Young, and Quinn, 2002).

Lessons Learned

Evaluations of parity at the State and Federal level reveal some important lessons for those who are implementing changes to comply with the 2008 Parity Act. As Lake et al. (2002) note about California's experience, "The results highlight the regulatory complexity of what appears to be a relatively straightforward mandate to expand coverage for mental health services."

One of the primary conclusions was the need for better communication. In many cases, evaluators found limited knowledge of parity regulations among consumers, employers, and providers. In California, inadequate communication may have contributed to disruptions in care for consumers during a transition to managed behavioral health organizations by some health plans (Lake et al., 2002).

Vermont stakeholders suggested the need to mount a proactive education campaign during the first year of parity implementation (Rosenbach et al., 2003). This may involve assigning a responsible party, assessing information needs, choosing appropriate methods of communication, and determining when education efforts should take place (Lake et al., 2002).

After passage of parity legislation in Oregon, the State Insurance Division held several trainings and discussion groups to work on transition and implementation with consumer groups and other stakeholders. In addition, the Insurance Division hosted multi-stakeholder advisory meetings to seek input on the development of administrative rules to help implement the law (State of Oregon, 2009).

California evaluators noted that communication among health plans, providers, and employers should include clarification of critical implementation issues. These include when and how referrals should be made for mental health services, which diagnoses are covered, and how cost-sharing and benefit limits should be applied to individuals with different diagnoses or at different stages of treatment (Lake et al., 2002).

Researchers and evaluators also expressed concerns about cost containment under managed care. Barry et al. (2006) note, “it is important to remember that under parity, the traditional incentives to avoid enrolling people with high expected costs remain at least as strong as in the past, while the mechanisms available to health plans for affecting selection have expanded with managed care.” They caution that expanding benefits under parity does not solve the problem of unmet need or ensure use of evidence-based practices in mental health care. As Shern et al. (2009) point out, development of regulations that ensure a meaningful range of evidence-based interventions, including psychosocial services, is a critical implementation task.

Additional findings include:

- In California, the implementation of “partial parity” for a limited set of serious mental illnesses and serious emotional disturbances created administrative challenges and caused confusion for some stakeholders (Lake et al., 2002). Evaluators cautioned that States need to weigh the potential administrative costs of covering limited diagnoses, versus the potentially increased health care costs associated with expanding parity to all mental health diagnoses.

- Also, in California, evaluators noted that stakeholders should attempt to identify strategies for addressing shortages in certain provider specialties or programs viewed as important for meeting increased service demand, such as child psychiatry and eating disorder programs (Lake et al., 2002).
- An evaluation of parity for State employees in Ohio found that the impact of parity is likely to differ across health plans depending on the pre-parity benefits and the organization of the health plan (HHS, 2004).
- Because all of the existing State parity and mandated coverage laws were written and applied prior to passage of the 2008 Parity Act, coordination and interpretation of how State and Federal laws combine or potentially conflict is an important task for 2009 (NCSL, 2009).

Some specific implementation issues for 2009 are featured below in the responses to interviews we conducted with stakeholders in the private and public sectors. Though individuals and organizations have concerns about effective implementation of the 2008 Parity Act, they remain optimistic that the legislation signals increasing recognition of the fact that there is no health without mental health. Ongoing collaboration among key players, which was critical to passage of parity legislation, can aid its successful implementation (Dixon, 2009).

In 2006, Barry et al. (2006) concluded, “Passage of comprehensive parity would allow policymakers, health care managers, and clinicians to shift attention away from benefit design and toward figuring out how to get effective treatment for people who would benefit.” In 2009, consumers, providers, payers, and advocates believe this time has arrived.

Interview Format and Key Stakeholders

Due to the gracious participation of key stakeholders and thought leaders, AHP was able to collect information through the interview

portion of the environmental scan that was both broad in scope and in many cases highly detailed. AHP interviewed 22 individuals from across the behavioral health field representing both public and private sectors. The intent was to gather and disseminate their understanding of the implications of parity and to assess whether or not parity would enhance access to behavioral health coverage and treatment in the United States, thus supporting the original authors' intention in crafting the legislation.

