CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Peter R. Orszag, Director

February 26, 2008

Honorable Fortney Pete Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

As you requested, the attachment to this letter responds to your questions concerning the Congressional Budget Office's (CBO's) cost estimate for H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007.

I hope this information is helpful to you. The CBO staff contacts for this analysis are Shinobu Suzuki (226-9010) and Stuart Hagen (226-2666).

Sincerely,

Peter R. Orszag

Attachment

cc: Honorable Dave Camp
Ranking Member

Congressional Budget Office

Responses to Questions Posed by Chairman Stark About CBO's Cost Estimate for H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007

Question. H.R. 1424 requires group health plans that provide mental health benefits to cover all mental health or substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. What effect does this requirement have on state regulated insurance plans and ERISA plans? How does this estimate compare with the estimate of S. 558?

Answer. Nearly all plans that offer mental health benefits now cover at least severe mental illness, and many cover virtually all mental health conditions. In plans that cover all mental health conditions, severe mental illness accounts for nearly all spending on mental health services: actuaries estimate that about 90 percent of mental health costs are for treatment of severe mental illness. Thus, for plans that provide mental health and substance-related benefits, the costs of covering at parity all ailments listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) would not differ significantly from the costs they would incur if there were no such requirement. (In the Congressional Budget Office's (CBO's) estimates of the budgetary effect of the mental health parity provisions of H.R. 1424 and S. 558, the impact on premiums—an increase of 0.4 percent—rounded to the same amount with or without the DSM provision.)

Question. If a group health plan provides mental health and substance-related disorder benefits and covers medical and surgical benefits for substantially all items and services furnished outside any network of providers, H.R. 1424 requires the plan to also provide out-of-network (OON) benefits for mental health and substance-related disorder benefits. What effect does this provision have on the cost of health insurance? How does this estimate compare with S. 558?

Answer. CBO's cost estimate was based in part on data provided by the Hay Group. According to those data, the incremental cost of OON parity to plans that provide mental health benefits is negligible compared with the total cost of mental health parity. Therefore, the OON provision has a negligible effect on CBO's estimate of the budgetary effect of the mental health parity provisions in the two bills.

Question. What effect does the absence of a rule of construction relating to medical management have on health costs? How does this estimate compare with the construction clause included in S. 558?

Answer. CBO assumed that, absent language to the contrary in the Ways and Means Committee's version of H.R. 1424, plans would be free to use the same medical management tools and controls that they do under current law. Thus, CBO estimated that adding a provision that explicitly allowed plans to use management tools, as in S. 558, would not have a significant effect on the estimated cost of the bill.

Question. CBO estimates that 60 percent of the premium increase for group health plans would be offset by the behavioral responses of employers and employees to the new requirements, such as eliminating coverage for mental health benefits and reducing the scope or generosity of the health insurance benefits that employers offer or employees choose.

i. How many individuals did CBO assume would lose access to mental health benefits as a result of this behavioral response? How many people would gain access to these benefits?

ii. What assumptions did CBO make about the additional costs employers would encounter as a result of these patients losing access to mental health benefits, including the loss of productivity from untreated mental health or medical conditions? How much will employers gain in productivity as a result of more people being able to treat their mental health and substance-related disorders?

iii. What assumptions did CBO make about the indirect costs (e.g., from co-morbidities) that would be triggered by reduced access to mental health benefits? Does CBO also assume lower health spending resulting from greater access to mental health and substance-related treatments?

iv. How many individuals did CBO assume would lose access to health insurance coverage as a result of this behavioral response?

v. How many individuals did CBO assume would pay higher co-payments for health benefits as a result of this behavioral response? How many individuals will be able to access mental health and substance-related benefits as a result of lower cost-sharing and fewer treatment limits?

vi. How many individuals are paying higher cost sharing as a result of being moved into a high-deductible health plan? How much more are they paying on the individual and aggregate levels compared to a decade ago?

vii. Is there any difference between H.R. 1424 and S. 558 in these estimates?

Answer. The 60 percent offset used in CBO's analysis is based on empirical evidence of the behavioral response of employers and employees to changes in the price of health insurance coverage, whether that change is due to a new requirement related to mental health coverage or another factor unrelated to mental health. As that price rises, the

quantity of health insurance demanded by employers and employees falls by 60 percent of that increase; that is, the net increase in total health insurance premiums that are affected by the price increase is 40 percent of the unit price increase. In general, CBO applies the 60 percent offset in scoring legislative proposals that would affect the price of health insurance.

Although evidence on the magnitude of the behavioral response is relatively plentiful, there is much less evidence on the precise ways in which that behavioral response manifests itself. Therefore, CBO did not break out the indirect effects. For example, some employers might cease offering mental health coverage; others might preserve their mental health benefits but make other adjustments, such as eliminating other types of health benefits or increasing cost sharing on all benefits; and still other employers might elect to stop offering health insurance coverage altogether. CBO assumed that as employers responded to the new parity requirements they would incorporate many factors—including the potential impact of their decisions on the productivity, health outcomes, and health care costs of their employees—into their decisions regarding employee health benefits. Given the many possible behavioral responses and the lack of data, CBO did not predict the precise manner in which employers and employees would respond to the change in the price of health insurance. Rather, CBO's estimate reflected the magnitude of the behavioral response in terms of aggregate spending for health insurance premiums and the consequent impact on federal tax revenue.

Question. CBO estimated in 2001 that S. 543 would increase premiums for group health insurance by an average of 0.9 percent. The September 7, 2007 CBO cost estimate for H.R. 1424 estimates an increase in premiums for group health insurance by an average of about 0.4 percent. Please explain why the more recent CBO estimate assumes a much lower rate of increase in premiums.

Answer. The 2001 estimate, which also relied in part on modeling by the Hay Group, was based primarily on data from the Federal Employees Health Benefits (FEHB) program. The 2007 estimate, which is based on more recent data from FEHB and private-sector employers, suggests that the cost of providing mental health and substance-related benefits, in general, and of offering those benefits at parity with medical and surgical benefits is lower than the previous estimate. In addition, more employers that offer mental health benefits now do so at parity with medical and surgical benefits than did so in 2002. Thus, fewer employers would be newly affected by a change in the law today.

Question. The CBO cost estimate of H.R. 1424 reports average cost figures which would include plans that are exempt from the provisions of the bill. In 2002, CBO estimated that plans covered by the provisions in the bill would see cost increases ranging from 30 to 70 percent. Please provide an estimate of how much costs for these plans would increase under H.R. 1424.

Answer. In a July 12, 2002, memorandum, CBO estimated that firms newly affected by requirements for mental health parity would see an increase of 30 percent to 70 percent in the cost of their mental health benefits. As noted in the answer to the previous question, recent data indicate that the cost of offering mental health benefits is lower than the previous estimate, and employers that offer such benefits are now more likely to offer them at parity or close to it. CBO therefore estimates that firms newly affected by the parity requirements of H.R. 1424 would see an increase of less than 25 percent in the cost of their mental health benefits.