Parity Research and Reports

Major Study of Parity Cost Proves Its Affordability

A prominent health care economist calls a study of the effects of mental health parity benefits for federal employees the "capstone" of efforts to establish a research basis proving the affordability of parity.

The time is right to push for parity in Medicare for mental health benefits, including substance abuse, according to APA President Steven Sharfstein, M.D.

A long-awaited report on the results of offering parity through the Federal Employees Health Benefits (FEHB) program provides powerful evidence that can be used to refute claims that parity is unaffordable. The release of "Evaluation of Parity in the Federal Employees Health Benefits (FEHB) Program: Final Report" came shortly before the introduction of the Medicare Copayment Equity Act by Sens. Olympia Snowe (R-Maine) and John Kerry (D-Mass.) in late May (Psychiatric News, July 1).

APA's Department of Government Relations led the effort to develop the legislation and mobilize support from the Mental Health Liaison Group, which in addition to APA represents more than 30 professional and advocacy organizations. The bill would end the 50 percent copayment required for outpatient psychiatric services funded through Medicare (Psychiatric News, July 1).

"We have yet another evaluation showing that parity does not break the bank," said Sharfstein. "This study is particularly impressive because it was national in scope and analyzed the effects of parity benefits in the largest employer-sponsored health insurance program in the country."

He added that President George W. Bush frequently has pointed to the FEHB program as a model insurance program. Health economist Thomas McGuire, Ph.D., offered another reason for the importance of the FEHB study.

"It was done by the `first string,'" he said. "These are the people and

research organizations you would want to do the work."

The participating organizations included the Health Solutions division of Northrop Grumman Information Technology Inc., Department of Health Care Policy at Harvard Medical School, RAND Corporation, University of Maryland School of Medicine, and Westat.

The principal investigator was Howard Goldman, M.D., Ph.D., a professor of psychiatry at the University of Maryland and editor of Psychiatric Services. The study encompasses data from 1999 through 2002. The final report was submitted to the Department of Health and Human Services and the Office of Personnel Management at the end of 2004 and made public in May.

McGuire agreed with Sharfstein that the size and scope of the study give weight to the findings. "The FEHB [program] evaluation is the capstone of the line of research that has established the affordability of providing parity of benefits in health insurance," he said (see box on page 36 for key findings).

McGuire is a professor of health economics in the Department of Health Care Policy at Harvard Medical School and co-editor of the Journal of Health Economics.

The report is timely because the Mental Health Parity Act of 1996, which provides legislative authority for a limited federal parity mandate, will sunset at the end of the year unless it is reauthorized. The act has been reauthorized annually since 2002.

Study Examines Effects of Policy Shift

In January 2001 the Office of Personnel Management (OPM) implemented a directive to the approximately 250 health plans providing benefits to federal employees and their families through the FEHB program to comply with a policy requiring that mental health and substance abuse (MH/SA) services be covered to the same extent as general medical care with respect to deductibles, copayments, and limits on physician visits and inpatient days.

Services to be covered were identified as "clinically proven treatment for mental illness and substance abuse.. .conditions listed in the

DSM, Fourth Edition." OPM encouraged plans to manage the costs of care by such methods as the establishment and use of network providers. OPM did not require plans to provide parity in benefits for plan members who chose to use out-of-network providers.

The parity policy represented a genuine change in MH/SA benefits for the approximately 8 million individuals covered through FEHB insurance plans. Before implementation of parity, 98 percent of the plans continuously participating in the program over the four-year study period contained at least one benefit feature that was more restrictive for MH/SA care. Some health plans, for example, limited annual outpatient mental health care to 28 visits.

In fall 2000, the U.S. Department of Health and Human Services issued a contract for a study to evaluate the implementation and impact of the new policy in terms of changes in access, utilization, cost, quality of care, and other issues. The research was also supported by six other federal agencies.

Researchers Used Multiple Approaches

The list of key research questions included items that could be answered using relatively simple methods. For example, researchers were asked to determine whether the FEHB plans complied with the new policy. Through review of plan documents and interviews, they determined that all plans complied.

