

**Parity for Whom?**  
**Exemptions and the Extent of State Mental Health**  
**Parity Legislation**

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**Abstract**

Between 1997 and 2003 the share of workers subject to mental health parity laws increased substantially. But, because of exemptions for self-insured firms and small firms, coverage is much lower than a simple tally of state mandates would suggest. Limits on the types of conditions covered further weaken these laws.

Private health insurance plans typically restrict coverage for mental health benefits more than other types of health care. In recent years, mental health advocates have pushed to enact policies at the state and federal levels to reduce this discrepancy. The most prominent example, the 1996 Federal Mental Health Parity Act (MHPA), was initially hailed as a major achievement. But political compromises made to ensure passage weakened its potential impact. As a result, many view the MHPA as "primarily symbolic rather than substantive."<sup>1</sup>

Importantly, by establishing the principle of parity and raising its prominence as a policy issue, the MHPA served as an impetus for stronger policies at the state level. Since the MHPA went into effect in 1998, most states have enacted some form of mental health parity legislation. Many of these laws go substantially beyond the MHPA by establishing full or nearly full parity, at least for certain definitions of mental illness. But, even in states enacting strong regulations, the reach of these new rules is limited. Self-insured employer-sponsored health plans, which cover many employees, are exempt from state mandates under ERISA. Many state parity laws include explicit exemptions for small firms (typically defined as

those with 50 or fewer employees). Clauses limiting the types of disorders covered further limit these laws.

These exemptions have been cited as possible explanations for the fact that several studies find no effect of state parity laws on access to mental health services and related outcomes.<sup>2</sup> This Datawatch summarizes the extent and scope of state level mental health parity legislation in terms of the number of insured private sectors employees covered by these laws, explicitly accounting for the ERISA exemption for self-insured health plans, exemptions for small employers, and the range of conditions covered by the law.

### **The MHPA and State Parity Legislation**

The MHPA requires group health plans covering mental health care to offer annual and lifetime dollar limits that are comparable to those for medical/surgical benefits. Because it is a Federal law, the MHPA applies to self-insured employer-sponsored plans.

Despite these strengths, the MHPA has many holes. It explicitly exempts firms of 50 or fewer employees. Firms can claim an exemption if compliance causes health care costs to increase by more than 1 percent. And, the MHPA does not mandate that plans include mental health benefits

or preclude design features that restrict coverage. For example, in response to the MHPA, many plans introduced limits on the number of outpatient visits and inpatient days to replace the dollar-denominated limits that were no longer allowed.<sup>3</sup>

Since the MHPA went into effect in 1998, however, every state but Idaho and Wyoming has enacted mental health parity legislation, with some states passing multiple incremental bills over this period. Most state parity laws go beyond the MHPA in one or several dimensions by expanding the scope of the benefit mandate. Some do this by enacting stricter definitions of parity, but only requiring that insurers offer one plan that complies with these stricter rules. Such "mandated offering" laws are fairly weak, as they do not require employers purchase the "parity" plans. Some states take a slightly stronger approach by mandating parity for plans already offering mental health benefits, but not requiring such benefits be offered.

The strongest state laws mandate that mental health benefits be covered. We focus broadly on states with "strong parity laws" but also try to distinguish the impact of these laws separately by the type of benefits they require.

## **Data and Methods**

Our primary source of data is the Medical Expenditure Panel Survey - Insurance Component (MEPS-IC), a nationally representative survey of private sector establishments sponsored by the Agency for Healthcare Research and Quality (AHRQ) and conducted by the US Bureau of the Census. We use data from the 1997 to 2003 survey years.

The MEPS-IC measures whether an establishment offers health insurance, the number and type of plans offered, and plan characteristics, including whether a plan is self-funded. This information is essential for determining whether a plan qualifies for an ERISA exemption. Information on firm size is used to identify employers that qualify for small group exemptions.

Information on state parity laws was obtained from several sources.<sup>4</sup> When these sources disagreed or were ambiguous, the information was checked against the actual state codes. Following prior research in this area, we first grouped states into broad "strength of coverage" categories. We define strong parity laws to be ones that mandate mental health benefits, prohibit limits on visits or days and limit the extent to which health plan enrollees can be charged higher cost-sharing for mental health services.