Participants included market leaders and thought leaders in the behavioral health field as well as subject matter experts and individuals responsible for the implementation of Parity within their own organizations. Private sector respondents collectively represent a cross – section of commercial payers including Medicaid managed care plans, traditional insurance companies, managed behavioral health organizations, third-party administrators, and EAP administrators. Thought leaders from the public sector included Single State Authorities, leaders in professional organizations, advocates for and leaders of consumer groups. Their responses reflect national, regional and state-level perspectives.

Each interview lasted between 30-45 minutes. The format was composed of open-ended questions regarding the scope of implementation, resources required in the behavioral health system, perceived impacts on consumers, and the major challenges to implementing parity.

Unlike a typical opinion survey that provides answer categories and counts responses, these questionnaires were designed to provide more in-depth, qualitative information. From the wealth of information gathered in this way, researchers at AHP conducted a “thematic analysis,” grouping answers into topics and identifying how frequently respondents reported answers within those thematic categories. Because certain topics were addressed under multiple questions, responses were then organized according to the overarching issues of access, quality, and cost. The topics outlined below were those endorsed most frequently by respondents.

While the information gathered in this portion of the document is by no means exhaustive, it does provide readers with a wide variety of

perspectives and a valuable array of tactical as well as strategic considerations, lessons learned, and insights into successful implementation and compliance with the law. Of equal importance, it provides innovative solutions proposed by individuals with considerable first-hand experience. A synthesis of the input follows.

Key Stakeholder Interviews

Access

Access is conventionally defined as the degree to which consumers can readily seek treatment services for their disorders and that adequate coverage and sufficient numbers and types of providers and services exist to meet their needs within acceptable timeframes. Access also refers to the availability of accurate information, advocacy, screening, diagnosis, treatment planning, and referrals. Access issues concerning diversity, language, gender, faith, sexual orientation, or other sociocultural variables were not within the scope of this study.

In general, public sector respondents tended toward cautionary feedback and did not appear to believe that parity will enhance access to services or make it easier for consumers to navigate the continuum of care. Because the legislation does not specify covered conditions or address the specifics of “medical necessity,” these participants consider parity to be primarily a change in payment methodology. Of primary concern was whether commercial health plans, employers, and other purchasers would continue to offer behavioral health coverage in the absence of a mandate. They believe there is a legitimate risk of consumers losing access to coverage. Regarding access to information and records, the public sector is also very sensitive to the unique privacy issues inherent in behavioral health care. Private sector responses concerning access emphasized adequate and high-quality provider networks and the shortage of several key types of providers.

The themes most often mentioned regarding access include the following:

- **Provider networks are insufficient.** The vast majority of respondents stated that provider networks suffer from shortages in several practice/specialty areas, particularly child psychiatrists, child psychologists, primary care physicians with appropriate behavioral health training, and “prescribers” in general. There is a shared sense of concern for the aging of the behavioral health workforce and the tendency for new physicians to choose specialties as opposed to primary care. There is a risk that individuals with moderate behavioral health issues will receive inadequate treatment if primary care physicians (PCPs) have difficulty making referrals to behavioral health specialists. A second challenge is posed by out-of-network benefits and the risk that providers will opt to drop their network participation in favor of balance-billing out-of-network consumers at higher rates. The majority of respondents agreed that creating financial incentives such as enhancing reimbursement rates is one logical remedy to provider network and access concerns (notwithstanding medically underserved areas). Public sector respondents also note that numerous providers who are not conversant in the managed care system may be forced out of the field, further exacerbating the shortage.

- **The human resources needed for implementation are in short supply.** In addition to specialty providers required by networks, respondents believed that clinical resources such as psychiatrist medical directors, certified case managers, psych-certified RNs, and specialist support for PCPs are insufficient to meet the expanding role health plans need to play. Plans and payers require access to consultants and subject matter experts with experience in the areas of provider contracting, implementation, benefit design, and utilization/case management in order to provide operational expertise and training.

