Mental Health and Substance Abuse Benefits in Carve-Out Plans and the Mental Health Parity Act of 1996

Roland Sturm and Joyce McCulloch

Legislation passed in the fall of 1996 required employers and insurers offering mental health benefits to raise dollar coverage limits on mental health services to the level of medical services. We analyze the benefit designs of 4,000 current behavioral health carve-out plans and contrast them to medical benefits. We find that almost 90 percent of all plans are inconsistent with the current legislation and need to be rewritten in the coming year. The restructuring of designs required by the Parity Act provides a unique opportunity because plans often are inconsistent and unnecessarily complex, a legacy of past attempts by employers to contain costs and control adverse selection and moral hazard in an unmanaged fee-for-service environment. Under managed care, the need for deductibles, limits, or other demand-side cost-sharing mechanisms may have diminished and restructuring outdated designs could benefit both enrollees and employers. Key words: *benefit design, health insurance, managed care, Mental Health Parity Act*

The debates leading to the Mental Health Parity Act highlighted the uncertainty surrounding the effects of such legislation. This uncertainty stems from several sources. Nearly three quarters of individuals with private insurance are now enrolled in some form of managed care[1,2] and the changes in the marketplace, especially the growth of carve-out companies, happened very quickly—too quickly for research to keep up.

While there are regular surveys of medical insurance benefits, little is known systematically about the distribution of mental health care benefits or expenses under managed care or carve-out plans. Moreover, many classification schemes guiding surveys, such as the distinction between (unmanaged) fee-for-service and (managed) prepaid care, do not capture important features of mental health service delivery. For example, carve-out companies provide some of the most intensively managed care, but their mental health specialists could be paid on a fee-for-service basis or could be at risk for high utilization. Health maintenance organizations (HMOs) may have capitated contracts for primary care, but specialty care may be provided by specialists outside the HMO on a fee-for-service basis.

This article focuses on benefit design in existing plans and analyzes how these designs are affected by the legislation with an emphasis on carve-out plans. Carve-out arrangements for mental health and substance abuse are relatively new, but have grown dramatically over the last 10 years, and many human resource managers are not familiar with this sector. We therefore first describe a

Roland Sturm, PhD, *is an Economist at RAND in Santa Monica, California*

Joyce McCulloch, MS, *is Director of Data Analysis and Integration at United Behavioral Health in San Francisco, California.*

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carve-out mental health care setting before analyzing typical benefit structures in 1996.

Although the Parity Act is very limited in scope, we find that almost all existing benefit designs that include mental health are incompatible with the Parity Act and will have to be redesigned in 1997. Thus, the Parity Act will affect most human resource and benefit managers in the private insurance sector. This provides a unique opportunity to streamline benefit designs that often were continued from an unmanaged fee-for-service environment and therefore display a complexity of demand-side cost-sharing mechanisms (deductibles, copayments, limits) that may no longer be needed under managed care. However, we also notice that the vast majority of carve-out contracts offer both mental health and substance abuse benefits, often with identical benefits, and there may be a decoupling of benefits, an important issue that may have been overlooked in policy discussions.

Managed Care and Mental Health Carve-Outs

One of the biggest mental health insurance market changes in the 1990s was the growth of mental health carve-out contracts. Under carve-out contracts, a health insurance purchaser (typically an employer) "carves out" certain types of benefits from a general medical plan. Although carve-outs could exist for many conditions or services (and have long been the standard for dental or vision care), mental health and substance abuse have recently experienced a dramatic increase of carve-out arrangements. The argument for carve-outs has been better management of market failures resulting from moral hazard and better management of adverse selection.[3,4]

This article relies on proprietary data on carve-out contracts between private and public employers and one large national company, United Behavioral Health (UBH), formerly known as U.S. Behavioral Health. In 1996, UBH managed mental health and chemical dependency benefits for about 7 million people nationwide. Approximately three million are in network-based care management, with the remaining in nonnetwork care management or in public programs (Medicaid, Medicare). Approximately 420,000 people are covered under a sole-source arrangement in which the employer created one single behavioral health benefit for all members, regardless of the medical carrier chosen by the employee, thus avoiding selection effect across plans offered by the same employer. Although researchers have proposed single plans without choice as an advantage of carve-out arrangements,[3] most employers only carve-out mental health benefits for some employees (i.e., a carve-out arrangement does not necessarily mean one single benefit design).

