

MH Parity Testimony
Presented by
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Regarding the Actuarial Costs of
Mental Health & Substance Abuse Parity

I am Ronald E. Bachman, principal in charge of the Atlanta office healthcare practice for PricewaterhouseCoopers, L.L.P. I am an actuary by training and have achieved the designations FSA (Fellow of the Society of Actuaries) and MAAA (Member of the American Academy of Actuaries). I chaired a 1994 AAA Working Group on Mental Health and was on the 1996 AAA MH Task Force. I have provided consulting advice and pricing information on mental health and substance abuse to employers, insurers, HMOs, State & Federal governments, and providers of care. Nationally, I have clients on both sides of this issue. I have more clients who are generally opposed to parity than those who are in favour of it. My work must be non-partisan and factual.

At the national level, I worked with Senators Domenici and Wellstone and the Congressional Budget Office on the Mental Health Parity Act of 1996. More recently, I produced a national study for the current federal bill entitled, "The Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003."

I am not here as a lobbyist or advocate for the Michigan legislation. I am here today to provide factual non-partisan information on mental health and substance abuse costs estimated as the impact of the proposed Michigan parity legislation. The Michigan Psychological Association and the American Psychological Association engaged me to perform a Michigan specific cost analysis in 1998. Neither the APA or the MPA nor any other mental health group or coalition influenced my assumptions, analysis, or conclusions. My analysis is the same as I would provide to my insurer, employer, and HMO clients.

I am here to put facts on the table for your consideration and answer any questions you may have. Some of what I say may be in disagreement with the proponents of the legislation. They know that and have accepted it in order to strengthen my level of credibility with you.

What is the factual analysis of costs? There are several credible sources you can consider - the Congressional Budget Office, the National Institute of Medicine, and (of course) PwC. The CBO analysis based on national costs provides a framework and benchmark for accepting the Michigan specific numbers. In 1996, the CBO estimated the cost increase of a national parity proposal similar to the Michigan bill at 4.0%. By 2001, the CBO estimate was lowered to approximately 2.0% for states like Michigan without current MH parity legislation in place. The CBO national average cost of parity is 0.9%. when considering that over 30 states have passed improved forms of MH coverage over during the 1990's.

PwC produced a Michigan cost analysis in 1998 that estimated the gross costs of MH & SA parity would be 3.3%. The gross cost of MH only parity would be 2.5%. The advocates have chosen not to incur the costs to redo those numbers. I can state that with the continued advances in clinical and medical care, MH & SA costs have moderated from those levels. An analysis done today for Michigan would more closely approximate the lower 2002 CBO estimates of 2.0%.

I have not included in my cost estimate any medical offset, any reduction due to future increases in managed care, and have not recognized any additional efficiencies in future clinic/medical improvements in the delivery of mental health services.

In addition, employers faced with cost increases take various actions to offset those costs. Employee generally pay 25-50% of the premium through payroll deductions, copayments can be changed, plans go to competitive bidding, etc. The CBO estimates the net impact of a cost increase on employers to be 40% of any gross amount. For the Michigan bill this means that the impact on employers is likely to be less than 1.3% for MH & SA Parity and 1.0% of MH only parity.

Based upon generally accepted actuarial analysis, the costs of the Michigan proposed MH & SA parity legislation reflects an insurance premium impact of less than 1.3%.

Now, each state is different and unique. Certainly Michigan has its own political and demographic characteristics that impact the acceptance of parity legislation. Since 1996, about 30 states have passed some expanded form of MH parity. They are all somewhat different and state laws only affect employers with fully insured medical plans.

For full MH parity, there is much to overcome. There is the status quo of limitations, exclusions, and non-coverage. Add to that employer concerns about the potential impact of costs, charges of increased unemployment from added costs, and union issues related to collective bargaining of benefits, and you have a very difficult political and business environment. Advocates of parity struggle to understand the rationale for how employers can treat employees with MH conditions differently from those with heart conditions. Opponents of parity struggle with the issue of cost and the state "big-brother" mandating coverages.

Much has been made of the MH cost issue. Actual experience, economic forecasting, and actuarial projections indicate that the cost debate is over. How many studies are needed to prove the point. Some ask, "What part of modern science and medicine do you not understand?" From a more cynical point of view, there are many members of the Flat Earth Society, citizens who still do not believe that the Russians are capable of space travel, and many that still doubt that smoking causes cancer.

In August 2001, the Congressional Budget Office, the official economic consultants to Congress, estimated the cost of mental health parity "would equal about 0.9% of employer-sponsored health insurance premiums compared to having no mandate at all." This result is consistent with a concurrent PwC actuarial study that showed a national cost impact for MH Parity of 1.0%.

More importantly, actual experience supports the position that mental health parity is affordable. In study after study of actual experience, the results with long historical records are amazingly consistent. Here are some examples:

Large Groups:

North Carolina – 1992 Implementation for State Employees

Result – 38% drop in MH costs

Texas – 1992 Implementation for State Employees

Result – 48% drop in MH costs

Ohio – 1990 Implementation for State Employees

Result – "...a dramatic drop in inpatient days per 1000 members (75%) and a large drop in outpatient visits per 1000 members (40%), despite the increased benefits.

