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BEHAVIORAL HEALTH ISSUE BRIEF SERIES

Issue Brief # 13

Behavioral Health Benefits For Public Employees: Effect of Mental Health Parity Legislation

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Executive Summary

With the passage of the Mental Health Parity Act of 1996 (MHPA), Congress took an important first step toward equalizing treatment under medical plans between physical and mental illnesses by requiring parity in annual and lifetime dollar limits between physical and mental illness. But the Act was limited in scope: it did not mandate mental health benefits nor prohibit other common types of differentials between physical and mental illnesses, such as higher cost-sharing or lower limits on outpatient visits or inpatient treatments. Before Congress' action in 1996, a few of the states had adopted some type of parity requirement. Since 1996, state parity activity has accelerated.

Recently, the Center for Health Services Research and Policy through a grant from the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services, examined contracts providing for mental health benefits for state employees in eight states to assess whether legislative attempts to require parity between physical and mental illnesses resulted in noticeable differences in behavioral health benefits for state employees.

We concluded that, except in states that have mandated full parity for some or all types of mental illnesses, behavioral health benefits for state employees have not changed significantly as a result of the state parity laws, since they still remain subject to traditional restrictions, such as higher cost-sharing and greater limitations on outpatient visits and inpatient treatment days, than those imposed on physical illnesses. Thus the considerable state activity surrounding mental health parity may have little effect on state employees' access to mental health services, since although state laws required parity in dollar limitations, they generally permitted the continuation of other plan design features that are more restrictive for mental health coverage. However, many of the contracts we examined were multi-year contract and may not have fully reflected recent state activity. Moreover, if Congress renews the Mental Health Parity Act when it expires in September, 2001, and expands

the scope of the Act to cover some of these other plan design features, states with more limited parity laws are likely to follow. In that case, perhaps state employees with mental illnesses may see significant change in the future.

I. Introduction

The passage of the Mental Health Parity Act of 1996 (MHPA)¹ by Congress was viewed as an important first step toward equalizing treatment under medical plans between physical and mental illnesses. Under the Act, new Federal minimum standards were imposed on a temporary basis on most employer-sponsored employee benefit plans.² These rules prohibited employers from imposing annual or lifetime dollar limits on mental health benefits that were more restrictive than dollar limits imposed on benefits for physical illnesses.³

The Act, however, did not require plans or issuers to provide mental health benefits. Nor did it prevent the use of other types of differentials between physical and mental illnesses, such as higher cost-sharing for mental health treatments, lower limits on the number of outpatient visits or the number of days of inpatient treatment, different definitions of medical necessity for physical and mental illnesses, requirements that patients obtain prior authorization for treatment, or other gatekeeping requirements. So the actual impact of the Act on the day-to-day operation of health plans may be more limited than the rhetoric that both its proponents and opponents have suggested.

Moreover, the Act provided for two significant exceptions: one for group health plans of small employers and another for group health plans that experienced increased costs from the new requirements. “Small employers” are generally defined as those with at least two, but no more than fifty, employees in the preceding calendar year.⁴ To take advantage of the “increased costs” exemption, compliance would have to increase group health plan costs by at least 1%.⁵ Finally, the Act did not include substance abuse benefits in its parity provisions, but rather was limited solely to mental health benefits, a distinction that in practice is often difficult to draw.

As is frequently the case, Congress’ action in 1996 followed the lead of the states, eight of which had previously adopted some type of parity requirement.⁶ Because the MHPA only

¹ This law was enacted as Title VI of the VA-HUD Appropriations Act for the 1997 Fiscal Year (P.L. 104-204) on September 26, 1996.

² The MHPA provisions are scheduled to sunset on September 30, 2001.

³ Employee benefit plans sponsored by private sector employers and regulated under the Employee Retirement Income Security Act of 1974 (ERISA) are covered by the MHPA. The Act also applies to group health plans established by certain state and local governments for public employees, church plans, and certain other plans. However, self-insured state and local government plans may elect to be exempt from the Act. Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191 (August 21, 1996), Section 102 (adding new section 2721(b) to the Public Health Service Act).

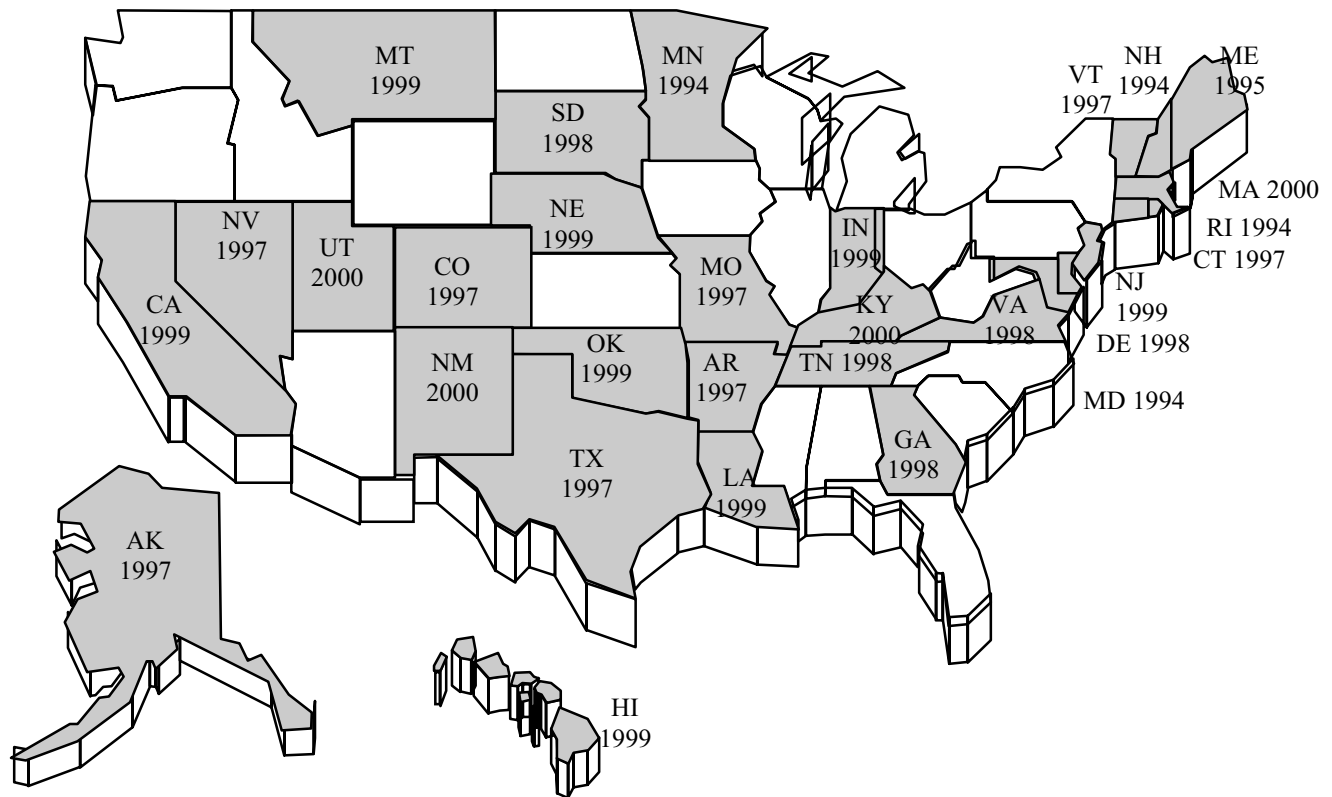
⁴ Section 712(c)(1) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1185a(c)(1).