- **Providing access to education for payers, providers, and consumers is considered key to implementing parity successfully and achieving access goals.**
The challenge of properly educating health plan members, providers, and other key stakeholders is viewed as one of the highest priorities. Plan members need to understand what their benefits are, what is covered, and how best to navigate the system of care and plan policies. Providers require a similar education in terms of plan benefits, rules, and policies. In addition, they need to understand how to work within

a managed care system, market themselves to utilization and case managers as well as plan members, and navigate insurance company practices, including the utilization review and authorization process. Employers in particular need to be educated in terms of the real costs of providing parity. Employers and plans will also need to understand the differences between various approaches to managing parity, including behavioral health carve-outs, carve-ins, and employee assistance program (EAP) gatekeeping.

- **Communication between and within stakeholder groups and access to accurate information is crucial.** Respondents believe that regulatory agencies should develop a repository of frequently asked questions (FAQs) for both payers and providers; operate a hotline to provide payers and providers with timely answers to implementation questions; and convene collaborative meetings with both payers and providers. Additionally, a number of respondents noted that plan members and providers should have easy access to a clear appeals process.
- **Perceptions of mental health and substance use disorder treatment may be enhanced and improved.** Participants note that parity is likely to reduce the stigma surrounding treatment, thereby opening the door to consumers who would not have sought help in the past. Several participants also reported that parity serves to elevate issues of behavioral health care, which is especially important given the current push for health care reform.
- **Parity will increase access for many consumers as restrictions on services are lifted, though risks and obstacles remain.** While a majority of respondents view the nondiscriminatory nature of parity as cause for celebration and a significant gain for consumers, several added the caveat that realization of these benefits depends greatly upon implementation and regulatory guidance. Respondents also note there remain many barriers to treatment beyond the issue of coverage.
- **The absence of a mandate invites the risk that employers will eliminate behavioral health benefits.** While the public sector may see this as a more serious threat, a number of private sector respondents

also see this as a valid concern that should be addressed by educating employers, their brokers, and plan administrators.

- **All stakeholders require access to standardized medical necessity criteria.** The private sector response calls for access to guidance and clarity regarding covered disorders, providers, and levels/types of service covered. Those from managed care backgrounds are fluent in accreditation requirements for research-based level of care guidelines or patient placement criteria; they require specificity from regulators as to how and when to apply them. Public sector responses tend toward a desire to see the use of standards-based tools, oversight, and accountability. There is also a desire to address patient placement criteria for substance abuse treatment in particular. The majority of respondents across sectors addressed the need to provide plan members and their providers with these criteria in a manner consistent with the law.

- **There is a need to provide access to an appropriate service mix or continuum of services and care providers.** Responses in this area varied somewhat between public and private respondents though there was consensus on the need for a service mix commensurate with what regulators determine coverage should entail. While respondents from the public sector agree it would be a positive development if regulations required all appropriate types of service that support mental health and substance abuse treatment, respondents understand that parity is no guarantee of access to this extent. Public sector respondents understand the unique and complex needs associated with substance use disorders, for example, and point to the need for community-based, recovery-focused, wraparound services. Their private sector counterparts do not disagree but believe it is prudent to await direction from Federal and State regulators concerning coverage prior to addressing continuum of care issues.

- **The patient-centered medical home model and primary care physicians will enhance access.** There was general consensus among private sector respondents that PCPs fulfill an important function in the behavioral health care system. There was also agreement that emerging medical home models may prove beneficial to the behavioral health

needs of plan members, particularly those who require case management/care coordination services.

- **Enhancements to information technology will facilitate improved access.** Improved integration of data is needed to allow for the sharing of information across organizational boundaries. Use of personal health records and the development of health information exchanges will support this aim.

Quality

Throughout the interview process, themes related to quality were addressed by both public and private respondents repeatedly and thoroughly. Quality was viewed through a wide lens encompassing quality assurance in provider networks, quality in treatment planning, quality in authorizing medical necessity, and quality as indicated by consumer safety and outcomes.

