

November 2011

# MENTAL HEALTH AND SUBSTANCE USE

## Employers' Insurance Coverage Maintained or Enhanced Since Parity Act, but Effect of Coverage on Enrollees Varied

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Highlights of [GAO-12-63](#), a report to congressional committees

## Why GAO Did This Study

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that employers who offer health insurance coverage for mental health conditions and substance use disorders (MH/SU) provide coverage that is no more restrictive than that offered for medical and surgical conditions. Employers were required to comply with the law for coverage that began on or after October 3, 2009. The Department of Labor (DOL), the Department of Health and Human Services (HHS), and the Department of the Treasury share oversight for MHPAEA. MHPAEA also requires GAO to examine trends in health insurance coverage of MH/SU.

This report describes (1) the extent to which employers cover MH/SU through private health insurance plans, and how this coverage has changed since 2008; and (2) what is known about the effect of health insurance coverage for MH/SU on enrollees' health care expenditures; access to, or use of, MH/SU services; and health status. GAO surveyed a random sample of employers about their MH/SU coverage for the most current plan year and for 2008. GAO received usable responses from 168 employers—a 24 percent response rate. The survey results are not generalizable; rather, they provide information limited to responding employers' MH/SU coverage. GAO reviewed published national employer surveys on health insurance coverage and interviewed officials from DOL, HHS, and other experts. GAO also reviewed studies that evaluated the effect of MH/SU coverage on enrollees' expenditures, access to, or use of, MH/SU services, and health status.

View [GAO-12-63](#) or key components. For more information, contact John E. Dicken at (202) 512-7114 or [dickenj@gao.gov](mailto:dickenj@gao.gov).

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### Employers' Insurance Coverage Maintained or Enhanced Since Parity Act, but Effect of Coverage on Enrollees Varied

## What GAO Found

Most employers continued to offer coverage of MH/SU since MHPAEA was passed. Of the employers that responded to GAO's survey, 96 percent offered coverage of MH/SU for the current plan year and for 2008, before MHPAEA was passed. Approximately 2 percent of employers reported offering coverage for only mental health conditions but not substance use disorders for the current plan year and for 2008. Conversely, about 2 percent of employers reported discontinuing their coverage of both MH/SU or only substance use disorders in the current plan year. The types of MH/SU diagnoses included and excluded in employers' MH/SU benefits remained consistent between the current plan year and 2008. Of the employers who provided information about diagnoses included in their MH/SU benefits for both the current plan year and 2008, 34 percent reported that their most popular plan in the current plan year excluded at least one MH/SU diagnosis from their benefits, and 39 percent of employers reported excluding at least one MH/SU diagnosis from their benefits for the 2008 plan year. The most common change to MH/SU benefits reported among those who responded to the survey was enhancing benefits through the removal of treatment limitations, such as the number of allowed office visits. Reported use of lifetime dollar limits on MH/SU treatments also declined from 2008 to the current plan year. Among employers who reported information on cost-sharing, copayments and coinsurance amounts for in-network providers generally stayed about the same, fluctuating minimally from 2008 to the current plan year. Published national employer surveys on health insurance coverage also reported results consistent with GAO's survey data. Employers may continue to modify certain nonfinancial requirements—such as changes to the services they cover (the scope of services) and nonquantitative treatment limits—in their MH/SU benefits in response to agencies' issuance of final implementing regulations for MHPAEA. Officials from DOL and HHS reported that the final regulations may provide additional detail on these nonfinancial requirements.

Research suggests that coverage for MH/SU has a varied effect on enrollees. Research examining the effect of health insurance coverage for MH/SU on enrollee expenditures generally found that the implementation of parity requirements reduced enrollee expenditures. Studies that examined the effect of health insurance coverage for MH/SU on enrollee access to, and use of, MH/SU services had mixed results, with some studies indicating there was little to no effect and others indicating that there was some effect—such as finding that restricting coverage had a negative effect on use of services. Little research has explored the relationship between health insurance coverage and health status. Of the studies we reviewed, two examined the effect of health insurance coverage for MH/SU on enrollee health status and found different effects.

GAO provided a draft of the report to DOL and HHS. Both agencies provided technical comments, which have been incorporated as appropriate.