But the list of questions also included items that required more sophisticated and innovative methods of arriving at answers. Researchers were asked to determine whether the quality of care was affected by the parity policy and how providers "experienced" the policy.

Researchers studied data for major depression and substance abuse disorders, two tracer conditions, to assess changes in quality of care for these conditions. They compared claims information about treatment to determine whether patterns of care were consistent with practice guidelines.

Focus groups of psychiatrists, psychologists, and other mental health

personnel in different regions of the country helped determine how providers experienced the change in policy. None reported a clear understanding about how the parity benefit affected service provision, and some confused federal with state parity requirements.

The most important set of questions concerned the impact of parity on cost, access, and utilization of MH/SA services. It was important for researchers to be able to separate the impact of parity on changes in those areas from changes that would have occurred without implementation of parity.

To identify health plans that did not offer parity but did offer mental health and substance abuse benefits typical of those offered by large employers, Goldman and his colleagues turned to a database by Med-Stat, a company that collects data about health plans.

"For purposes of comparison," he said, "we matched those plans with a set of similar FEHB plans that did offer parity." The aim, he said, was to come as close as possible to designing an experiment that would determine whether changes in cost, access, and utilization were due to the implementation of parity or to other health care trends.

Both the FEHB and the MedStat plans showed similar increases in the items measured, suggesting that implementation of parity alone did not increase cost, access, and utilization.

An important difference, however, between plans offering parity benefits and those that did not was the cost to beneficiaries for MH/SA services.

When parity went into effect, all copays and limits were changed to comply with the new policy. The median copay dropped from $20 to $10 per visit for outpatient mental health services; for inpatient care, the respective figures were $40 and $0.

"Users of services in most but not all plans experienced a decrease in out-of-pocket spending, indicating that parity provided the intended additional financial protection for MH/SA expenditures for many enrollees," according to the report.

Use of Carveout Vendors Increased Slightly

Health care economist McGuire told Psychiatric News, "Implementation of parity requires some form of cost-control measures in order to be financially viable."

Studies of the effects of implementation of parity at the state level found that costs typically increased "a few percent" and sometimes not at all and that implementation was accompanied by increased use of carveouts and other managed care measures intended to control costs (Psychiatric News, September 19, 2003; June 21, 2002; June 7, 2002).

FEHB plans were asked to report "whether the health plan contracts with a vendor—such as a managed behavioral health organization—for management of behavioral health benefits." Information was also elicited about whether carveouts were established post- or pre-parity and whether they were established in response to the parity policy.

Researchers separated the FEHB plans into two groups for administrative reasons. In the first group, 62 (26 percent) reported that they had carved out benefits either in anticipation of, or in response to, implementation of parity. Of the 156 plans in the second group, 103 (66 percent) reported having a contract with a carveout vendor to manage behavioral health care benefits. Eighty-one of the 103 plans, however, reported preexisting carveouts that were implemented for reasons other than FEHB parity.

Darrel Regier, M.D., M.P.H., director of the American Psychiatric Institute for Research and Education and APA's Division of Research, said, "The report provides an excellent foundation for our ongoing examination of how the implementation of parity affects psychiatrists and other providers of mental health services, in addition to valuable new information about cost and utilization."

He pointed out that important questions about the effects on the mental health workforce and on patient care remain unanswered. Among them: Did parity change the proportions of various kinds of mental health providers supported through the FEHB program? Did parity impact access for patients in terms of availability of specific kinds of providers?

With support from the American Psychiatric Foundation, Regier and his colleagues have been conducting a survey of Washington, D.C.–area psychiatrists to gain more information on the impact on psychiatrists and patients' access to care. Parallel surveys are being conducted by the American Psychological Association and the National Association of Social Workers.

"Although some questions remain about the impact of managed parity on clinical practitioners," Regier said, "the study provides convincing evidence that parity mental health benefits under the FEHB program reduced out-of-pocket costs for patients—particularly for those using inpatient services—and that ending discriminatory insurance coverage for patients with mental disorders is a completely affordable national health policy goal."

"Evaluation of Parity in the Federal Employees Health Benefits (FEHB) Program" is posted at <http://aspe.hhs.gov/daltcp/reports/parity.htm>.