⁵ Section 712(c)(2) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1185a(c)(2). In order to take advantage of this exemption, plans must implement the parity requirements and then measure the cost of compliance; interim regulations preclude a plan from relying on projections of anticipated cost. Plans must also notify participants that they intend to rely on this exemption. 29 CFR § 2590.712(f); 26 CFR § 54.9812-1T(f); 45 CFR § 146.136(f).

⁶ According to the National Alliance for the Mentally Ill (NAMI), the eight states that had adopted parity provisions in the 1991-1996 period were Maine, Maryland, Massachusetts, Minnesota, New Hampshire, North Carolina, Rhode Island and Texas. In three of those states (Massachusetts (by administrative order only), North Carolina and Texas), the requirements applied only to benefits for state employees.

preempted state laws that would prevent the application of the Federal law,⁷ state activity involving parity has accelerated. According to a recent study by the General Accounting Office, 30 states have mandated some form of mental health parity, as shown in the following map:⁸

Figure 1. -- Year of Adoption of Parity Legislation by State



This issue brief focuses on several key issues of importance to people with mental illnesses: Which mental health services are covered under state employee benefit plans? Which are excluded? In states that have adopted parity legislation, what does “parity” mean? Are the behavioral health benefits provided for state employees in non-parity states different than in parity states? What distinctions between benefits for mental and physical illnesses still exist? In short, our goal was to assess whether legislative attempts to require parity between physical and mental illnesses resulted in noticeable differences in behavioral health benefits for state employees.

⁷ The MHPA did not contain any special preemption provisions, therefore the general preemption approach adopted in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191 (August 21, 1996) would apply. See Section 101 of HIPAA (adding new section 704(a)(1) to ERISA).

⁸ General Accounting Office, “Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited,” GAO/HEHS-00-95 (May 2000), page 8. The GAO relied on information supplied by the National Conference of State Legislatures (Tracy Delaney, *Overview of State Laws Affecting Coverage of Mental Illness and Substance Abuse Treatment* (Washington, DC: NCSL, Health Policy Tracking Service, Mar. 1, 2000)) [hereinafter referred to as “GAO Report”].

II. Documents Reviewed

We examined Requests for Proposals (RFPs) and standard contracts between eight large state employee benefit plans and managed care organizations to determine the extent to which the mental health benefits provided to state employees reflected this movement toward parity in benefits between mental and physical illnesses. The employee benefit plans included in the study were those covering state employees in Arkansas, California, Colorado, Maine, Maryland, Ohio, New York and Wisconsin.⁹ Five of these states had previously adopted mental health parity legislation: Arkansas in 1997,¹⁰ California in 1999, Colorado in 1997, Maine in 1995, and Maryland in 1994, although the requirements vary from state to state. The reviewed contracts were generally in effect for some portion of the year 2000, although most are multiyear contracts. In some cases, based on availability, we also examined contracts that are currently in effect to see if any changes in coverage had been adopted. Four of the states (California, Colorado, Maine and Wisconsin) provided mental health benefits through a comprehensive service agreement covering services for both physical and mental illnesses, while four others (Arkansas, Maryland, Ohio, and New York) covered mental health benefits through a separate carve-out contract (although we were usually able to examine the documents providing for coverage of physical illnesses as well). Although neither the MHPA nor state parity laws generally affect coverage for substance abuse treatment, we also looked at contract provisions governing those services to determine if the mental health parity trend had any spillover effect on substance abuse benefits.

III. A Snapshot of Behavioral Health Services for State Employees

Covered Services

State employees have access to a wide variety of covered services in the eight states we examined. Inpatient and outpatient care, therapy, residential treatment services, partial day treatment programs, medication management services, detoxification and prescription drugs were generally covered. Table 1 below provides a snapshot of key covered services. Note that some states simply cover inpatient and outpatient treatment and do not enumerate particular services. Similarly, the fact that a state may not have specified that a particular treatment modality is covered does not necessarily mean that it will not be available for participants. For instance, every state employee benefit plan RFP we examined covers substance abuse and/or alcohol dependence treatment. A core treatment for those conditions is detoxification services, yet not all the RFPs or contracts specifically reference it. On the other hand, a participant who needed that type of service might not understand that it was a covered service if it was not spelled out in materials that he or she received about the health plan.

⁹ See Appendix A for a list of documents reviewed in connection with this study.

¹⁰ However, plans covering state employees were exempt from the parity requirements.

Table 1. Selected Covered Services: Does the RFP require coverage of the service?

Service	AR	CA	CO	ME	MD	OH	NY	WI
Care coordination/case management	X			X			X	
Crisis care		X					X	
Electro-convulsive therapy							X	
Family therapy	X					X	X	
Individual therapy	X	X	X			X	X	X
Group therapy	X		X			X		
Hospital detoxification		X	X		X		X	X
Inpatient services	X	X	X	X	X	X	X	X
Inpatient services for children								
Long-term residential								
Medication management	X		X		X	X	X	
Non-hospital residential detoxification			X		X		X	
Outpatient treatment	X	X	X	X	X	X	X	X
Partial day treatment programs	X		X		X		X	
Prescription drugs	X ¹¹	X	X				X ¹²	
Short-term residential	X							
Transportation (ambulance)			X				X	

Although there is substantial similarity in the way that states describe covered benefits in their contracts and RFPs, some states describe required behavioral health benefits in a manner that is different from other states. For instance, Wisconsin provides for “transition services” which it defines as care “provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services as required by Wis. Stat. § 632.89.” (Wisconsin Comprehensive RFP, Section 4.D. Uniform Benefits, page D-18.) Although this seems to be a definition unique to Wisconsin, the services provided may not be so different from some of the short-term intensive counseling services required in other states.

