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Effects of Substance Abuse Parity in Private Insurance Plans Under Managed Care

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Preface

This document presents the written testimony of Roland Sturm, Ph.D., as submitted to the U.S. House of Representatives Subcommittee on Criminal Justice, Drug Policy and Human Resources on Thursday, October 21, 1999.

Effects of Substance Abuse Parity in Private Insurance Plans Under Managed Care

Testimony Presented to the U.S. House of Representatives Subcommittee on Criminal Justice, Drug Policy and Human Resources

by
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RAND Health

I am a senior economist at RAND and director of economic and policy research in the UCLA/RAND Center on Managed Care. RAND is a nonprofit institution that helps improve policy and decisionmaking through research and analysis. This statement is based on research funded by the Robert Wood Johnson Foundation and the National Institute on Drug Abuse. The opinions and conclusions expressed are mine and do not necessarily reflect those of RAND or the research sponsors.

My research has focused on costs and utilization patterns for substance abuse treatment in today's health care environment. New data are needed to inform policy decisions about substance abuse treatment because the health care delivery system has changed dramatically. For most privately insured Americans, behavioral health (which includes mental health and substance abuse care) is now managed by specialized managed care companies. Treatment patterns have changed dramatically, and patterns criticized in the past as excessively costly, such as automatic 28-day inpatient stays, are almost nonexistent.

These changes in how substance abuse treatment is delivered mean that legislation will have different consequences today than it would have had 20 years ago. However, estimates of the cost consequences of proposed legislation, including reports by the Congressional Research Service[1,2] or the Substance Abuse and Mental Health Services Administration[2,3], were based primarily on actuarial assumptions, which reflect utilization patterns from the 1970s and 1980s. Many of those do not reflect today's mental health or substance abuse treatment system in the private sector[4-6].

The results that I present here are based on a study published in the Journal of Behavioral Health Services and Research[7]. We examined the use and costs of substance abuse treatment in 25 managed care plans that currently offer unlimited substance abuse benefits with minimal co-payments ("parity" level benefit) to their enrollees in 38 states. However, care is managed and services must be preauthorized and received through a network provider to be fully covered, a typical service arrangement in employer-sponsored plans.

Providing unlimited substance abuse benefits in these plans costs employers slightly more than $5.00 per plan member per year in insurance premiums paid to providers. Employees account for the largest costs, child dependents the smallest; thus limits on substance abuse care have the most substantial cost consequences for employees. In terms of benefit limits, a $10,000 annual cap on benefits would reduce the cost of unlimited benefits by only 6 cents. A $5,000 annual cap would reduce the cost to $4.33 per member per year.

