Mental health benefits financed by employers

Employee health insurance plans typically provide less extensive coverage for mental disorders than for other types of illness; this pattern is particularly true for outpatient care

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Although most employer-financed health insurance plans cover mental disorders, benefits have traditionally been more restricted than for other illnesses. Coverage for mental disorders is usually for shorter periods and maximum dollar benefits are often lower. Also, plans commonly pay a smaller share of mental health care expenses.

These differences are more pronounced for outpatient mental health care. Coverage of mental health care in a hospital is the same as for other types of hospital care for four-tenths of the employees in medium and large private firms; outpatient mental health care is almost always subject to stricter limits than other illnesses.

Several reasons are commonly advanced for treating mental health care differently than other types of medical care. One reason is that mental disorders are not as easy to define as other illnesses.[1] Also, mental health problems can be subjective, with treatment continuing for an indeterminant period than when confinement is caused by other illnesses. These characteristics are often extended to outpatient care, when treatment may be highly elective on the part of the health insurance subscriber.[2]

This article is based on data from the Bureau of Labor Statistics' 1985 survey of benefits for full-time employees in medium and large firms. A sample of approximately 1,500 establishments yielded information on the detailed provisions of more than 2,200 health insurance plans either fully or partially financed by employers. The statistical universe covers 43,000 firms employing more than 23 million people.[3]

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Mental health care coverage

Prior to the 1940's, treatment for mental disorders was usually provided only in State mental hospitals. Most general hospitals had little, if any, psychiatric facilities. Health insurance carriers, which emerged in the late 1930's, confined benefits to nonpsychiatric illnesses or disabilities. Consequently, mentally ill patients, who might require extended periods of hospitalization, were excluded.

After World War II, general hospitals opened onsite psychiatric clinics and added psychiatrists to their staffs. These developments prompted commercial insurance carriers to include hospitalization coverage for mental illness.

Another factor in the growth of mental health benefits was the adoption of State laws mandating inclusion of mental care in health insurance policies offered by commercial carriers. By 1984, more than half of the States had enacted such statutes.

Blue Cross and Blue Shield plans followed commercial carriers into the mental health care field. Historically, Blue Cross and Blue Shield organizations had very few member hospitals with psychiatric facilities, but they began to expand their coverage because of greater integration of psychiatric and medical care.[4] By 1971, all Blue Cross and Blue Shield plans provided mental health coverage in their hospital and medical benefits.[5]

In the 1950's, outpatient mental health coverage was introduced by commercial carriers; by the late 1960's, it was

widespread in plans funded both by commercial insurers and Blue Cross and Blue Shield. Initially, this coverage provided the same level of benefits as for nonpsychiatric ailments. Soon, however, insurers placed limits on outpatient mental care to avoid paying for treatment that might continue for an indefinite period.

The pattern set in the 1950's remains very much in evidence. Outpatient mental health care generally has special limitations on coverage, while for some employees, inpatient mental care has the same coverage as for other ailments. In almost all health plans, coverage has been expanded to include some outpatient mental health care.[6]

An overview of coverage patterns, 1980–85

The 1980–85 employee benefit surveys document the extent to which health insurance participants in medium and large firms have coverage for mental disorders. Since 1980, coverage for care in general hospitals has remained steady at 98 to 100 percent of health plan participants. During this same period, coverage for outpatient mental health care has increased from 93 to 97 percent of participants. (See table 1.)

Survey findings emphasize the marked differences in how health insurance plans cover hospital care, as opposed to outpatient care, for mental illnesses. While 42 percent of participants received the same benefits for mental health hospitalizations as for other illnesses in 1985, 5 percent received the same level of coverage for outpatient mental health care.

During the 1980–85 period, a large number of participants faced stricter limits on mental health care than those applied to other illnesses. The proportion of participants subject to more stringent limits on hospitalization for mental health care increased from 44 to 57 percent, and the proportion with stricter limits on outpatient care rose from 83 to 91 percent.

An examination of health insurance coverage for hospital and outpatient mental health care for 1985 follows. Several key provisions were studied: limits on days of hospital coverage; limits on periods covered or dollar amounts payable for outpatient care; and coinsurance, stop-loss, and maximum lifetime payment provisions under major medical coverage.[7]

Limitations on hospital care

In 1985, one-half of plan participants had mental health care provisions that specifically limited the number of days of hospital room and board.[8] As used in this article, room and board includes ancillary hospital services such as drugs, blood tests, nursing care, and diagnostic x-ray and laboratory work.