However, one benefit that Wisconsin required that was not found in the other contracts we examined was outpatient mental health coverage for a full-time student attending school in Wisconsin but out of the plan’s service area. The RFP describes this coverage as follows:

5. Out-of-Plan Coverage for Full-Time Students
 If a Dependent is a full-time student attending school outside the HMO Service Area, the following services will be covered:
 ...
 b. Outpatient mental health services and treatment of alcohol or drug abuse if the Dependent is a full-time student attending school in Wisconsin, but outside of the Plan Service Area. In that case, the Dependent may have a clinical assessment by a Non-Plan Provider the

¹¹ Excluded under this carve-out plan but required to be covered in same way as drugs for physical illnesses under medical plan.

¹² Excluded under this carve-out plan but required to be covered in same way as drugs for physical illnesses under medical plan.

Plan designates. If outpatient services are recommended, coverage will be provided for five (5) visits outside of the Plan's Service Area. Additional visits may be approved by the Plan. If the student is unable to maintain full-time student status, he/she must return to the Plan's Service Area for the treatment to be covered. This benefit is subject to the dollar limitation shown in the Schedule of Benefits for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the Participant. **Wisconsin Comprehensive RFP**, Section 4.I., page D-20.

HMO Contractors who are successful bidders in Wisconsin will have to expand their networks beyond their service areas in order to accommodate the needs of Wisconsin's students.

Cost Sharing for Covered Services

All of the states in this study require public employees to contribute to the cost of their coverage through copayments. Arkansas, Colorado, and New York further require participants to satisfy a deductible. In Arkansas, a separate deductible applies to inpatient care only, while in Colorado, services for mental health fall within the annual deductible for comprehensive services. New York's annual deductible only applies to non-network services.

Table 2. Copayments and Deductibles for Inpatient and Outpatient Behavioral Health Services

State	Deductible	Co-payment	Out-of-Pocket Limit
Arkansas	<u>Inpatient: \$250 per admission</u> (applies to all enrollees regardless of plan chosen but no out-of-network coverage)	<u>Inpatient:</u> 10% coinsurance per admission <u>Outpatient:</u> \$25/office visit Intensive outpatient: no copay <u>Residential treatment:</u> 10% coinsurance	Individual: \$1,000 Family: \$1,500
California		<u>HMO:</u> <u>Mental health-inpatient:</u> none (but limited to 30 days/calendar year for illnesses that do not meet the criteria for severe mental illness or serious emotional disturbances of a child) <u>Mental health-outpatient:</u> \$20/visit (but limited to 20 visits/calendar year for illnesses that do not meet the criteria for severe mental illness or serious emotional disturbances of a child). <u>Mental health-outpatient:</u> \$5/visit, but unlimited days of coverage for severe mental illnesses, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of a	

State	Deductible	Co-payment	Out-of-Pocket Limit
		<p>child.</p> <p><u>Substance abuse-inpatient:</u> none</p> <p><u>Substance abuse-outpatient:</u> \$5/visit (but limited to 20 visits/calendar year)</p> <p><u>PPO:</u></p> <p><u>Mental health-inpatient:</u> 10% (if non-network: 40%)</p> <p><u>Mental health-outpatient:</u> 10% (if non-network: 40%)</p>	
Colorado	<p><u>RFP:</u> Annual deductible for all services under comprehensive plan: \$1,000</p>	<p><u>RFP:</u> <u>Biologically based mental illness:</u> same as any other physical illness (i.e., 10% copay for inpatient & outpatient in network; 30% for inpatient and outpatient out-of- network)</p> <p><u>Other mental illnesses- inpatient:</u> 10% copay in network; 30% for out-of-network (but maximum of 45 inpatient or 90 partial days/calendar year combined for in/out of network)</p> <p><u>Other mental illnesses-outpatient:</u> 10% copay in network; 30% out-of-network (but maximum of 30/visits/calendar year for in/out network combined with substance abuse outpatient visits)</p> <p><u>Substance abuse-inpatient:</u> 10% copay for in network; 30% for out-of-network</p> <p><u>Substance abuse-outpatient:</u> 10% copay for in network; 30% for out-of-network (but maximum of 30/visits/calendar year for in/out network combined with other mental illnesses outpatient visits)</p> <p><u>HMO</u></p> <p><u>Mental Health-inpatient:</u> \$50/day up to 45 days/year (1 day for each 2 sessions of day/night care)</p> <p><u>Mental Health-outpatient: individual visit:</u> \$15/visit (1-20 visits); \$30/visit (21+ visits); <u>group visit:</u> \$15/visit</p> <p><u>Substance abuse-inpatient:</u> \$50/day for maximum of 30 days in any 12-month period</p> <p><u>Substance abuse-outpatient:</u> counseling visits only in specialized facility: \$15/visit (1-20 visits); \$30/visit (21+ visits)</p>	<p><u>RFP:</u> \$5,000 (individual/family) excluding deductible</p>
Maine		<p><u>Mental health (parity illnesses) inpatient:</u> none if authorized provider/service; 25% if non-authorized</p>	