We next considered three specific parity provisions: whether the law covers all mental illnesses (as opposed to a limited set of "serious" or "biologically-based" conditions) and whether it covers alcohol treatment or drug treatment. Serious or biologically-based mental illnesses usually include schizophrenia, bipolar disorder, panic disorder, obsessive-compulsive disorder, and major depressive disorder (the most common of the serious mental disorders).

The outcome of most interest is the percentage of insured private sector employees who are subject to strong parity laws as well as specific parity provisions.<sup>5</sup> The denominator for these ratios is the number of employees covered by a health plan sponsored by an employer. The numerator is calculated by combining information on the content and timing of each state law with information on firm size and self-insurance status.

We present national estimates based on our definition of "strong" parity states. An Appendix table presents detailed state-by-state estimates of parity coverage and exemptions. This table can be used to construct alternatives estimates of parity coverage.

## **Results**

Exhibit 1 summarizes trends in laws meeting our definition of strong parity. Four states (MD, MN, NH, and RI), accounting for four percent of all insured private sector employees, had such laws prior to the MHPA. The potential coverage rate jumped to 14 percent in 1998 and grew steadily between 1998 and 2000. Because of laws enacted in two large states (California in 2001 and Illinois in 2002) the potential coverage rate increased to 44 percent in 2002. West Virginia enacted a strong parity law in 2003, raising the rate to 45 percent.

However, as the graph shows, the actual impact of these state laws was substantially reduced by the exemptions for self-insured plans and small firms. While their exact impact varies by state, on average these exemptions cut the number of employees actually covered roughly in half. As a result, we estimate that by 2003 strong parity rules applied to only one-fifth of all private sector workers with employer-sponsored insurance.

Exhibit 2 also reveals the differing impact of the two exemptions. The self-insurance exemption accounts for almost all of the difference between potential and actual coverage. State firm size exemptions account for only 13 percent of the difference in 2003 (or 3 percentage points).



Since the self-insurance exemption comes from federal legislation (ERISA), states can do little to increase the percentage of their enrollees covered by parity rules.

Even the actual coverage rates displayed may overstate the extent of coverage as some laws that are strong in the sense of requiring a minimum level of coverage for mental disorders still limit the range of disorders covered. To provide a sense of the prevalence of these limitations, Exhibit 3 compares trends in mandated coverage for three specific parity provisions: all mental illnesses, alcohol treatment and drug treatment. In addition to the strong parity mandates described above, we account for an earlier 1985 NJ law that singles out the treatment of alcohol abuse. The portion of workers covered by this NJ mandate is shown shaded in the bar for alcohol treatment mandates. For clarity, the chart includes only the percent of workers *actually* covered by the different provisions.

While about 20 percent of private sector employees with employer-sponsored insurance were covered by strong parity laws in 2003, only 3 percent were covered by strong laws that applied to all mental illnesses. Coverage rates for alcohol and drug abuse treatment were slightly higher (3.6 and 5.2 percent, respectively).

## **Discussion**

Since 1997, nearly every state has enacted legislation aimed at improving the coverage of mental health benefits. However, the impact of these laws is limited by exemptions. By far the most important exemption is for self-insured firms, which are exempt from state regulatory provisions under ERISA. As a result, strong parity laws applied to only one-fifth of all U.S. workers with employer-sponsored health insurance coverage.<sup>6</sup> This estimate suggests that full mental health parity can only be achieved at the federal level.

The weak 1996 MHPA resulted in large part from initial forecasts that full parity would significantly increase insurance premiums.<sup>7</sup> Recent research, however, suggests that because of the "carving out" mental health benefits and the use of other managed care techniques, the cost of strengthening Federal parity legislation may not be as large as previously believed.<sup>8</sup> By replacing demand-side cost-sharing with supply-side controls such as utilization review, prior authorization and restricted networks, managed behavioral health plans can offset reduced consumer cost-sharing under parity. A new consensus, reflected in the peer-reviewed literature and in more recent CBO projections, suggests that parity would increase premiums