An important change in insurance arrangements that has received little notice is the growth of managed care offering individuals the choice of managed network and unmanaged or nonnetwork benefits, known as a point-of-service (POS) option. UBH administers over 4,000 network-based benefit plans and the majority of those plans offer POS options. The POS option, often restricted to outpatient care, allows unmanaged out-of-network care, but at a 20–50 percent premium over precertified services with a network provider. Within all plans, employers usually place annual or lifetime limits on cost, a strategy no longer allowed under the Mental Health Parity Act, or limit the number of days or sessions allowed per level of care per year. Deductibles

and copayments also vary by benefit plan and those strategies will continue. Specific diagnostic exclusions are typically eliminated from the designs, although different limits may be placed on mental health versus chemical dependency benefits. Typically, employers grant carve-outs the authority to flexibly substitute benefits in order to extend and individualize each patient's care as needed within the defined limits.

Benefit designs are similar across carve-outs because they primarily reflect employer preferences, but carve-out companies can differ in how they structure networks and case management. UBH relies completely on contracted independent providers and fee-for-service payments and does not capitate or employ any provider, but such arrangements also exist in the market. The UBH network is comprised of nearly 35,000 mental health specialists (18% psychiatrists, 36% doctoral-level clinical psychologists, 30% clinical social workers, 16% other master's level counselors) and over 1,600 facilities. Mental health specialists must be licensed to practice independently by the state in which they practice, be members in good standing in the professional community, and have five years' experience. Approximately 85 percent of clinicians work independently while the remaining are affiliated with group practices or facilities. Payment for services is based on national rates and dependent on the provider's license, but there are no differences by geographic region. Contracted facilities must be licensed and accredited (by the Joint Commission on Accreditation of Healthcare Organizations or other accrediting organizations) and meet established standards regarding medical record keeping and compliance with contractual insurance requirements. Rates are established with each applicable program within the facility and are negotiated to reflect community and industry rates. Providers' credentials, network status, license, and malpractice insurance are reexamined and verified at least every two years.

The Mental Health Parity Act of 1996

Although several attempts to mandate equal coverage for mental health had failed, supporters of mental health mandates were able to add an amendment (Title VII—Parity in the Application of Certain Limits to Mental Health Benefits) to an unlikely bill, the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act. The amendment, known as the Mental Health Parity Act, was signed by President Clinton on September 26, 1996 (P.L. 104-204). Despite all the rhetoric that suggested otherwise, the Mental Health Parity Act has a very limited scope. The Parity Act does not require employers to offer mental health coverage, only that dollar limits on coverage have to be equal to dollar limits on medical benefits *if* mental health coverage is offered. Nor does the Parity Act impose any conditions on deductibles, copayments, limits on days or visits, or require coverage for substance abuse, thus leaving employers and insurers many options to react to the law, including dropping mental health benefits completely. In addition, the law exempts plans if the application of the law would result in a cost increase of at least one percent of total medical costs and it exempts small employers (50 employees). The Parity Act also has a limited duration (1998–2001).

Many states already mandate that insurance policies cover mental health or sub-

stance abuse and such state mandates are generally more demanding (and costly) than the Parity Act. Moreover, more than 30 states are currently (spring 1997) considering their own versions of additional mental health legislation, many with stronger content including provisions about deductibles and copayments. However, state regulations do not apply to self-insured health plans, which are subject to the Employee Retirement Income Security Act of 1974 (ERISA). ERISA preempts states from regulating employer provisions of health plans, but states can regulate third party health insurers. Many large employers are self-insured, and about 40 percent of Americans with health coverage through a private employer are therefore in plans that are not subject to state mandates. The interaction with existing rules increases the impact of the Mental Health Parity Act, which does not preempt stronger state regulations, in the following two ways:

1. In states that mandate mental health benefits, the act raises limits for insurance plans, which cannot drop mental health coverage completely;
2. The Mental Health Parity Act also applies to self-insured plans that are not subject to state mandates.