State	Deductible	Co-payment	Out-of-Pocket Limit
		<p><u>Mental health (non-parity illnesses) inpatient:</u> none, but limited to 31 days/calendar year (combined authorized & non-authorized); 20 if non-authorized provider/service</p> <p><u>Mental health (parity illnesses) – outpatient:</u> \$5 copay if authorized provider/service; 25% if non-authorized</p> <p><u>Mental health (non-parity illnesses) – outpatient:</u> \$5 copay if authorized provider/service; 50% if non-authorized</p> <p><u>Substance abuse–inpatient:</u> none for authorized provider/service (but limited to 31 days/calendar year); 10% for non-authorized</p> <p><u>Substance abuse–outpatient:</u> none if authorized provider/service; 10% if non-authorized, but overall combined limit of \$1,500/person/calendar year</p>	
Maryland		<p><u>PPO & POS</u> <u>Mental Health/Substance Abuse-in network inpatient:</u> if preauthorized, plan pays 100% of vendor’s negotiated rates; if admission not preauthorized, no coverage</p> <p><u>Mental Health/Substance Abuse-out-of-network inpatient:</u> if care preauthorized, plan pays 80% of vendor’s negotiated rates; if admission not preauthorized, no coverage</p> <p><u>HMO: inpatient:</u> no copayment if in network; no coverage if out-of-network</p> <p><u>PPO & POS:</u> <u>Mental Health/Substance Abuse-in network outpatient:</u> if preauthorized, plan pays 80% of vendor’s negotiated rate for first 5 visits, 65% for next 25 visits, 50% for any further visits; if not preauthorized, plan pays 40% of vendor’s negotiated rate for first 5 visits, 32.5% for next 25 visits, 25% for further visits</p> <p><u>Mental Health/Substance Abuse-out-of-network outpatient:</u> if preauthorized, 40% of vendor’s negotiated rate for first 5 visits; 32.5% for next 25 visits, 25% for further visits; if not preauthorized, 20% of vendor’s negotiated rate for first 5 visits, 16.25% for next 25 visits, 12.5% for further visits</p> <p><u>HMO:</u> outpatient: plan pays 80% for preauthorized visits up to 5 per calendar year; 65% for visits 6-30 visits per calendar year; 50% for 31 or more visits per</p>	

State	Deductible	Co-payment	Out-of-Pocket Limit
		calendar year; no coverage for out-of-network visits	
New York	Annual deductible for non-network services only.	<u>Substance Abuse-outpatient:</u> copays of \$5/\$8/\$10/visit depending on covered employee group <u>Mental health-outpatient:</u> \$15/visit (but no copays for certain services such as crisis intervention visits (up to 3/crisis))	
Ohio		<u>Inpatient:</u> \$100/hospital admission <u>Outpatient:</u> \$10/visit	
Wisconsin		<u>Mental health/Alcohol/Drug Abuse Services: outpatient:</u> \$1,800/participant/contract year <u>Mental health/Alcohol/Drug Abuse Services: transitional services:</u> \$2,700/participant/contract year <u>Mental health/Alcohol/Drug Abuse Services: inpatient:</u> lesser of 31 days or \$6300 <u>Overall limit on all Mental health/Alcohol/Drug Abuse Services:</u> \$7,000/participant/contract year (Note: RFP states that the annual dollar limits for mental health benefits are suspended due to the Federal Mental Health Parity Act but that any benefits paid for MH will be applied to the annual maximum for alcohol and drug abuse treatment to determine whether any benefits are available for those services)	

California, Colorado and Maine differentiate in their copayments between services for the types of mental illnesses covered by their parity legislation and other mental illnesses. The non-parity mental illnesses and substance abuse services are generally subject to both a dollar and visit limit for outpatient services and a day limit for inpatient services. For instance, in California, outpatient treatment of severe mental illnesses or serious emotional disturbances of a child (diagnoses that are covered by California’s parity legislation as discussed below) are not subject to the 20-visits/calendar year limitation that non-parity mental illnesses are. In addition, the copayment per visit is only \$5, compared to \$20 for non-parity mental illnesses (California HMO Contract, Standard Benefit Package, HMO Model-Basic Plan, page 8).

Additional Limits on Covered Services

Many of the state employee benefit programs impose limits on covered services. For instance, all require services to be preauthorized, although some of the states surveyed impose a greater cost-sharing requirement or other financial penalties for failure to receive preauthorization, rather than denying coverage of non-preauthorized services. In Maine, for example, if the participant fails to secure prior authorization for mental health or substance abuse services, providers may “balance bill” the participant (*i.e.*, require the participant to pay the provider for any

shortfall between the cost of the service and the amount the provider is reimbursed by the health plan). In addition, the care may be subject to retrospective review and may be disallowed completely as a covered service.¹³ In Maryland, failure to obtain preauthorization will result in a 50% reduction in coverage under the PPO and POS plans or no coverage at all under the HMO option (Maryland HMO RFP, 2001 Summary of Maryland State Employees Health Benefits, pages 41-42).

The following table illustrates some of the additional limitations on covered services contained in the examined contracts:

Table 3. Other Limitations on Services for Behavioral Health Benefits

State	Annual limit on days/visits	Other limits
Arkansas	None	
California	<p><u>HMO:</u></p> <p><u>Mental health-inpatient:</u> 30 days/calendar year for illnesses that do not meet criteria for severe mental illness or severe emotional disturbances for a child)</p> <p><u>Mental health-inpatient:</u> unlimited days of coverage for severe mental illnesses, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of a child.</p> <p><u>Mental health-outpatient:</u> 20 visits/calendar year for illnesses that do not meet criteria for severe mental illness or severe emotional disturbances for a child</p> <p><u>Mental health-outpatient:</u> unlimited visits for severe mental illnesses, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of a child.</p> <p><u>Substance abuse-outpatient:</u> 20 visits/calendar year</p> <p><u>Basic PPO:</u> <u>Mental Health-outpatient:</u> 20 visits/plan year</p>	<p><u>PPO:</u> Authorization required after 7th visit</p>
Colorado	<p><u>Biologically based mental illness:</u> same as any other physical illness</p> <p><u>Other mental illnesses- inpatient:</u> 45 inpatient or 90 partial days/calendar year combined for in/out of network</p>	

¹³ Maine Comprehensive Services RFP, page 12: (“A participant seeking mental health/substance abuse treatment is required to contact MCC Behavioral Care to discuss the participant’s needs with a case manager. The case manager will approve and authorize care with an appropriate provider within the MCC preferred provider network whenever possible. If the participant does not comply with the utilization management provisions administered by MCC, benefits will be reduced as described in Appendix A.”) Maine Comprehensive Services RFP, Appendix A, unnumbered page describing Mental Health and Substance Abuse benefits: (“This coverage level applies when the member does not contact MCC for preauthorization of mental health and substance abuse services. Please note: The member may have to pay balance bills in addition to deductible and coinsurance amounts. Care may be subject to retrospective review.”).