The most significant area of difference between public and private sector responses relating to quality center around the proposition that parity will accelerate the integration of primary care and behavioral health. The majority of participants from the public sector do not believe parity will have an impact on the integration of care. Several public sector respondents stated that health plans will tend toward behavioral health carve-outs, making integration difficult. One respondent noted that integration of substance abuse treatment in particular does not happen easily, nor is funding for treatment a guarantee. In contrast, the majority of private sector respondents believe that integration is already taking place; they state that parity will either accelerate this process or be a neutral factor.

Participants cited the following quality-related themes most often:

- **Regulations need to clarify service level expectations and address coverage of specific conditions.** A majority of respondents from the private sector note the difficulty of designing a benefit to meet the intent of such broad legislation and request specificity around covered

conditions. This issue applies to coverage of disorders such as autism and ADHD.

- **Established evidence-based practices should be identified and implemented.** Respondents agree that best practices are vital to effective treatment and positive clinical outcomes at every level of care. The public sector is particularly interested in the establishment of scientifically validated medical necessity and patient placement criteria.
- **Provider credentialing and monitoring must be improved and standardized to ensure quality care.** A majority of private sector respondents recommend national standards for education, licensure, malpractice, and liability insurance, as well as health plan credentialing activities.
- **Medical necessity criteria and level of care guidelines should be clearly defined and transparent.** While plans can continue to manage care, participants note the parity law has yet to fully address how medical necessity is defined, what appeals processes are acceptable, and what types of medical necessity/level of care guidelines are sufficient and valid. Respondents are hopeful that regulations will answer many of these questions.
- **Quality will be enhanced through improved diagnostic capabilities and standardized tools.** Public sector respondents in particular believe that the use of standardized and evidence-based tools to screen, diagnose and plan treatment is integral to ensure quality care and outcomes. Use of the American Society of Addiction Medicine (ASAM) patient placement criteria for substance use disorders is a prime example.
- **Training and clinical support for primary care physicians should be emphasized.** PCPs currently treat the vast majority of mild to moderate behavioral health care conditions in their clinics or offices and are likely to bear an increasing burden where behavioral health care provider networks are inadequate. Private sector responses note that PCPs require support in making appropriate diagnosis, referrals, and coordinating care.

- **The treatment of serious mental illnesses in adults and serious emotional disturbances in children will pose unique challenges.** The majority of respondents agreed that these types of illnesses have primarily been the purview of the public health and public school systems and will pose a challenge in some parts of the country depending on how regulations are interpreted and enforced. Some private sector participants reported that they believe this issue also represents a good opportunity to explore “blending” or “braiding” private and public sector benefits and services.
- **The use of health information technology is necessary to manage quality assurance.** Technology such as electronic medical records and health information exchanges are seen as central to meeting interoperability, data exchange, and integration goals, as well as to the efficient coordination of care. All of these objectives are perceived to be necessary to manage quality and achieve superior outcomes in the modern health care system. Organizations are likely to use case management systems that meet the needs of both medical/surgical and mental health/substance use conditions. As much as health information technology is viewed positively from all sides, public sector respondents remain very alert to the importance of privacy constraints, such as CFR 42, for individuals with mental health and substance use conditions.

Cost

For the purposes of this environmental scan, cost refers to the myriad financial considerations imposed by the 2008 Parity Act and its implementation. Costs include the cost of services or claims costs, as well as the administrative costs borne by health plans and providers. Costs also include consumer and plan member premium and out-of-pocket costs, as well as premium costs borne by employers.

While consumers, employers, health plans, and managed behavioral health organizations (MBHOs) have a vested interest in constraining costs, respondents from the private sector did not address this as frequently as might be expected. This may be because most plans and managed care organizations are familiar with the actual cost increases associated with State parity laws and many have studied reports

published since 1996 demonstrating cost increases well within the 2 percent range. When the issue of general cost increases is noted, the focus is on ERISA employers, third party administrators, and MBHOs, entities our respondents agree will be impacted most.