The Anatomy of Benefit Designs under Managed Care

One of the most striking features of benefit plans across employers is how unstandardized they are. Essentially, every one has its unique features in some dimension. This diversity reflects past attempts to manage moral hazard or adverse selection problems or to contain costs and suggests that employers are groping for a solution without reliable information on the impact of design mechanisms. If reliable information about those impacts had been available, one would have seen more standardized benefits. In this section, we describe which design mechanisms are most commonly used and how they are impacted by the Parity Act.

There are two ways that benefits can be studied. The most common approach is surveys, for example, by Bureau of Labor Statistics or consulting firms such as Hay/Huggins or A. Foster Higgins. One major problem of survey research is to define questions that capture all relevant details of benefit designs, a serious limitation of surveys. Indeed, most surveys are extremely limited in their information about mental health and substance abuse benefits. The other approach is to study contracts and administrative data that contain complete information, which is the approach we have taken. The difficulty with this approach is data reduction to summarize the wealth of individual information.

We use a classification system that almost completely covers all practically relevant benefit designs. Each benefit design element has one value for each of the main categories in Table 1. Although we consider deductibles, stop loss provisions, and coverage limits as special cases of copayments for our analyses, we discuss them separately below.

We have information on 4,160 plans that were in operation at the end of 1996 (and several hundred terminated plans, which we deleted). Those plans fall into two broad categories: about 1/6 are Employee Assistance Programs (EAP) plans, which typically means three or five free visits to a mental health specialist, but no other coverage, and the remaining plans provide more comprehensive benefits. Although EAP plans are extremely limited, they are not considered in-

Table 1. Taxonomy of benefits

Type of	Number of categories	Examples
1. Service	38	MH outpatient therapy, CD detox, MH assessment, MH/CD day treatment
2. Provider	4	Network provider, indemnity
3. Period	7	Annual, day, 1st course of treatment, lifetime, visit
4. Measurement unit	5	Dollar amount, day, admission, session, course of treatment
5. Threshold level (transition between insurance tiers)	Continuous	(The number measures when this tier of benefits becomes applicable; e.g., 5 might mean that this rate starts at the 5th visit, 0 is not applicable)
6. Patient responsibility	Continuous	Measures the copay amount, or coinsurance rate
7. Unit in which patient responsibility is measured	2	Dollar amount or percent of charges

surance and are not affected by the Parity Act. Most of the more comprehensive plans cover both mental health and substance abuse services: only 21 of over 3,500 plans are limited to substance abuse care and only 13 plans are limited to mental health care.

Limits

Common design features of mental health and substance abuse plans are limits, which directly counter the goal of insurance by shifting the risk of catastrophic expenses to the patient's family (or the public sector). Under the Parity Act, dollar limits will no longer be allowable for mental health, only for substance abuse, and most contracts need to be rewritten. An important reason for the widespread use of limits was to manage adverse selection because unlimited coverage would have attracted families that were most likely to have very high mental health costs.

Excluding plans that only provide EAP benefits, we find that there is an average of about four limits per plan. We counted 1,229 different types of limits in our data. This is puzzling because the goal of protecting the insurer (which in this data set generally means the employer offering those benefits) against cost outliers or adverse selection could have been achieved efficiently with a very small number of strategically chosen limits that also avoid creating undesirable incentives (such as low limits on outpatient use that could lead to substituting very costly inpatient care for the limited outpatient use). From an administrative point of view, this variety is inefficient. Although probably too minor to be noticed individually, across a large number of cases and contracts, this variety creates a costly administrative burden.