State	Annual limit on days/visits	Other limits
	<p><u>Other mental illnesses-outpatient:</u> 30/visits/calendar year for in/out network combined with substance abuse outpatient visits</p> <p><u>Substance abuse-outpatient:</u> 30/visits/calendar year for in/out network combined with other mental illnesses outpatient visits</p>	
Maine	<p><u>Mental health (non-parity illnesses) inpatient:</u> 31 days/member/calendar year (two days of day treatment equal one day inpatient)</p> <p><u>Mental health (non-parity illnesses) – outpatient:</u> 40 visits/member/calendar year</p> <p><u>Substance abuse – inpatient:</u> 31 days/calendar year (two days of day treatment equal one day inpatient)</p> <p><u>Substance abuse – outpatient:</u> \$1,500/person/calendar year</p>	<p>Prior authorization necessary for in-network services (copay differential for in/out of network providers/services). If enrollee fails to get prior authorization for MHSA benefits, balance billing is permitted and care subject to retrospective review.</p>
Maryland	<p>HMO No benefits if use non-HMO provider</p>	<p>PPO & POS Prior authorization required; if care not preauthorized, plan payment reduced by 50% <u>Inpatient:</u> Out-of-network expenses during any one inpatient stay limited to \$1,500 of vendor’s negotiated rate; maximum of 60 days per benefit period for partial hospitalization</p>
New York	<p><u>Mental Health/Substance Abuse: outpatient:</u> certain enrollees (depending on employer) in MHSA core only program are limited to 20/visits/year for MH and 60/visits/year for SA services</p> <p><u>Mental Health-inpatient:</u> one network practitioner visit/day of inpatient care; certain enrollees (depending on employer) in MHSA core only program are limited to 30 days/year for mental health inpatient treatment</p> <p><u>Substance abuse-inpatient:</u> limited to 3 stays/lifetime (but more can be approved on case-by-case basis if demonstrated that significant improvement would occur); certain enrollees (depending on employer) in MHSA core only program are limited to 30 days/year for substance abuse inpatient treatment</p>	<p>Lifetime maximum for non-network substance abuse benefits is \$100,000 or \$250,000 depending on employer. No lifetime maximum for non-network mental health services.</p> <p>Annual maximum benefit for non-network services is \$50,000/enrollee or dependent for substance abuse services. For certain employers, annual maximum for non-network mental health services is \$1,000,000. For most NYS public employees there is no annual maximum for non-network mental health services.</p>

State	Annual limit on days/visits	Other limits
		Network benefits must be accessed by calling Clinical Referral line (although no penalty if enrollees self-refer to network provider). Additional limits on non-network benefits.
Ohio	None	Services must be preauthorized by calling MHSA vendor.
Wisconsin	<u>Mental health/Alcohol/Drug Abuse Services: inpatient:</u> lesser of 31 days or \$6300 (Note: the RFP says that the annual dollar limits for mental health benefits are suspended due to the Federal Mental Health Parity Act but that any benefits paid for MH will be applied to the annual maximum for alcohol and drug abuse treatment to determine whether any benefits are available for those services)	

Limitations may also be imposed on mental health services by narrowly defining the covered benefit. For example, California Public Employee Retirement System’s PPO offering (PERSCare) provides only limited behavioral health benefits generally focused only on stabilizing an acute condition. In its summary of benefits, PERSCare describes its inpatient mental health benefit as “Hospital/physician services to stabilize an acute psychiatric condition, up to 30 days per calendar year” (California PPO Contract (PERSCare), page 3). Outpatient services are similarly limited to “medically necessary treatment to stabilize an acute psychiatric condition, up to 30 precertified visits per calendar year” (California PPO Contract (PERSCare), page 3).

In contrast, Maine describes the mental health benefits that are required for public employees in broad terms in its RFP: “Mental Health: Varying benefits by diagnosis – State mandates for mental illnesses apply.” (Maine Comprehensive Benefits RFP, Section 3. Benefits Summary, page 8.)

Although prescription drugs necessary to treat behavioral illnesses are covered in all states, only half of state employee benefit plan contracts examined specifically require drugs as part of behavioral health benefits. In two of the states (Arkansas and New York) that provide behavioral health benefits through a carve-out program, drugs to treat mental health and substance abuse conditions are generally available through the medical plan, not through the vendor providing mental health services.

Arkansas specifically requires the vendors to work together as follows:

- 4.1 Services
- ...
- J. Prescription Drugs

Prescription drugs are excluded from the Mental Health/Substance Abuse program, but remain a benefit for enrolled members. The contractor's providers shall prescribe medications as appropriate, based on the clinical needs of the patient. The contractor shall work with the Pharmacy Benefit Manager to utilize formularies, contracted pharmacies and prior authorization protocols and to partner in the management of mental health drug costs. (Arkansas Mental Health RFP, No. RFP-01-0669, page 5.)

New York only covers prescription drugs while a participant is an inpatient because the state has a separate prescription drug program for its public employees:¹⁴

Exclusions and Limitations:

Covered services do not include and no benefits will be provided for the following:

...

9. Prescription drugs, except when medically necessary and when dispensed by an approved facility, residential or day treatment program to a covered individual who, at the time of dispensing, is receiving inpatient services for mental health and/or substance abuse care at that approved facility. Take-home drugs are not covered. ... (New York Mental Health RFP, Exhibit 1.A – Certificate of Insurance, MHSA Core Only, page 85.)

Distinguishing between physical and mental illnesses

Only a few reviewed contracts actually defined the terms “mental health” or “substance abuse” in their RFPs. If complete parity were required, defining these terms would be unnecessary, since presumably if all physical and mental illnesses are required would be treated the same. However, if parity is more limited in scope (such as under the MHPA and state parity laws) or not required, disputes may arise regarding whether a particular illness is a mental or physical one and therefore is subject to limitations under the plan. Contracts defining these terms specifically linked their definitions to objective diagnoses. For example, Arkansas covers “O. Any Mental Health/Substance Abuse Service for the treatment of disorders, disabilities or additions as designated in diagnostic categories of the Diagnostic and Statistical Manual IV of the American Psychiatric Association ...” (Arkansas Mental Health RFP, Section 4.3, Exclusions and Limitations, page 7). In addition, the RFP further states that “... Substance Abuse Services are services and supplies for the diagnoses and treatment of alcoholism and chemical dependency disorders that are listed in the Diagnostic and Statistical Manual IV of the American Psychiatric Association.” (Arkansas Mental Health RFP, Section 4.3, Exclusions and Limitations, page 7.)