Limitations on inpatient care for mental illnesses in plans other than those sponsored by Health Maintenance Organizations (HMO's) are presented in table 2.[9] Three-fifths of the participants had stricter limits on room and board for mental health care than for other illnesses. Coverage was limited to 30 or 45 days per mental illness, or 30 or 60 days per year. In contrast, other illnesses were limited to 365 days.

HMO's provided fewer days of room and board coverage for mental disorders than for other illnesses. Limits on days

Table 1. Trends in mental health benefits by limits of coverage, medium and large firms, 1980–85

Limitations	Percent of full-time participants in health insurance plans[1]					
	1980	1981	1982	1983	1984	1985
Hospital care						
With coverage	98	100	99	100	100	99
Covered the same as other illnesses	54	59	56	54	48	42
Subject to separate limitations[2]	44	41	43	46	52	57
Limit on days or visits	33	30	31	30	29	34
Limit on dollars	21	15	15	18	24	26
Major medical coinsurance limited to 50 percent	3	1	2	3	3	3
No major medical ceiling on out-of-pocket expenses	(3)	(3)	(3)	(3)	(3)	12
Other limitations[4]	1	2	8	8	9	8
Not covered	2	(5)	1	(5)	(5)	1
Outpatient care						
With coverage	93	93	91	95	97	97
Covered the same as other illnesses	10	10	7	7	7	5
Subject to separate limitations[2]	83	83	84	88	90	91
Limit on days or visits	20	21	19	20	23	26
Limit on dollars	58	62	63	68	70	71
Major medical coinsurance limited to 50 percent	54	54	54	54	54	54
No major medical ceiling on out-of-pocket expenses	(3)	(3)	(3)	(3)	(3)	52
Other limitations[4]	4	12	13	12	14	17
Not covered	7	7	9	5	3	3

[1] During 1980–85, health insurance participation held steady at 96–97 percent of all employees covered by the survey.
[2] The total is less than the sum of the individual items because many plans had more than one type of limitation.
[3] Not tabulated this year.
[4] Includes plans requiring copayments or a separate deductible for inpatient or outpatient mental health care, or plans where the rate of reimbursement for outpatient care varied during the treatment period.
[5] Less than 0.5 percent.

NOTE: Because of rounding, sums of individual percents may not equal totals.

of coverage for mental health care in the hospital were usually provided on an annual rather than on a confinement basis. The most common restriction was 30 days per year, but limitations of 45 or 60 days were frequently found. For other illnesses, the number of days was usually unlimited.[10]

Limitations on outpatient care

The term "outpatient" refers to care obtained in the outpatient department of a hospital as well as for outside services. Almost nine-tenths of the participants in non-HMO health plans received some outpatient mental health care as a major medical benefit. Two-thirds of these participants were in major medical plans which imposed limitations on days or dollar amounts for such treatment, but not for other care. (See table 3.) The most common limitations for mental health were: a maximum dollar amount per year, frequently $1,000; a maximum dollar amount per day of care, usually $10, $20, or $30; and a maximum number of days of care per year, most often 50 days. Many plans imposed more than one of these limitations.

Coinsurance levels (the employer's share of expense) payable under major medical insurance benefits differed

Table 2. Percent of full-time participants in non-HMO plans by maximum number of hospital room and board days for mental health care, medium and large firms, 1985

Limitation on inpatient care	Percent of participants
Total	100
Same number of days as other illnesses	41
Maximum days per illness	39
Fewer than 30	(1)
30–60	3
70	2
90–119	1
120	7
125–364	(1)
365	24
More than 365	2
Other[2]	3
Fewer days than other illnesses	59
Maximum days per illness	30
Fewer than 30	(1)
30	10
31	1
45	12
60	1
61–119	3
120	3
Maximum days per year	26
20	1
30	11
31–44	1
45	2
50	(1)
60	7
61–119	1
120	3
More than 120	1
Other[3]	4

[1] Less than 0.5 percent.
[2] Includes participants in plans where the maximum number of days applied to a specified time period such as 1 year.
[3] Includes participants in plans where the maximum number of days was on a lifetime basis or a specified time period other than 1 year.

NOTE: Because of rounding, sums of individual percents may not equal totals.

Table 3. Percent of full-time participants in non-HMO plans with major medical coverage for outpatient mental health care by special limitations, medium and large firms, 1985[1]

Coverage and limitations	Percent of participants
Total	100
Covered without special limitations on days or dollars for outpatient mental health care	33
Covered with special limitations on days or dollars for outpatient mental health care[2]	67
Days per year	22
Less than 50	3
50	14
52	6
More than 52	1
Dollar amount per day	30
$10	5
$11–$14	1
$15	3
$20	7
$21–$24	(3)
$25	4
$26–$29	(3)
$30	5
$31–$39	1
$40	4
More than $40	1
Dollar amount per year	39
$250	(3)
$500	5
$501–$749	1
$750	2
$751–$999	(3)
$1,000	15
$1,001–$1,499	2
$1,500	5
$2,000	4
$2,001–$3,000	3
More than $3,000	1
Dollar amount per lifetime	9
Less than $10,000	1
$10,000	1
$15,000	2
$20,000	1
$20,001–$49,999	2
$50,000	1
More than $50,000	(3)
Other limitations	(3)

[1] Excludes plans where outpatient limits are combined with room and board limits.
[2] The total is less than the sum of the individual items because many plans had more than one type of limitation.
[3] Less than 0.5 percent.