We classify limits by the first five dimensions in Table 1 (type of service, type of provider, time period, measurement unit, and threshold value); for limits, the last two dimensions are by definition 100 percent coinsurance (i.e., the patient is responsible for all charges exceeding the limit) and the amount

Table 2. Type of services with limits

Type of service	Number of limits	Percent
MH & SA–outpatient	4,936	32.7
MH & SA–inpatient	2,869	18.9
MH & SA–all services	3,299	21.8
MH only–outpatient	880	5.8
MH only–inpatient	707	4.7
MH only–all services	180	1.2
SA only–outpatient	430	2.9
SA only–detox	216	1.4
SA only–inpatient	1,225	8.1
SA only–all services	380	2.5
Total	15,122	100.0

of the limit. Tables 2–5 provide some descriptive statistics on the distribution of limits. Table 2 summarizes limits by type of services (reflecting broader classes of services, our database distinguishes 38 types of services), Table 3 by type of provider, Table 4 by type of period, Table 5 by type of measurement unit.

Table 2 shows that about three-fourths of all limits are jointly for mental health and substance abuse. However, the Parity Act only affects mental health, thus possibly leading to a decoupling of benefits starting this year. Table 3 shows the high prevalence of POS options. The number of limits are evenly split between network and nonnetwork providers (although limits are typically lower for nonnetwork providers), about one-fourth each, or apply to both groups (half of all limits). About two-thirds of the limits are on an annual basis, and less than 30 percent are lifetime limits (Table 4). Limits on charges per day or per visit are rare (and probably not very effective) as are other types of limits. Finally, more than half the limits are expressed in dollars, with days for inpatient care (under 30 percent) the second most common category (Table 5). Although only dollar limits are

Table 3. Provider type affected by limit

Period	Frequency	Percent
All providers	7,671	50.73
Indemnity	96	0.63
Nonnetwork	3,560	23.54
Network	3795	25.10
Total	15,122	100.00

Table 4. Utilization periods for which limits are defined*

Period	Frequency	Percent
Annual	9,977	66.0
Lifetime	4,183	27.7
Visit	428	2.8
Day	316	2.0
Others	218	1.5

*Other limits are episodes, number of course of treatment; each type accounts for less than 1 percent of limits.

Table 5. Measurement units for limits

Measure definition of limit	Number of limits	Percent of all limits
Dollars	7,641	50.5
Sessions	2,700	17.9
Days	4,169	27.6
Treatments	612	4.0

subject to the provisions of the Parity Act, this affects almost 90 percent of all plans because most plans have dollar limits even if they have limits on inpatient days or outpatient sessions. Some outpatient care is limited by the number of visits, but dollar limits are more common. Limits on the number of treatments are primarily for substance abuse treatment, for example, a limit of two episodes of treatment.

The average annual limits are around $20,000 for mental health care or mental health and substance abuse care jointly and the lifetime limits around $60,000 and limits for substance abuse care are around $11,000. In contrast, the average lifetime limit in medical plans is now over $1 million.[5] Figure 1 plots the distribution of annual limits (sum of all types of care, not individual limits on inpatient or outpatient care). About half of all limits are in the $15,000–20,000 range and less than one percent are over $50,000. In contrast, less than one percent of medical plans have limits under $100,000.[5]

Deductibles

Deductibles are an initial threshold amount for eligible services that the enrollee has to pay before insurance covers additional services. The problem with deductibles is that they discourage early access for problems and it might be rational for an individual to delay seeking care even if that increases the risks of much more costly interventions later (such as hospitalizations). Thus, in contrast to fire or accident insurance, deductibles may not be an efficient design feature for health insurance.