New York defines “mental health care” as:

... medically necessary care rendered by an eligible practitioner of approved facility and which, in the opinion of the insurer, is directed predominately at treatable

¹⁴ See, New York Mental Health RFP, Section III.C.1(a)(2)(f) Network Benefits, at page 29 (“f. Prescription drugs, if billed by an approved facility. (Prescription drugs dispensed by a licensed pharmacy are not covered under this Program but under a separate prescription drug program).”)

behavioral manifestations of a condition that the insurer determines: (a) is an clinically significant behavioral or psychological syndrome, pattern, illness or disorder; (b) substantially or materially impairs a person's ability to function in one or more major life activities; and (c) has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders. (New York Mental Health RFP, Section III.B. Definition of Terms, page 23.)

Exclusions

Although all state contracts reviewed exclude treatment for behavioral health that is not medically necessary or experimental or investigational, a few of the contracts also exclude conditions requiring long term care in custodial settings (Ohio) and other specific services, such as herbal medicine (Ohio), hypnotherapy (Wisconsin), marriage counseling (Wisconsin), and biofeedback (Wisconsin).

Alternative medical therapies, such as message therapy and yoga, were also generally excluded (e.g., Maine). Some states excluded psychiatric therapy or other types of treatment for mental illness required as a condition of parole or probation (California, Colorado).

Medical Necessity

All of the state employee benefit plans limited covered services to those that were medically necessary. Some of the contracts contained special definitions of medical necessity for behavioral health services. For instance, New York's RFP includes the following language in its sample certificate of insurance:

13. Medically Necessary means a service which [the vendor] has certified to be: (a) medically required; (b) having a strong likelihood of improving your condition; and (c) provided at the lowest appropriate level of care, for your specific diagnosed condition, in accordance with both generally accepted psychiatric and mental health practices and the professional and technical standards adopted by [the vendor].

Although a practitioner may recommend that a covered person receive a service or be confined to an approved facility, that recommendation does not mean:

- (a) that such service or confinement will be deemed to be medically necessary; or
 - (b) that benefits will be paid under this Program for such service or confinement.
- (New York Mental Health RFP, Exhibit IA, MHSA Core Only, page 76.)

Because Maine provides its behavioral health services to state employees through a comprehensive service agreement, its RFP did not contain a separate definition of medical necessity for those services. However, it did provide one of the few explanations of the process used for determining medical necessity:

Determinations for Medically Necessary services are based upon regional and national standards of care and clinical criteria established by Participating Providers of Healthsource Maine. Primary Care Physicians and other health care professional shall provide Healthsource Maine with information to determine coverage of health care services. The Medical Director will, as necessary, consult with participating specialists to review a Member's care to determine if the requested services are

Medically Necessary and appropriate. A decision will be made within 2 business days of receiving all necessary information and a letter will be mailed to the Member approving or denying coverage. The Medical Director will review all services which are denied on the basis of medical necessity. (Maine Comprehensive Services RFP, Point of Service Group Subscriber Agreement, Section 4. Covered Health Services, page 14.)

IV. A Peek at the Parity States: What is Parity?

According to the General Accounting Office, as of March 2000, 43 states and the District of Columbia had adopted laws addressing mental health coverage in group health plans and most of them require some form of parity.¹⁵ The scope of mental health parity laws varies considerably. A number of states track the requirements of the Federal Mental Health Parity Act by requiring parity between mental and physical illnesses only with respect to annual or lifetime dollar limits.¹⁶ About half of the states have laws more comprehensive in scope than the MHPA, because they require parity in either service limits or cost-sharing, or both, as well as in dollar limits.¹⁷ However, other states have required “full parity” (i.e., equal treatment of physical and mental illnesses), but only with respect to certain types of mental illnesses.¹⁸

For example, in Maine, parity between benefits for mental illnesses and physical illnesses is limited only to what its RFP calls “organically-based mental illnesses.” Under Maine law,¹⁹ all group policies, contracts and certificates of insurance executed, delivered, issued for delivery, continued or

¹⁵ General Accounting Office, “Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited,” GAO/HEHS-00-95 (May 2000), page 8. The GAO relied on information supplied by the National Conference of State Legislatures (Tracy Delaney, *Overview of State Laws Affecting Coverage of Mental Illness and Substance Abuse Treatment* (Washington, DC: NCSL, Health Policy Tracking Service, Mar. 1, 2000)) [hereinafter referred to as “GAO Report”].

¹⁶ According to the GAO, these states are Alaska, Arizona, Florida, New Mexico (effective 2000), South Carolina, and West Virginia. GAO Report, page 8. However, this list is somewhat misleading. The GAO categorizes states as having laws more comprehensive than the MHPA if they mandate mental health coverage, even if the parity requirements in those states only cover dollar limits (e.g., Kansas, Montana, Nevada). Certain other states require full parity for certain mental illness, and parity in only dollar limits for other types of mental illnesses (e.g., Delaware, Maine).

¹⁷ Arkansas (full parity), Colorado (full parity), Connecticut (full parity), Delaware (full parity for serious mental illnesses), Georgia (also requires parity in cost-sharing), Hawaii (full parity for serious mental illnesses, but only requires “comparability” in dollar limits and cost-sharing for mental illnesses), Indiana (full parity), Kentucky (full parity), Louisiana (full parity), Maine (full parity for serious mental illnesses), Maryland (also requires parity in inpatient hospitalization and cost-sharing), Minnesota (full parity), Missouri (full parity for recognized mental illness), Nebraska (full parity for serious mental illnesses), New Hampshire (full parity for biologically-based mental illnesses), New Jersey (full parity for biologically-based mental illnesses), North Carolina (full parity for state employee benefit plans only), Oklahoma (full parity for severe mental illnesses), Pennsylvania (cost-sharing must not prohibit access to care), Rhode Island (full parity for serious mental illnesses), South Dakota (full parity for biologically-based mental illnesses), Tennessee (also requires parity in cost-sharing), Texas (full parity for biologically-based illnesses for state employees only; also parity in cost-sharing for cost-sharing), Vermont (full parity) and Virginia (full parity to achieve same outcomes for biologically-based mental illnesses). The GAO lists California as having parity laws more limited than the federal law but notes that a law that exceeds the federal law becomes effective October 2000. Under that law, full parity for severe mental illnesses is required.

¹⁸ Among the states whose employee benefit contracts we reviewed that took this approach were Arkansas, California, Colorado, and Maine.

¹⁹ Maine Rev. Stat. § 2325-A.5-C.B(1).

renewed in the state on or after July 1, 1996 must provide benefits for the treatment and diagnosis of certain mental illnesses that are no less extensive than the benefits provided for medical treatment of physical illnesses. Insurance policies issued to small employers (those with 20 or fewer employees) are excluded from the requirements. The mental illnesses subject to parity are: (1) schizophrenia, (2) bipolar disorder, (3) pervasive developmental disorder, or autism, (4) paranoia, (5) panic disorder, (6) obsessive-compulsive disorder; and (7) major depressive disorder.