NOTE: Because of rounding, sums of individual percents may not equal totals.

between outpatient mental health care and other outpatient services. Where major medical plans provided mental health care, 8 of 10 participants had the same coinsurance requirements for hospitalization for treatment of mental illness as for other illnesses. (See table 4.) However, only one-fifth of these participants were eligible for outpatient mental health care at the same coinsurance rate as other types of care. Plans commonly paid 50 percent of outpatient mental health care expenses, in contrast to the 80 percent for nonpsychiatric ailments typically reported by the employee benefit survey.

Although most plans paid the same coinsurance rate for mental health care in general hospitals as for other illnesses, some plans had stop-loss provisions for other ailments but

Table 4. Percent of full-time participants in non-HMO plans with major medical coverage for mental health care by coinsurance provisions, hospital care and outpatient care, medium and large firms, 1985

Coinsurance provision for mental health care	Care in a general hospital	Outpatient care
Total participants in percent	100	100
Coinsurance same as for other major medical expenses	82	20
80 percent	71	17
With stop-loss[1]	55	12
Without stop-loss	16	6
85 percent	4	1
With stop-loss[1]	4	1
Without stop-loss	–	–
90 percent	3	1
With stop-loss[1]	2	1
Without stop-loss	1	(3)
Other fixed percentage	3	(3)
With stop-loss[1]	2	(3)
Without stop-loss	2	(3)
Variable coinsurance[2]	1	(3)
Coinsurance more restrictive than for other major medical expenses	18	81
50 percent	3	66
With stop-loss[1]	(3)	3
Without stop-loss	3	63
80 percent	11	6
With stop-loss[1]	4	–
Without stop-loss	7	6
Other fixed percentage	3	4
With stop-loss[1]	2	(3)
Without stop-loss	1	4
Variable coinsurance[2]	1	3
Coinsurance varies by days	1	2
Total with stop-loss	70	17
Total without stop-loss	30	83

[1] After individual incurs a specified amount of expenses, the plan pays the remaining expenses at 100 percent.
[2] After individual incurs a specified amount of expenses, the plan pays the remaining expenses at a different percent which is less than 100.
[3] Less than 0.5 percent.

NOTE: Because of rounding, sums of individual percents may not equal totals. A dash indicates no participants in the category.

not for mental illnesses. Participants in these plans are considered as having "more restrictive" coinsurance provisions. (See table 4.)

Stop-loss provisions (limitations on out-of-pocket employee expenses) also differed for outpatient mental health care compared to care for other illnesses. Seven-tenths of the participants in non-HMO plans had stop-loss coverage for mental health care in the hospital, but less than two-tenths had stop-loss coverage for outpatient care expenses. (See table 4.) Outpatient expenses, with a typical coinsurance rate of 50 percent, would cause the employees to reach their plan's stop-loss limit very quickly if such expenses were included.

Similarly, HMO plans usually placed stricter limits on outpatient mental health care. These plans limited coverage to 20 days per year but rarely had day limits on outpatient care for other illnesses. In addition, more than one-half of the HMO plans studied required copayments (typically $2 to $25 per visit) for each day of care. Some HMO plans varied the amount of copayment during a year. However, lifetime dollar maximums on benefits were rare.

Lifetime maximum payments

Major medical coverage usually imposes a lifetime ceiling on payments made by the plan for all insured benefits, including those for mental health care. But 1 of 5 plan participants covered by the survey also was subject to a separate lifetime limit on mental health expenses. The following tabulation shows these separate limits:

Limit on mental health expenses	*Percent of participants*
Total	100
Without a separate lifetime dollar maximum	80
With a separate lifetime dollar maximum	20
Less than $10,000	*
$10,000	4
$10,001 – $19,999	*
$20,000	2
$25,000	5
$30,000 – $49,000	1
$50,000	6
More than $50,000	3

*Under 0.5 percent.