In our sample of carve-out plans, deductibles are very common for unmanaged services by nonnetwork providers (over

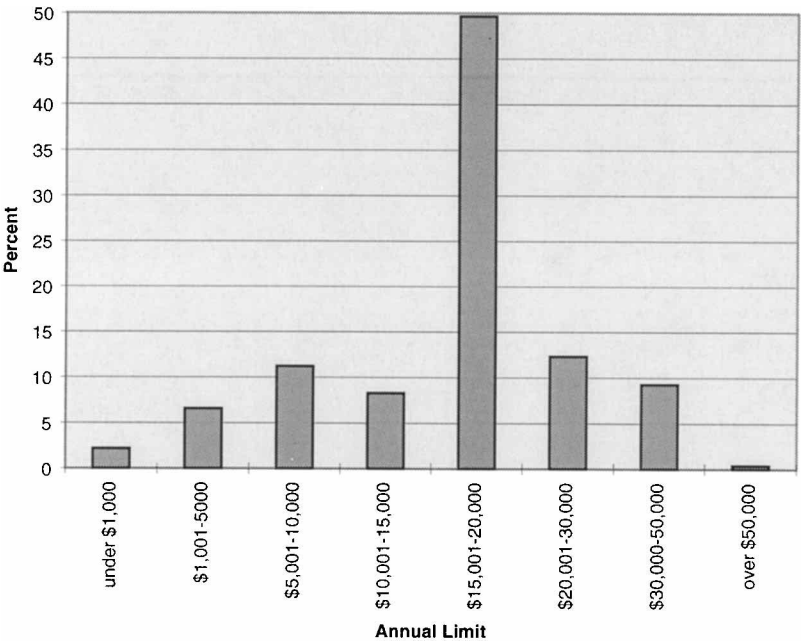

Figure 1. Distribution of annual limits (total for all services).

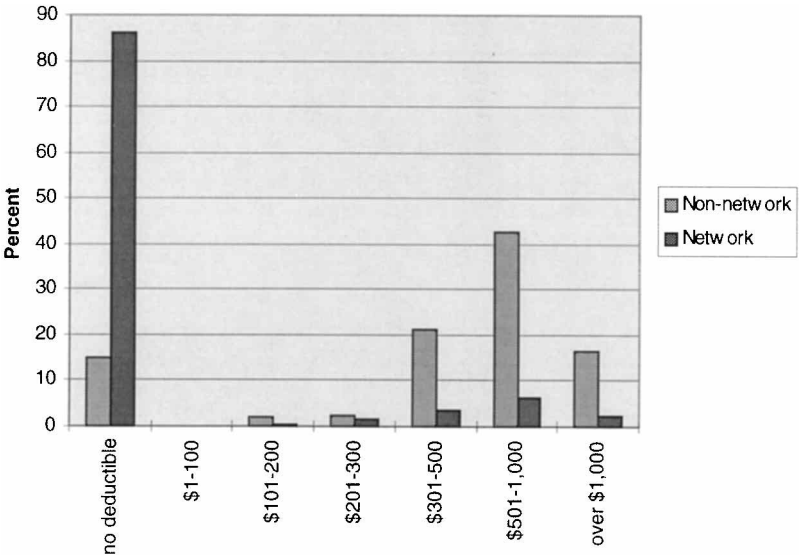

Figure 2. Annual family deductibles by type of provider.

90%), but rarely exist for managed network services (10–20%). This difference by type of provider reflects both the fact that care management is a supply-side strategy to manage moral hazard and therefore substitutes for deductibles and the fact that many plans offer a POS option and try to discourage use of nonnetwork services. Figure 2 shows the distribution of family deductibles for network and nonnetwork services (individual deductibles; are usually half the amount of family deductibles; this is a distinction not captured by our classification scheme in Table 1). When they exist, deductibles tend to be substantially higher than deductibles in medical [non–health maintenance organization (HMO)] plans. In 1993, among medical plans, only 5–10 percent had deductibles over $300 and the modal deductible was $100.[5] In contrast, in our sample of behavioral health plans, 80 percent of the nonnetwork deductibles for mental health and substance abuse are over $300 in this sample and the modal deductible is $250 (individual deductible) and $500 (family deductible).