Thus, the Maine Comprehensive Services RFP defines two different types of mental health benefits for its contractors: 1) benefits for organically-based mental illnesses (with the same diagnoses listed above); and 2) mental health services. According to the RFP, coverage for organically-based mental illnesses “will be provided at the same benefit level as for medical services when diagnosed by a licensed physician or a licensed psychologist who has received a doctorate in psychology specializing in the evaluation and treatment of human behavior.” (Maine Comprehensive Services RFP, Point of Service, Group Subscriber Agreement, Section 4.I (2). Covered Health Services, page 20.) Coverage for Mental Health Services is described as: “...services necessary for the diagnosis and short-term therapeutic treatment of other mental illnesses or disorders which, in the judgment of the Participating Provider, are subject to significant improvement through short-term therapy.” (Maine Comprehensive Services RFP, Point of Service, Group Subscriber Agreement, Section 4.I (3). Covered Health Services, page 20.) In both cases, prior authorization is necessary to receive in-network services. Out-of-network services for these benefits are not covered.

Colorado takes a similar approach. Under Colorado law,²⁰ parity is confined to “biologically-based mental illness.” Group health insurance policies, plan certificates and contracts are generally required to “provide coverage for the treatment of biologically-based mental illness that is no less extensive than the coverage provided for any other physical illness.” “Biologically based mental illness” is defined as (1) schizophrenia, (2) schizoaffective disorder, (3) bipolar affective disorder, (4) major depressive disorder, (5) specific obsessive-compulsive disorder and (6) panic disorder.”²¹

Accordingly, in describing required benefits for PPOs covering state employees, Colorado’s RFP’s plan design chart states simply that for biologically-based mental illnesses, covered services for both in and out of network treatments must be the “same as for any other physical illness,” while treatment for mental health inpatient is subject to a 10% copayment (30% if out-of-network). This applies after a deductible with a maximum of 45 inpatient days (90 partial days) per calendar year, combined for both in- and out-of-network. Similarly, mental health outpatient treatment is subject to a 10% copayment (30% if out of network) after deductible, with a maximum of 30 visits per calendar year (combined with substance abuse outpatient treatments). (Colorado HMO RFP, Section VI(A), page 56.)

California also uses the approach of defining certain illnesses as those requiring parity. Under the California Health and Safety Code,²² every health care service plan contract issued, amended or renewed on or after July 1, 2000 providing for hospital, medical or surgical coverage must provide coverage for the diagnosis and treatment of severe mental illnesses for all participants

²⁰ Colorado Statutes §10-16-104 (5.5)(a)(I).

²¹ Colorado Statutes §10-16-104 (5.5)(a)(II).

²² California Health and Safety Code, Section 1374.72(a).

and coverage of serious emotional disturbances of a child under the same terms and conditions as are applied to other medical conditions. The statute describes what it means by parity and how these critical terms are defined:

1374.72. ...

(b) These benefits shall include the following:

- (1) Outpatient services.
- (2) Inpatient hospital services.
- (3) Partial hospital services.
- (4) Prescription drugs, if the plan contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:

- (1) Maximum lifetime benefits.
- (2) Copayments.
- (3) Individual and family deductibles.
- (d) For the purposes of this section, "severe mental illnesses"

shall include:

- (1) Schizophrenia.
- (2) Schizoaffective disorder.
- (3) Bipolar disorder (manic-depressive illness).
- (4) Major depressive disorders.
- (5) Panic disorder.
- (6) Obsessive-compulsive disorder.
- (7) Pervasive developmental disorder or autism.
- (8) Anorexia nervosa.
- (9) Bulimia nervosa.

(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

...

(3) Notwithstanding any other provision of law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

Although this parity requirement is newly enacted in California, the current standard HMO contract reflects its principles. In the description of permitted limitations for inpatient mental health benefits, the following language appears:

At a minimum plans must not limit days of coverage for severe mental illnesses including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious

emotional disturbances of a child. (California HMO Contract, Standard Benefit Package, HMO Model – Basic Plan, page 7.)

V. Non-Parity States: Reflecting the Federal Mental Health Parity Act

In a few instances, the effect of the Federal Mental Health Parity Act on required benefits was acknowledged by state employee benefit plans. In describing the maximum benefits payable for Mental Health/Alcohol/Drug Abuse Services, Wisconsin's RFP first lists the dollar maximums for outpatient services (\$1800 per participant per contract year), transitional services (\$2,700 per participant per contract year) and inpatient services (30 days or \$6,300, whichever is less, per participant per contract year). Then the RFP notes: "Annual dollar maximums for mental health services are suspended due to the Federal Mental Health Parity Act. Annual dollar maximums remain in force for treatment of alcohol and drug abuse." (Wisconsin Comprehensive RFP, Section 4.D. Uniform Benefits, page D-37.) However, a version of the Uniform Benefits schedule, effective for 2001, adds a maximum benefit for inpatient, outpatient and transitional services of \$7,000 per participant per contract year and revises the notation above to add the following sentence: "Any benefits paid during the year for mental health services will be applied toward the annual benefit maximum for alcohol and drug abuse treatment when determining whether benefits for alcohol and drug abuse treatment remain available." (Wisconsin Comprehensive RFP, D. Uniform Benefits Schedule for Contract Year 2001, page 38.) Thus, even though mental health benefits may not be capped annually if benefits for physical illnesses are not, Wisconsin has applied any expenses attributable to mental health services on a dollar-for-dollar basis to eliminate coverage for alcohol and drug abuse. This is an interesting manifestation of the spillover effect of the Federal parity law, although in a direction that its advocates might not have anticipated.

The Mental Health RFP for New York's public employees also references the Federal Mental Health Parity Act, by noting that as of January 1, 1998, there is no annual maximum dollar benefit for non-network mental health benefits for state employees, although enrollees and dependents of participating agencies have a \$1,000,000 lifetime maximum benefit for mental health benefits, the same as their maximum benefit for benefits resulting from physical illnesses (New York Mental Health RFP, Section III.C., page 31).

