MEMORANDUM

To: Interested Parties

From: Jennifer Bowman and Stuart Hagen (Health and Human Resources Division)

Date: May 22, 2002

Re: CBO's estimate of S. 543, The Mental Health Equitable Treatment Act of 2001

The purpose of this memorandum is to clarify whether CBO's cost estimate for S. 543, released on August 22, 2001, is consistent with the committee report (S. Rept. 107-61) or, alternatively, interpreted the legislation as allowing the exclusion of specific illnesses or categories of illnesses. The Committee Report states that "the reported bill reflects the agreement of the committee and the intent of the sponsors to require the coverage of services for all mental illnesses listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders [DSM] with the exception of substance abuse and chemical dependency. While the bill does not require a plan... to provide any mental health benefits, it prohibits insurers to limit coverage on the basis of a mental health diagnosis. That is, the bill does not allow insurers to choose specific illnesses or categories of illnesses in the DSM to exclude from coverage... Thus, while S. 543 allows a plan to exclude a specific mental health service... it does not allow a plan to exclude a specific mental illness, disorder, or diagnosis if it is listed in the DSM..."

CBO's estimate of S. 543 assumed that the bill's language requires affected group health plans to cover all illnesses listed in the most recent edition of the DSM. This interpretation is consistent with the language in the committee report. In estimating the cost to private group health plans of complying with S. 543, CBO used claims data of health plan enrollees that are representative of the private health insurance market in terms of their demand for and utilization of mental health services. The health plan benefits of those enrollees did not exclude any mental diseases from coverage.

Almost all of the increase in health plan costs associated with mental health parity is due to increases in payments for plan enrollees suffering from severe mental illness. Covering or not covering various non-severe mental illnesses would not have a significant impact on costs. Thus, the question of whether S. 543 requires plans to cover all conditions in the most recent edition of the DSM has little effect on the estimate of the cost of complying with the mental health parity provision. The more important issue for estimating costs is whether the bill requires plans to cover services that are not medically necessary, or to cover new services that they did not previously cover. CBO concluded that, under the bill, plans would retain the ability to use exclusions of specific services, as well as medical necessity and other cost management techniques, for the following reasons:

- S. 543 does not prevent a group health plan or health insurance issuer from using medical management of mental health benefits, including concurrent and retrospective utilization

review and utilization management, and the application of medical necessity and appropriateness criteria.

- One of the criteria in the DSM for establishing a diagnosis requires a clinician to determine a specific level of functional impairment that results from the mental health condition. Under typical utilization management of mental health benefits, patients who had a mental health condition that was not serious enough to cause the level of functional impairment listed in the DSM would not meet diagnostic criteria for the condition. Claims associated with treatment for those conditions could be excluded on the basis of medical necessity.

- The bill defines mental health benefits as including "benefits with respect to services, as defined under the terms and conditions of the plan or coverage..., for all categories of mental health conditions listed in the DSM..." The bill does not require plans to provide coverage of all potential services that could be used to treat a particular condition; it only requires plans to cover those services that are part of an authorized treatment plan and are medically necessary – provided that comparable criteria are used for determining whether mental health and medical and surgical services are medically necessary and appropriate.