Stop-loss provisions limiting out-of-pocket spending

Stop-loss provisions, which shift all additional health care costs to the insurer, are the opposite of deductibles and limits, which shift the responsibility of all initial or additional health care costs to the enrollee. To protect enrollees against catastrophic financial losses, more than 80 percent of medical (non-HMO) plans limit the maximum annual out-of-pocket expenses for covered services. In 1993, the average dollar stop-loss provision was around $2,500 in medical plans.[5]

In contrast, we find that 70 percent of nonnetwork and almost 90 percent of network behavioral health benefits have no such limit on enrollee out-of-pocket spending. Fig-

ure 3 graphs the distribution of family stop-loss amounts when such provisions exist.

The existence of stop-loss provisions in behavioral health plans together with relatively low limits on covered benefits appears contradictory. In fact, given the almost universal use of limits, one would have expected no stop-loss provisions at all. We have found plans with substantial coinsurance rates (40–50%), which suddenly drop to zero as the enrollee hits the stop-loss limit and then suddenly increases to 100 percent after only a few thousand dollars of additional benefits as the limit on covered services is exceeded. If the goal is to protect the enrollee against substantial expenses (the reason for limiting out-of-pocket expenses through stop-loss provisions), such schemes make little sense. These incoherent combinations of coverage limits, deductibles, and out-of-pocket spending limits reflect the haphazard way in which behavioral health benefits have been developed.

Copayments and coinsurance

Copayments can be a fixed amount that the patient has to pay for each service (e.g., $10 per visit) or a proportional amount that the patient has to pay (e.g., 20% of charges). The latter is often termed coinsurance. On average, each plan has four to five different types of copayments for different services. At first, the variation in copayments with several hundred different structures appears as confusing as the variation in limits. However, 80 percent fall into three broad groups:

1. a fixed copayment per inpatient stay for network services
2. a fixed copayment per session for network services
3. a fixed coinsurance rate for network and nonnetwork services

Table 6 summarizes the distribution of the most common copayment/insurance types. For Table 6, we collapse the service catego-

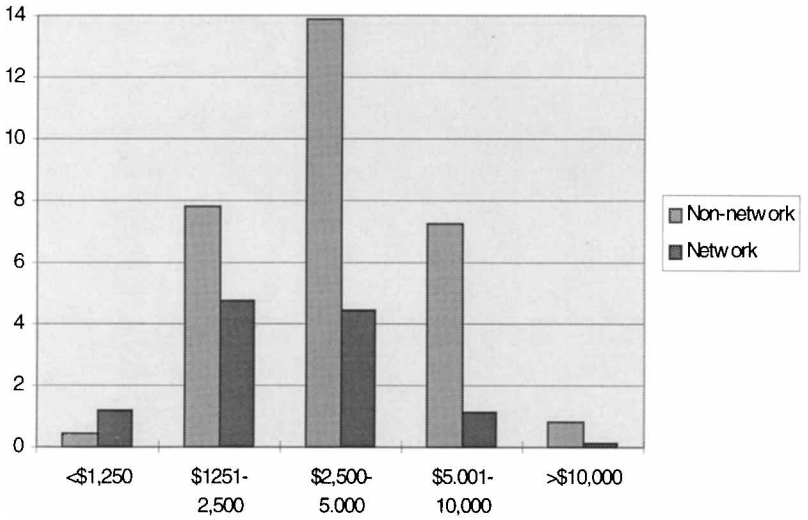

Figure 3. Annual family stop-loss by type of provider.

Table 6. Most common copayment and coinsurance types

Service*	Network provider	Copay or insurance	Mean	25th percentile	Median	75th percentile
In	Yes	$	$174	$100	$200	$200
Out	Yes	$	$18	$10	$20	$25
In	No	%	31%	20%	35%	40%
Out	No	%	43%	30%	50%	50%
In	Yes	%	11%	0%	0%	15%
Out	Yes	%	9%	10%	20%	20%

* Inpatient dollar amounts are per admission, outpatient dollar amounts per visit.

ries into two (inpatient and outpatient) and the provider categories into network and nonnetwork providers. We only considered initial copay/insurance rates here, a small group of plans has changes in those rates with increasing utilization (in addition to the changes caused by limits, deductibles, or stop loss provisions), but this is not very common.