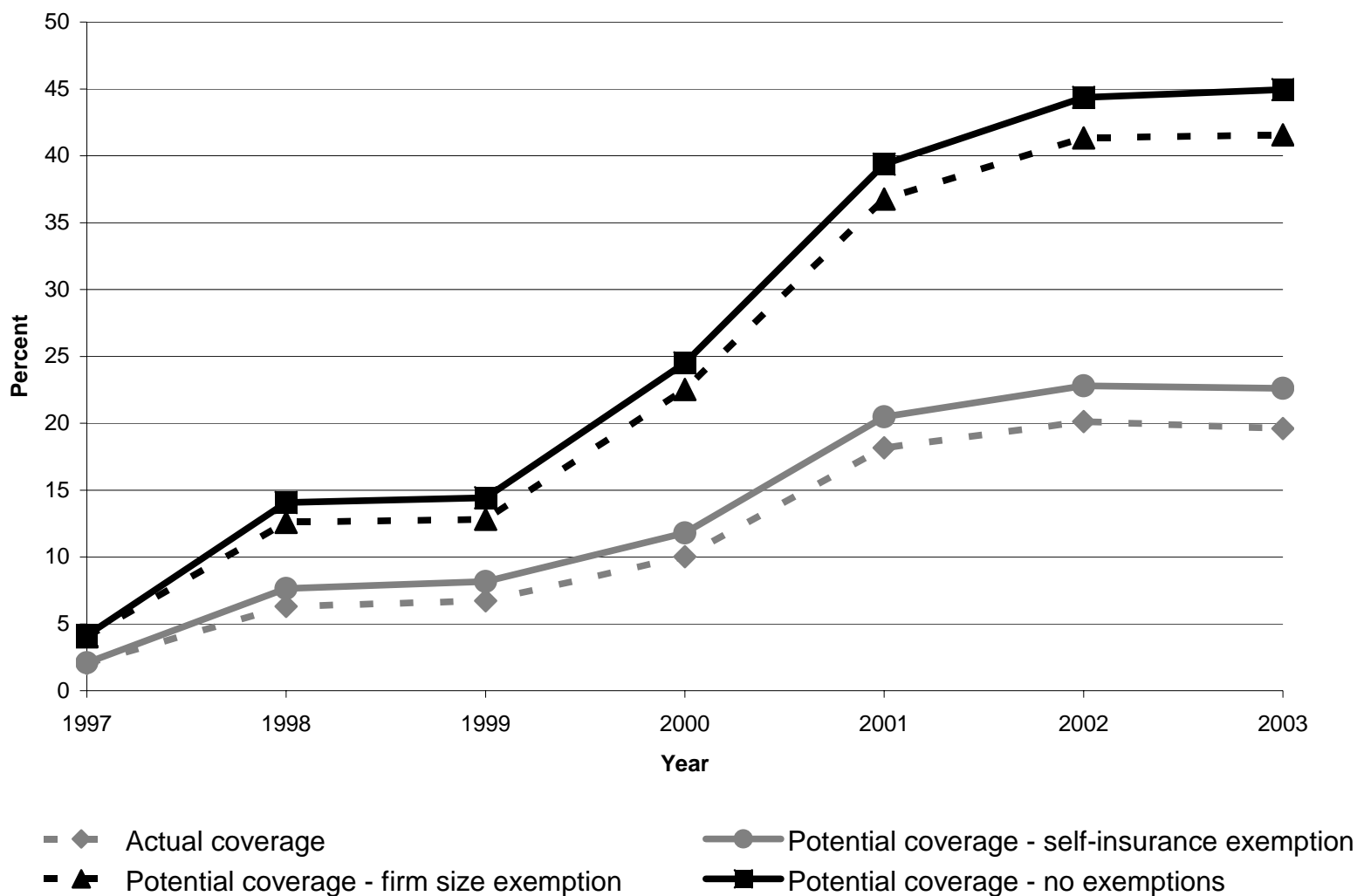
by less than 1 percent.<sup>9</sup> Nonetheless, employers and insurers remain concerned about the costs of mandates. And stronger federal parity legislation has yet to be enacted.