Most of the major medical plans with a separate lifetime limit for mental health care also had lifetime maximums for all covered expenses, ranging from $250,000 to $1 million. In such cases, mental health expenses drew against the overall lifetime limit. Moreover, there was no correlation between the two limits as overall maximums ranged from twice to 200 times the mental health limit. Finally, major medical plans frequently have a provision which restores lifetime maximums by up to $1,000 at the end of a calendar year; such provisions do not always apply to separate lifetime maximums for mental health care. □

——*FOOTNOTES*——

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[1] Sam Muszynski, Jo Brady, and Steven S. Sharfstein, M.D., comps. *Coverage for Mental and Nervous Disorders: Summaries of 300 Private Sector Health Insurance Plans* (Washington, American Psychiatric Press, Inc., 1983), ch. 2.

[2] Jerry S. Rosenbloom and G. Victor Hallman, *Employee Benefit Planning* (Englewood Cliffs, NJ, Prentice Hall, Inc., 1986), pp. 134–35. For a contrary view, see *Trends in Health Insurance Coverage for Mental Illness* (Washington, The National Association of Private Psychiatric Hospitals, 1986); John C. Garner, "Consider Outpatient Mental Benefits," *Business Insurance*, Dec. 23, 1985, p. 39; and Jeffrey A. Buck, "Should Mental Health Care Services Be Structured Like Medical Care?" *Inquiry*, Fall 1982, pp. 211–21.

[3] This study is part of a series of annual surveys conducted in private sector establishments in the United States, excluding Alaska and Hawaii, employing at least 50, 100 or 250 workers, depending on the industry. Industrial coverage includes mining; construction; manufacturing; transportation, communications, electric, gas, and sanitary services; wholesale

trade; retail trade; finance, insurance, and real estate; and selected services. Major findings for 1985 are reported in *Employee Benefits in Medium and Large Firms, 1985*, Bulletin 2262 (Bureau of Labor Statistics, 1986). For information on the background and conduct of the survey, see Robert Frumkin and William Wiatrowski, "Bureau of Labor Statistics takes a new look at employee benefits," *Monthly Labor Review*, August 1982, pp. 41–45.

[4] Herman M. Somers and Anne R. Somers, *Doctors, Patients, and Health Insurance* (Washington, The Brookings Institution, 1961), p. 389.

[5] American Hospital Association, *Financing Mental Health Care in the United States* (U.S. Department of Health, Education, and Welfare, National Institute of Mental Health, 1973), p. 100.

[6] Muszynski and others, *Coverage for Mental and Nervous Disorders*, pp. 9–11. For additional background see Joseph F. Follman, Jr., *Insurance Coverage for Mental Illness* (New York, American Management Associations, Inc., 1970); Charles P. Hall, "Financing Mental Health Services Through Insurance," *American Journal of Psychiatry*, October 1974, pp. 1079–88; and Louis S. Reed, Evelyn S. Meyers, and Patricia A. Scheidenmandel, *Health Insurance and Psychiatric Care: Utilization and Cost* (Washington, American Psychiatric Association, 1972).

[7] *Coinsurance* refers to the ratio in which the participant and the insurer share health care expenses resulting from an illness or injury. *Major medical* plans cover many categories of health care and usually have both coinsurance and deductible provisions. A *deductible* is a specified amount of medical expense that a participant must pay before benefits will be paid by the plan. A *stop-loss* provision limits the participant's out-of-pocket expense by increasing the coinsurance percentage paid by the plan to 100 percent, after the participant has incurred a specified level of expense.

[8] For most of the remaining one-half of participants, hospitalization for mental health care was covered under major medical benefits. While these plans did not directly limit the days of room and board covered, they did impose indirect limits through the application of deductible, coinsurance, and maximum lifetime dollar payment provisions.

[9] A Health Maintenance Organization is a prepaid health care plan that delivers comprehensive medical services to enrolled members for a fixed periodic fee. For a detailed analysis of how HMO's cover mental health care, see Allan P. Blostin and William Marclay, "HMOs and other health plans: coverage and employee premiums," *Monthly Labor Review*, June 1983, pp. 29–31.

[10] Blostin and Marclay, p. 28.

The protected work environment

One reason why internal labor markets are created by company policy or union agreements is that the industry depends a great deal on informal, on-the-job training in which a new worker is taught by supervisors or fellow workers. Workers are often unwilling to teach a new worker the skills they have learned, for fear that once a young and strong worker acquires the skill, he or she may become more productive than older workers and may displace them. Acquiring a skill by watching and learning from experienced workers has been called "stealing the job." To encourage older workers to train new workers, the company has to give them assurance that their jobs are protected. Thus, a structured, protected internal labor market with rules and due process is developed.

—*Using Labor Market Information in Career Exploration and Decision Making: A Resource Guide* (Garrett Park, MD, Garrett Park Press, 1986), p. 64.