There is also general agreement among private sector respondents that out-of-pocket costs will decrease for plan members. Public sector responses indicate a serious and abiding concern that employers and their payers will eliminate behavioral health coverage entirely in order to avoid higher expenses. Several respondents in the private sector echo their concern, with one individual predicting parity will inadvertently increase the number of uninsured with each “up tick” in premium costs. A number of respondents note a pressing need for education and advocacy directed at payers who may otherwise be inclined to truncate coverage because they do not fully understand the actual cost models.

Additional cost related considerations include:

- **Clear guidance through the timely release of regulations is essential to efficient implementation, compliance, and cost controls.** Respondents call for Federal guidance around the following: the definition of “predominant” benefits that form the basis for equity and parity; whether or not a separate deductible is allowed; and clarity concerning diagnosis, provider types, and levels of service covered by the law. Costs will be higher for plans that do not accurately estimate the content of forthcoming regulations and need to make adjustments in subsequent plan years. One participant notes that regulations should not be punitive while another states that a phasing in of penalties would be appropriate for plans acting in good faith and making every effort to comply. Some respondents express doubt as to whether full compliance is possible within the given timeframe.
- **Out-of-network benefits present payers with a challenge.** Payers will bear the additional burden and expense of handling out-of-network providers and managing deductible accumulators. Many plans and carve-outs do not provide for out-of-network coverage and will be required to reconfigure claims processing systems accordingly. Out-of-network costs will be greater to the consumer, and reimbursement

combined with balance billing may in fact create incentives for providers to abandon their in-network status.

- **The decision to carve-in behavioral health benefits or carve-out to an MBHO will have a significant impact on cost.** Responses are varied on this issue due to the disparate interests represented by participants. Several respondents strongly recommend a deeply integrated carve-in approach that they believe allows for holistic treatment of behavioral health and general health conditions. Their responses emphasized plans' ability to coordinate care seamlessly within a single, multidisciplinary team under the same roof. A similar number of respondents are proponents of some form of carve-out, with one recommending that purchasers contract with large national managed care organizations that have the capability to very quickly manage the entire implementation. They also propose that well established and experienced MBHOs have proven they can manage claims accumulators. The challenge, many admitted, is that predictive models and pricing estimations are difficult in the first year with so many unanswered questions.
- **The administrative burden on providers will increase their costs.** A large number of participants noted the need for process efficiency and automation in various areas including eligibility determination, patient registration, scheduling, service authorization, charting, and billing.
- **Case management is essential to manage costs associated with serious mental illnesses.** There is general consensus that complex cases involving chronic conditions will benefit from case management services. The addition of case management may be new for some plans and employers and they will require education in order to understand medical cost-offset models and long-term financial implications.
- **Plans need to be prepared for the financial ramifications of increased utilization.** Many individuals will increasingly maintain their private coverage, which will eventually impact the numbers of adults with serious mental illnesses and children with serious emotional disturbances receiving treatment in the private sector. Several participants noted the need for new predictive models and are conducting actuarial analyses to anticipate both near and long-term

costs, which may increase within 3 to 5 years. They attribute potential and unexpected increases in utilization to the long-term effects of member education, evolving social norms, and “population shifting” into private sector coverage and treatment.

- **Implementation can involve costs associated with changes to provider contracts and reimbursement.** Provider contracts are cited with some frequency and respondents believe that reimbursement levels may be impacted when the need arises to modify them and align them with parity regulations and new plan rules/benefits. The single most cited impact concerned PCPs and their ability to bill appropriately for mental health services involving more than one service in a given day.
- **Claims accumulators will be necessary to manage a single deductible.** In instances where regulations and plan policies involve a single deductible and out-of-pocket maximum, plans and their MBHO partners will require sophisticated claims accumulator exchanges that will enable claims generated for medical as well as behavioral health services to be tracked simultaneously and risk assigned accordingly. This process is complicated when two organizations—the plan and its MBHO—are responsible for claims processing and handling claims that can involve “mixed” medical and mental health services and codes.
- **Technology systems will need to be reconfigured to adjust to new plan rules and benefits.** Health plans and payers of all kinds will be required to modify the configuration of claims processing systems, data warehouse and reporting systems, and claims accumulator systems.