Fixed copayment amounts are typical for network services, but not for nonnetwork services, which generally involve coinsurance. Fixed copayments for network services tend to be relatively low; the median is a $20 copay for outpatient visits and a $200 copay for an inpatient admission. This roughly corresponds to a 25 percent coinsurance rate for outpatient services and a 5 percent coinsurance rate for inpatient services, which is a little bit higher than the rates for network services with coinsurance rates. The biggest difference, however, is between network and non-network copayments and Figure 4 highlights those differences for inpatient and outpatient utilization. A substantial number of enrollees have zero coinsurance for network outpatient services, which is not clear in Table 6.

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This article discussed the Parity Act and described our data sources on managed care. We analyzed benefits in about 4,000 carve-out plans, almost all of which cover both mental health and substance abuse services, often with identical limits. The Parity Act may lead to a decoupling of those two types of benefits, an issue that has not received much attention in the discussion.

Overall, the diversity in designs across plans and complexity within individual plans reflects past attempts to manage moral hazard or adverse selection problems or to contain costs. Most of these benefit designs were probably initially developed in an unmanaged fee-for-service environment. Under managed care, the need for deductibles, limits, or other demand-side cost-sharing mechanisms may have diminished and restructuring outdated designs could benefit both enrollees and employers. Almost 90 percent of all plans are inconsistent with the current legislation and need to be rewritten in the coming year, which provides a unique opportunity to make benefit design more efficient. However, better information on the

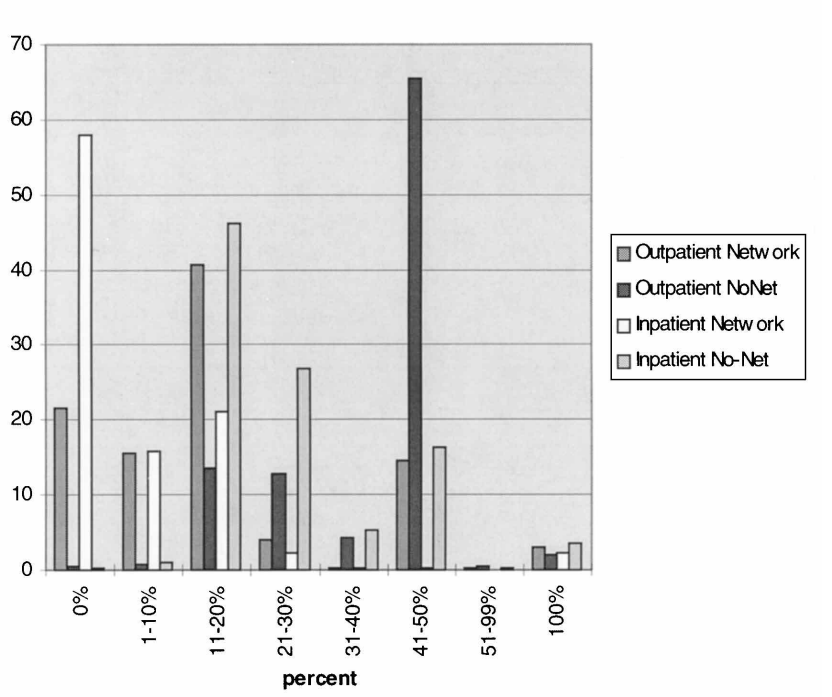

Figure 4. Coinsurance amounts.

impact of design mechanisms on access, intensity of care, and costs under managed care is needed before individual employers will be willing to give up traditional cost control mechanisms in their behavioral health plans, and there are only isolated case studies of the effects of carve-out managed care and expanded mental health benefits.[6–9]

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