Alaska – 1993 Implementation for State Employees

Result – 64% drop in MH costs at the end of 5 years

Statewide Experience:

Maine – 1996 Implementation

Results – Less than a 1% increase in total cost of health benefits

"The state parity law effective for new policies and those renewing on or after 7/1/96 has not shown a dramatic impact..."

New Hampshire – 1995 Implementation

Results – "Carriers and health plans reported varying experience with changes in premiums ranging from 'remaining flat,' to small and moderate increases, to decreases for managed care products..."

Vermont – 1998 Implementation

Results – "BCBSVT estimated the impact of the law on its 1998 rates as 0%...."

Pennsylvania – 1998 Implementation

Results – “The impact...on health insurance premiums in the Commonwealth...for plan year 1999 (is) approximately 0.43%. of the total monthly health care premium.”

Maryland (1995), Rhode Island (1995), Minnesota (1995)

Results – cost increases of less than 1%

Federal Employees Health Benefit Plan:

FEHBP – Implementation of MH & Substance Abuse (SA) parity 2001

Results – Total average cost increases in 2001 of 1.3%. (1.64% under fee-for-service plans and 0.3% under HMOs)

The FEHBP is the largest national experience in MH and SA parity covering more than 9 million lives.

Given these positive results, what are employers doing on a voluntary basis? The good news is that many large employers have been improving their MH benefits and providing additional support benefits under Employee Assistance Programs (EAPs). This is illustrated in a March 2000 report produced by the influential Washington Business Group on Health (WBGH). The report, subtitled “A Look at Parity in Employer-Sponsored Health Benefit Programs,” looks at a number of major employers including, American Airlines, AT&T, Delta Air Lines, Eastman Kodak, General Motors, IBM, and PepsiCo. The results parallel the State experiences I have just discussed .

These large employers (and I quote from the report):

“...described how through the introduction of appropriate care management they were able to provide generous mental health and substance abuse benefits, contain, and in some cases reduce costs, and at the same time improve their employees’ access to quality mental health and substance abuse care.”

“Perhaps the most important finding of this project is that employers provide generous mental health and substance abuse benefits to their employees and their families because they are convinced that doing so is essential to the corporate bottom line.”

So, you may ask, why are we still debating mental health parity? The minimal cost and the benefits of mental health parity to a corporation are clear.

As an actuary, I believe the debate centers on risk and risk assumption. The large companies have moved to parity or near parity as they learn the facts. They can do so because of the large number of lives they self-insure under their own medical plans. Employees and dependents can be covered at parity for a low cost because all are covered and the risk of any one individual’s claims is shared across the group of pooled lives.

Smaller employers do not have the luxury of insuring a large number of lives under a single contract. They cannot realize the benefits of parity: providing protection and security for their employees and improving productivity while reducing health costs, absenteeism, disability, and worker's compensation. Small employers can only recognize the values of parity if insurers offer parity and pool the risks for all small employers under similar insured plans.

Unfortunately, such pooling by an insurance carrier requires all groups to participate in the pool. If the insurer offers parity only as an optional coverage, only those groups likely to have MH claims in a given year will choose the coverage. This is called anti-selection. If a single insurer offered parity with its contracts and other carriers did not, the insurer providing MH parity would be "selected against" in the marketplace. The only way to properly use the pooling power of insurance is to require that all insurers "step off the curb together."

Such a mandatory requirement is likely to receive a negative reaction from both employers and insurers. In discussion after discussion I have had with insurance industry representatives, they agree that MH parity makes sense. They consider it a "sympathetic" benefit and believe it should be passed. However, they temper their enthusiasm for parity with concern about the many other "mandates" they expect will follow. They have difficulty in differentiating between the MH parity bill and other non-MH coverage mandates.

Let me conclude my remarks by making that differentiation.

Most mandates include new providers and new services not previously covered by insurance. With our third party healthcare reimbursement system, under which someone else pays the tab, many providers want the insurer to pay most of the bill rather than the actual consumer of the service. They try to force insurers to cover their services through new mandates.

But, MH parity is a mandate of a different sort. With Michigan's parity bill, there are no new providers or services recognized under the proposal. The proposal is really "financial parity" that requires equal reimbursement for already recognized medically necessary services provided by certified and already recognized providers. At its core, the bill simply removes artificial caps and limits on legitimate and needed care.

But having said all of that, the status quo is very difficult to change. Political and historical business arguments confound the truths, facts are distorted, and exaggerations are made for political positioning. To the advocates, the numbers are on their side. Cost is not the issue. To the opponents, a debate on mandates, specific language, and unintended consequences are legitimate concerns.

In the end, you the legislators can decide who is protected and who will not be financially protected for a MH diagnosis. For many, the costs treating the MH and SA condition will likely fall to the family's budget or into the public welfare system. Don't let the distortion of cost be the deciding factor. The facts show that MH parity is affordable.