General

Since parity must be implemented rapidly, numerous responses to the interview questions addressed strategic considerations, the release of regulations, and tactical implementation issues that transcend or fall outside cost, quality, and access categories. These comments merit mention as they are rich with insight and will have high utility for organizations charged with implementation, particularly those undertaking parity for the first time.

Issues of compliance and regulatory guidance not mentioned elsewhere include:

- **The provision of timely and consistent regulatory guidance is of primary importance to the private sector.** Health plans will be obligated to design, publish, and file benefit plans with State departments of insurance well in advance of the release of regulations. A Web portal, telephone hotline, and a list of FAQs will greatly facilitate timely compliance.
- **Regulations must incorporate meaningful provider input.** Participants from both the public and private sectors note that behavioral health care providers and particularly substance abuse providers have historically been marginalized when it comes to the development of behavioral health policy. Payers of all kinds are encouraged to include behavioral health providers, experts, and consumers in their planning and implementation.
- **Federal agencies may need to play an expanded role.** The three departments responsible for parity can act as an arbiter to enhance public/private partnerships, convene a summit of stakeholder groups, provide education and advocacy for consumers and their families, provide direct oversight, and enforce accountability. The Federal government can also assist stakeholders by continuing to involve behavioral health in the health care reform process, maintaining open communication.

Other strategic considerations our respondents noted include the following:

- Two respondents note significant interest in exploring public/private partnerships that “braid, blend,” and otherwise leverage the expertise and capacity of both sectors. Several States have begun innovative collaborative approaches, which may be helpful as health care reform models emerge.
- The benefits and value of carve-in and carve-out approaches need to be understood by those who lack experience with either.

- Committed leadership is believed to be essential to timely, comprehensive implementation.

It is clear that Federal agencies have, in fact, begun to respond to concerns about implementation of the 2008 Parity Act. The Center for Substance Abuse Treatment in the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, gathered a group of 12 leaders representing States, professional organizations, and advocates to discuss the impact that parity will have on access to substance abuse treatment. Many of the comments respondents made at that meeting reflect those in our environmental scan. This group noted in particular the need for Single State Agencies to work collaboratively with other State agencies—including Medicaid, insurance commissioners, and departments of labor—to help ensure a full continuum of services for individuals with substance use disorders.

About AHP

Advocates for Human Potential, Inc. (AHP), is a research and consulting firm that specializes in changing and improving the organizational systems that help individuals create full and productive lives. Founded in 1980, AHP's comprehensive range of services helps clients identify and define challenges and potential solutions, engage stakeholders, design or modify programs and organizational practices, provide training, and develop new resources. AHP also conducts research on difficult issues, evaluates programs and service system, and helps clients translate research into practice.

Our services are organized in the following areas: research and evaluation; technical assistance and training; system and program development, including strategic planning and information management; and resource development and dissemination, in core content areas. Those areas include mental health policy and services, substance abuse treatment and prevention, co-occurring disorders, workforce development, electronic medical records, trauma, homelessness, housing, employment program development, domestic violence, and criminal justice.

AHP provides extensive consultation to healthcare provider organizations; health plans; and Federal, state, local, and international governments. The company manages Federal contracts of all sizes for several U.S. agencies in the areas of mental health, substance abuse, co-occurring disorders, workforce development, homelessness, domestic violence, elder abuse, rural elder health, and performance review and improvement. These projects enhance understanding of critical issues, help agencies and their stakeholders improve performance, and provide the most current information to the field about effective programs and system development to better serve vulnerable populations.