VI. Conclusion

In reviewing the documents used by state employee benefit plans to purchase mental health services, it is often difficult to tell which states have adopted mental health parity legislation and which have not. Except in the states that have delineated certain mental illnesses to qualify for equal treatment with physical illnesses, so that differences in typical dollar and visit limitations on services are readily apparent, there is continued and widespread use of limitations on access to services. The narrow Federal approach to parity that simply prohibits dollar limits, but permits employers to continue imposing other limitations on mental health services, seems to have been replicated in many states.

In examining the effect of the MHPA on employee's access to mental health services, the GAO found that simply requiring parity in dollar limits may have little effect on employee's access to mental health services, since other plan design features that are more restrictive for mental health coverage have been retained.²³ In some cases, the GAO found that employers have compensated for their inability to impose different or lower dollar limits on mental health services by making other plan features more restrictive.²⁴ As long as these other restrictions on access to mental health benefits are permitted, significantly narrowing the gap between covered services for mental and physical illness seems unlikely.

Yet some progress has been made to achieve parity in treatment between mental and physical illnesses. As previously noted, recently some states have gone farther than the MHPA to require full parity for some, if not all, mental illnesses. This is an important step forward.

Most of the state employee benefit plan contracts we examined were multi-year contracts. Therefore they may not fully reflect the rapid acceleration of state activity in this area that has occurred in the past few years. In addition, the Federal Mental Health Parity Act is scheduled to expire in September, 2001. Congressional debate around its extension is likely to focus attention on whether simply prohibiting more restrictive annual and lifetime dollar limits for mental health care is sufficient to achieve parity. Advocates will likely urge Congress to move beyond a simple extension of the current requirements for parity in dollar limits to impose additional parity requirements applicable to cost-sharing and services. The experiences of states that have embraced full parity will be extremely relevant in the upcoming Congressional debate. If Congress expands the scope of the Federal Mental Health Parity Act, those states with more limited parity laws are likely to follow. Obviously, this is an area that bears watching closely as we continue to focus on the evolution of the availability of behavioral health services, not just for public employees, but for all citizens in need of such services.

²³ General Accounting Office, "Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited," GAO/HEHS-00-95 (May 2000), page 10.

²⁴ General Accounting Office, "Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited," GAO/HEHS-00-95 (May 2000), pages 13-14.

Appendix A

STATE EMPLOYEE BENEFIT PLAN CONTRACTS STUDY

LIST OF DOCUMENTS REVIEWED

Arkansas:

Arkansas Mental Health Insurance Request for Proposal, Bid No. RFP-01-0669 (February 5, 2001), for Contract Year beginning 10/1/01 through 9/30/02 for Arkansas Public School Employees and for Contract Year beginning 1/1/02 through 12/31/02 for Arkansas State Employees (with option to renew for two additional years) **[hereinafter referred to as Arkansas Mental Health RFP]**

Arkansas Health Insurance Request for Proposal, Bid No. RFP-01-0670 (February 5, 2001), for Contract Year beginning 10/1/01 through 9/30/02 for Arkansas Public School Employees and for Contract Year beginning 1/1/02 through 12/31/02 for Arkansas State Employees (with option to renew for two additional years) **[hereinafter referred to as Arkansas Health Insurance RFP]**

The Guide to Choice: Health and Life Insurance for Arkansas State Employees, Enrollment Period: October, 2000; Plan Benefit Year: January 1, 2001 through December 31, 2001 **[hereinafter referred to as Arkansas Handbook]**

California

Agreement for Group Coverage under the Public Employees' Medical and Hospital Care Act, for Contract Year beginning 1/1/00 through 12/31/00 **[hereinafter referred to as California Comprehensive Contract]**

Sample HMO Contract **[hereinafter referred to as California HMO Contract]**

Evidence of Coverage, PERS Choice (PPO) **[hereinafter referred to as California PPO Contract (PERS Choice)]**

Evidence of Coverage, PERS Care (PPO) **[hereinafter referred to as California PPO Contract (PERS Care)]**

Health Plan Decision Guide for 2001: California Public Employees' Retirement System **[hereinafter referred to as California Handbook 2001]**

New Health Plans Application, HMO Model and Association Plans **[hereinafter referred to as California New Health Plans Application]**

Colorado

Medical Plan Administration and Managed Care Networks Request for Proposal, State of Colorado, RFP-TK-01699 (May 6, 1999), for Contract Year beginning on 1/1/00 through 12/31/00 (with option to renew for four additional years) **[hereinafter referred to as Colorado HMO RFP]**

HMO Health Plans, San Luis Valley HMO Contract, 12/99 **[hereinafter referred to as Colorado HMO Contract (San Luis)]**

Aetna US Healthcare, Inc. Schedule of Benefits, effective 1/1/00 **[hereinafter referred to as Colorado HMO Contract (Aetna)]**

Evidence of Coverage, Kaiser Permanente Benefits and Services, 2000 **[hereinafter referred to as Colorado HMO Contract (Kaiser)]**

Maine

Maine State Employee Health Insurance Program Request for Proposal (October 25, 1999), for Contract Year beginning 4/1/00 through 3/31/01 **[hereinafter referred to as Maine Comprehensive Services RFP]**

Maryland

State of Maryland, Request for Proposals, Mental Health and Substance Abuse Services, Solicitation No. F10R0200267 (February 22, 2000), for Contract Year beginning 1/1/01-12/31/03 **[hereinafter referred to as Maryland MHSA RFP]**

State of Maryland, Request for HMO Proposals, Solicitation No. F10R9000122 (March 30, 1999), for Contract Year beginning 8/1/99 through 7/30/03 **[hereinafter referred to as Maryland HMO RFP]**

New York

Request for Proposals entitled “New York State Empire Plan Managed Mental Health and Substance Abuse Program” (April 6, 1998), for Contract Year beginning 1/1/99 through 1/1/04 **[hereinafter referred to as New York Mental Health RFP]**

Ohio

State of Ohio Request for HMO Proposals (August 12, 1999), for Contract Year beginning 7/1/00 through 6/31/01 **[hereinafter referred to as Ohio Comprehensive RFP]**

State of Ohio Employee Benefits Handbook, Health Care and Long Term Care, June 1999 (including United Behavioral Health Care benefits) **[hereinafter referred to as Ohio Benefits Handbook]**

Wisconsin

Terms and Conditions for Comprehensive Medical Plan Participation in the State of Wisconsin Group Health Benefit Program and Uniform Benefits for the 2000 Benefit Year (April 1999), for Contract Year beginning 1/1/00 through 12/31/00 [**hereinafter referred to as Wisconsin Comprehensive RFP**]