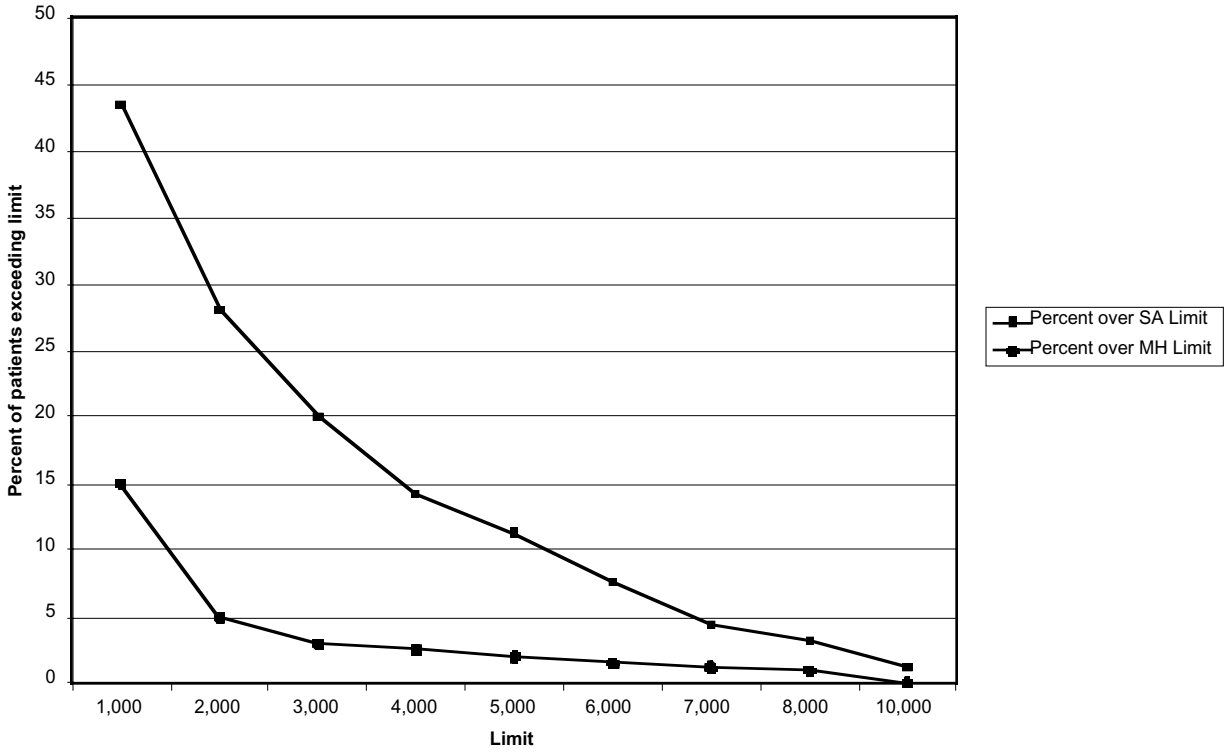
Based on a sample of several hundred employer-sponsored plans that were active in 1997, we estimate that about three-quarters of plans have caps for substance abuse of $10,000 or less. Changes in copayments or deductibles have cost reduction effects similar to the caps, but the resulting payments to providers are always lower than the costs of providing the parity benefit (about $5 dollars per member per year).

To put these numbers into perspective, the additional costs of adding full parity benefits for substance abuse treatment to a plan that previously offered *no substance abuse* benefits is in the order of 0.3 percent, based on a total annual health maintenance organization insurance premium of $1,500 per member. Expanding *existing substance abuse* benefits in a plan would have a correspondingly smaller effect. Note that the numbers reflect payments to providers (the part counted as the medical loss ratio); administrative fees or insurance profits are in addition.

We find no evidence that substance abuse mandates or parity could lead to health premium increases in the order of several percentage points in managed care plans. We

also concluded that limiting substance abuse benefits saves very little in managed behavioral health care plans, but affects a substantial number of patients who need additional care (see the figure). Substance abuse patients are quite costly, on average twice as costly as typical mental health care users; thus the same limits affect relatively more substance abuse patients than mental health patients, leaving the former at risk for a large part of their treatment costs. However, overall plan costs are small because substance abuse patients are rare in privately insured populations.

Figure 1: Percentage of Mental Health and Substance Abuse Users Exceeding $ Limit



In the private sector, individuals with substance abuse problems are much more likely to become ineligible for insurance. Employees, who account for a relatively larger share of substance abuse benefits than other type of members, are the most likely to lose coverage[8]. Patients who exceed benefits and lose insurance coverage are likely to end treatment prematurely, thereby reducing both their chance of recovery and the

probability of maintaining employment. Parity legislation by itself will probably not remedy this problem.

Cost and use data from comprehensively managed plans currently offering unlimited parity-level substance abuse treatment provide no support for excluding substance abuse from parity efforts because of cost reasons. It is unclear how decoupling mental health and substance abuse care in terms of benefits can save much money. However, decoupling is likely to create difficulties in coordinating treatment and lead to less efficient care. Since a high proportion of individuals have both MH and SA problems, poor coordination of care is a significant concern.

Our results suggest that parity for substance abuse treatment in employer-sponsored health plans is not very costly under comprehensively managed care, which is the standard arrangement in today's marketplace. However, this result does not apply to unmanaged indemnity plans and may only hold for large employers, but not for individuals or for small groups buying insurance. Our data also reflect a fairly "typical" employed population. Some industries may attract higher than average rates of substance abusers, resulting in somewhat larger treatment costs. Of course, providing comprehensive substance abuse treatment benefits in those industries would also have the largest social impact on reducing consumption and lowering the indirect social costs of substance abuse.

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