**Exhibit 1. State Level Mental Health Parity Laws, 1996 to 2003**

Year	Number of Laws Enacted	Number of States with "Strong" Parity Laws in Effect	Specific States
1996	1	4	MD, MN, NH, RI
1997	19	5	plus ME
1998	11	9	Plus AR, CO, TX, VT
1999	14	11	plus DE, SD
2000	9	18	Plus CT, HI, LA, MT, NJ, OK, VA
2001	7	21	Plus CA, MA, NM
2002	6	22	plus IL
2003	7 <sup>a</sup>	23	plus WV

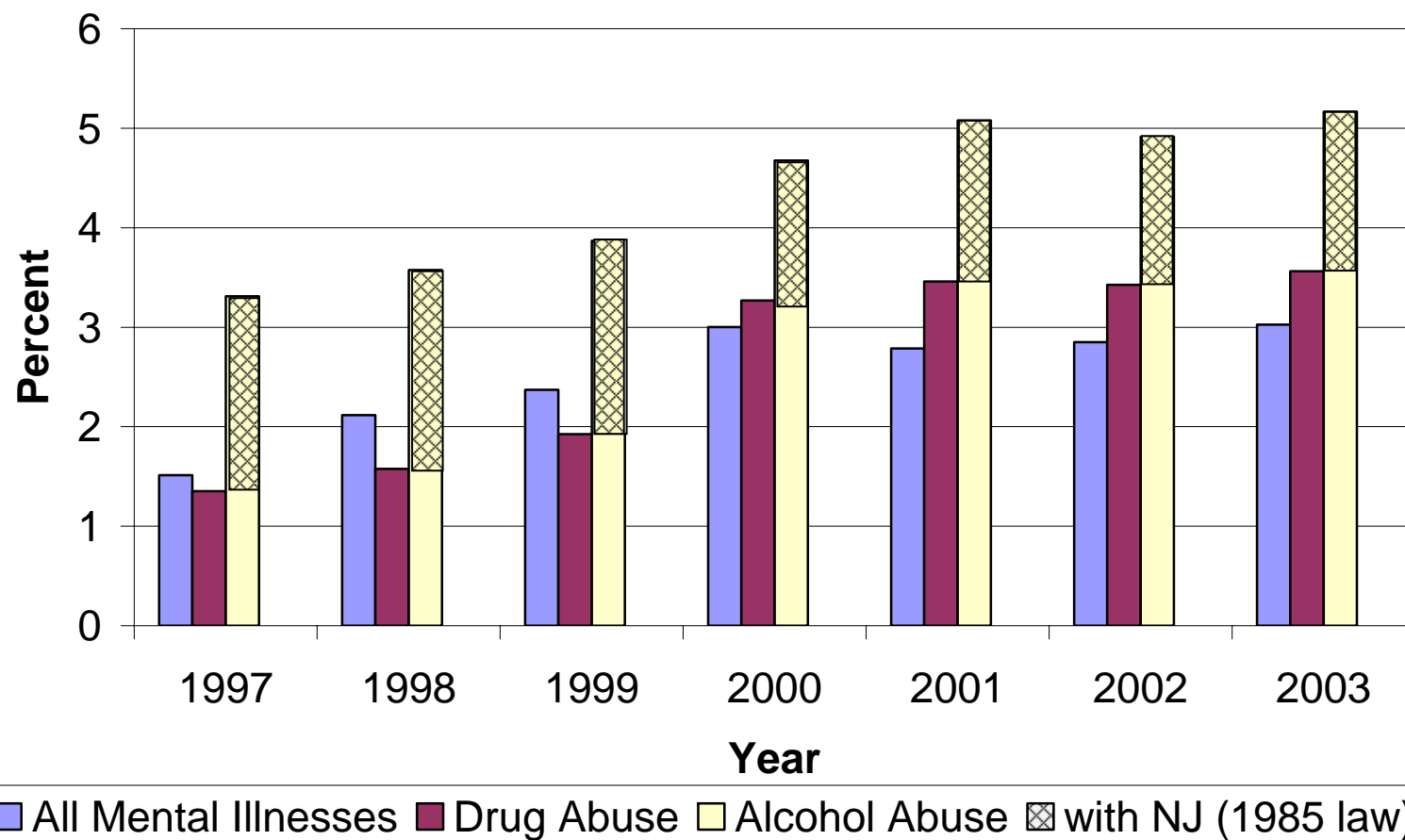
<sup>a</sup>Four of the laws enacted weakened existing legislation.  
Sources: Gitterman, D.P., R. Sturm, R.L. Pacula and R.M. Scheffler, "Does the Sunset of Mental Health Parity Really Matter?" *Administration and Policy in Mental Health* 28, no. 5(May 2001): 353-369; "State Laws Mandating or Regulating Mental Health Benefits (updated September 2005), <http://www.ncsl.org/programs/health/mentalben.htm> (accessed 1/23/2006); D.P. Gitterman, "The Politics of Mental Health Parity and U.S. Regulatory Federalism, 1990-2005," working paper, University of North Carolina, 2006; National Mental Health Association, "What States Have Done to Ensure Insurance Parity?", [http://www.nmha.org/state/parity/state\\_parity.pdf](http://www.nmha.org/state/parity/state_parity.pdf) (accessed 1/23/2006); author's review of state codes, legislation, and statutes through <http://www.law.cornell.edu/states/listing.html> (accessed 3/1/2007).