AHP's passionate and committed staff members, many of whom are nationally recognized, are known for their intimate knowledge of "what happens on the streets" as well as in the offices of policymakers, and they are equally comfortable in both settings. The insights they bring to large national projects are informed by diverse experience in the field. AHP is especially known for connecting the dots across disciplines, service systems, funders, and populations to develop comprehensive real-world solutions that meet the needs of consumers and providers.

References

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Barry, C.L., Frank, R.G., & McGuire, T.G. (2006). The costs of mental health parity: Still an impediment? *Health Affairs*, 25(3), 623-634.
- Dixon, K. (2009). Implementing mental health parity: The challenge for health plans. *Health Affairs*, 28(3), 663-665.
- Gillo, K., Goplerud, E., & Williams, L. (2003). *Improving private insurance alcohol treatment can save states money*. Washington, DC: Ensuring Solutions to Alcohol Problems, George Washington University Medical Center. Retrieved May 12, 2009, from http://www.ensuringsolutions.org/resources/resources_show.htm?doc_id=339043
- Goldman, H.H., Frank, R.G., Burnam, M.A., Huskamp, H.A., Ridgely, M.S., Normand, S.T., et al. (2006). Behavioral health insurance parity for federal employees. *New England Journal of Medicine*, 354, 1378-1386.
- Lake, T., Sasser, A., Young, C., & Quinn, B. (2002). *A snapshot of the implementation of California's Mental Health Parity Law*. Oakland, CA: California HealthCare Foundation.
- National Conference of State Legislatures. (2009). State laws mandating or regulating mental health benefits. Washington, DC: Author. Retrieved May 11, 2009, from <http://www.ncsl.org/programs/health/mentalben.htm>
- Parks, J., Svendsen, D., Singer, P., & Foti, M.E. (Eds.). (2006). *Morbidity and mortality in people with serious mental illness*. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council.
- Partnership for Workplace Mental Health. (2009). *Employer survey results: Mental health parity law*. Arlington, VA: Author. Retrieved May 26, 2009, from <http://www.workplacentalhealth.org/pdf/EmployerParitySurveyResults.pdf>
- Robinson, G.K., Connolly, J.B., Whitter, M., & Magaña, C.A. (2007). *State mandates for treatment for mental illness and substance use disorders*. (DHHS Publication No. SMA 07-4228). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- Rosenbach, M., Lake, T., Young, C., Conroy, W., Quinn, B., Ingels, J., et al. (2003). *Effects of the Vermont Mental Health and Substance Abuse Parity Law*. (DHHS

Publication No. SMA 03-3822). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Shern, D.L., Beronio, K.K., & Harbin, H.T. (2009). After Parity—What's next. *Health Affairs*, 28(3), 660-662.

Sing, M., & Hill, S.C. (2001). The costs of parity mandates for mental health and substance abuse insurance benefits. *Psychiatric Services*, 52(4), 437-440.

Sing, M., Hill, S., Smolkin, S., & Heiser, N. (1998). *The costs and effects of parity for mental health and substance abuse insurance benefits*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

State of Oregon. (2009). *2009 review of coverage of mental or nervous conditions and chemical dependency in accordance with ORA 836-053-1405(8)*. Salem, OR: Department of Consumer and Business Services Insurance Division.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Washington, DC: Author.

U.S. Department of Health and Human Services. (2004). *Evaluation of parity in the Federal Employees Health Benefits (FEHB) Program: Final report*. Washington, DC: Author.

Varmus, H.E. (1998). *Parity in financing mental health services: Managed care's effects on cost, access, and quality*. An interim report to Congress by the National Advisory Mental Health Council. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health.

Wood, E.P. (2005). Children and mental health parity. Washington, DC: National Conference of State Legislatures. Retrieved May 11, 2009, from <http://www.ncsl.org/programs/health/pmmp05.htm>

Zuvekas, S.H., Regier, D.A., Rae, D.S., Rupp, S., & Narrow, W.E. (2002). The impacts of mental health parity and managed care in one large employer group. *Health Affairs*, 21(3), 148-159.



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