**Exhibit 2. Percent of Employees Enrolled in Employer-Provided Health Insurance Plans Covered by Strong Parity Laws**



Source: Medical Expenditure Panel Survey, Insurance Component (MEPS-IC), 1997-2003.

**Exhibit 3. Percent of Employees Enrolled in Employer-Provided Health Insurance Plans Covered by Strong Parity Laws That Cover All Mental Illness, Drug Treatment, and Alcohol Treatment**



Source: Medical Expenditure Panel Survey, Insurance Component (MEPS-IC), 1997-2003.

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<sup>1</sup> D.P. Gitterman, R. Sturm, and R.M. Scheffler, "Toward Full Mental Health Policy and Beyond," *Health Affairs* 20, no. 4(July/August 2001): 68-76.

<sup>2</sup> R. Sturm, "State Parity Legislation and Changes in Health Insurance and Perceived Access to Care Among Individuals with Mental Illness: 1996-1998," *Journal of Mental Health Policy and Economics* 3, no. 4 (2000): 209-213; R.G. Frank, H.H. Goldman and T.G. McGuire, "Will Parity in Coverage Result in Better Mental Health Care," *New England Journal of Medicine* 345, no. 23 (2001): 1701-1704. J. Klick and S. Markowitz, "Are Mental Health Mandates Effective? Evidence from Suicides," National Bureau of Economic Research Working Paper No. 9994 (September 2003); Y. Bao and R. Sturm, "The Effects of State Mental Health Parity Legislation on Perceived Quality of Insurance Coverage, Perceived Access to Care and Use of Mental Health Specialty Care," *Health Services Research* 39, no. 4(2004): 1361-1377.

<sup>3</sup> US General Accounting Office, "Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited," (May 2000), GAO/HEHS-00-95.

<sup>4</sup> D.P. Gitterman, R. Sturm, R.L. Pacula and R.M. Scheffler, "Does the Sunset of Mental Health Parity Really Matter?" *Administration and Policy in Mental Health* 28, no. 5(2001): 353-369; "State Laws Mandating or Regulating Mental Health Benefits (updated September 2005), <http://www.ncsl.org/programs/health/mentalben.htm> (accessed 1/23/2006); D.P. Gitterman, "The Politics of Mental Health Parity and U.S. Regulatory Federalism, 1990-2005," working paper, University of North Carolina, 2006.

<sup>5</sup> We consider only mandates for private sector employees because the MEPS-IC samples private sector establishments.

<sup>6</sup> We cannot observe cost-increase exemptions but this exemption should be small.

<sup>7</sup> Congressional Budget Office (May 13, 1996): CBO's Estimate of the Impact on Employers of the Mental Health Parity Amendment in H.R. 3103. Washington, D.C.: Congressional Budget Office (unpublished); National Advisory Mental Health Council, Parity in Coverage of Mental Health Services in an Era of Managed Care: An Interim Report to

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Congress By The National Advisory Mental Health Council," Washington, D.C: National Institute of Mental Health, April 1997.

<sup>8</sup>National Advisory Mental Health Council, *Insurance Parity for Mental Health: Cost, Access, and Quality: Final Report to Congress by the National Advisory Mental Health Council*, Washington, D.C: National Institutes of Health, June 2000, NIH Publication No. 00-4787; R. Sturm, "How Expensive is Unlimited Mental Health Care Coverage Under Managed Care? *JAMA* 278, no. 18(1997): 1533-1537.

<sup>9</sup>H.H. Goldman et al., "Behavioral Health Insurance Parity for Federal Employees," 354, no. 13 (2006): 1378-1386.