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## Abbreviations

ASPE	The Assistant Secretary for Planning and Evaluation
DOL	Department of Labor
FEHBP	Federal Employees Health Benefits Program
HHS	Department of Health and Human Services
IFR	Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
Kaiser/HRET	Kaiser Family Foundation and Health Research and Educational Trust
MBHO	managed behavioral health organization
MHPAEA	Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
MH/SU	mental health conditions and substance use disorders
NQTL	nonquantitative treatment limitation
SPD	summary plan document

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November 30, 2011

### Congressional Committees

An estimated 26 percent of American adults suffer from some type of mental health condition each year, with about 6 percent of them suffering from a severe mental health condition such as schizophrenia or major depression.<sup>1</sup> An estimated 9 percent of Americans 12 or older were classified with a substance use disorder in 2010.<sup>2</sup> In 2008, 13 percent of American adults received mental health treatment services. For those adults with a severe mental health condition, just over half—59 percent—received mental health treatment services.<sup>3</sup> When mental health conditions are left untreated, they are more likely to result in hospitalizations. In 2006, one in five hospitalizations in the United States included a mental health condition either as a primary or secondary diagnosis.<sup>4</sup> Similarly, when substance use disorders are inadequately treated, they can complicate care for costly medical conditions, such as diabetes.

Historically, employer-sponsored health care coverage offered through private health insurance plans has typically provided lower levels of coverage for the treatment of mental health conditions and substance use disorders (MH/SU) than for the treatment of medical and surgical conditions (medical/surgical). Consequently, patients with MH/SU may not have received timely or sufficient treatment, or may have incurred high out-of-pocket costs. From 2007 to 2010, about 38 percent of Americans 12 or older who needed treatment for substance use disorders

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<sup>1</sup>National Institute of Mental Health, “Statistics: Any Disorder In Adults Among Adults,” NIMH Statistics (Bethesda, Md.: July 29, 2010), accessed September 14, 2011, [http://nimh.nih.gov/statistics/1ANYDIS\\_ADULT.shtml](http://nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml).

<sup>2</sup>Substance Abuse and Mental Health Services Administration, *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658 (Rockville, Md.: September 2011).

<sup>3</sup>NIMH, “Use of Mental Health Services and Treatment Among Adults,” NIMH Statistics (Bethesda, Md.: July 29, 2010), accessed September 7, 2011, [www.nimh.nih.gov/statistics/3USE\\_MT\\_ADULT.shtml](http://www.nimh.nih.gov/statistics/3USE_MT_ADULT.shtml).

<sup>4</sup>Agency for Healthcare Research and Quality, “Hospital Stays Related to Mental Health, 2006,” *Healthcare Cost and Utilization Project Statistical Brief #62* (Rockville, Md.: October 2008).

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did not receive treatment because of a lack of coverage, and could not afford the cost without coverage.<sup>5</sup>

To help address the discrepancies in health care coverage between MH/SU and medical/surgical, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).<sup>6</sup> The Department of Labor (DOL), the Department of Health and Human Services (HHS), and the Department of the Treasury (Treasury) share joint oversight responsibilities for MHPAEA and for issuing implementing regulations. Under MHPAEA, group health plan sponsors, including employers, must ensure that coverage of MH/SU be no more restrictive than coverage for medical/surgical.<sup>7</sup> Specifically, employers that choose to cover MH/SU must provide coverage equivalent to that offered for medical/surgical with respect to annual and lifetime dollar limits, financial requirements such as copayments, treatment limitations such as the number of covered outpatient office visits or hospital days, and the availability of in- and out-of-network providers. For

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<sup>5</sup>Substance Abuse and Mental Health Services Administration, *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658 (Rockville, Md.: September 2011).

<sup>6</sup>Pub. L. No. 110-343, Div. C, Tit. V, Sub. B, §§ 511-512, 122 Stat. 3765, 3881-3893 (Oct. 3, 2008). MHPAEA, passed as part of the Emergency Economic Stabilization Act of 2008, expands the parity requirements established by the Mental Health Parity Act of 1996 (Pub. L. No. 104-204, Tit. VII, §§ 701-702, 100 Stat. 2874, 2944-2950 (Sept. 26, 1996)), the first federal mental health parity law, which required parity in annual and aggregate lifetime dollar limits. MHPAEA expanded the 1996 federal parity requirements to include parity more broadly in financial requirements (including cost-sharing requirements), treatment limitations, and in- and out-of-network covered benefits. MHPAEA also requires parity for substance use disorder benefits.

<sup>7</sup>Generally, MHPAEA requires that financial requirements and treatment limitations imposed on MH/SU cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. MHPAEA also applies to Medicaid managed care, Children's Health Insurance Programs, and certain plans sponsored by state and local governments. Employers with 50 or fewer employees are exempt from the law. MHPAEA does not apply to individual health insurance plans. In addition, each year employers sponsoring group health plans can file for a 1-year exemption from MHPAEA requirements if the health plan's total costs—medical/surgical and MH/SU combined—increase by at least 1 percent (2 percent in the first year of implementing parity) and if those costs are solely attributable to parity. Since the legislation applies to group health plans and group health plans are primarily offered by employers, this report focuses on group health plans—or health insurance coverage offered in connection with such a plan—sponsored by employers. We therefore refer to group health plan sponsors responsible for compliance with MHPAEA as employers.

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employers that choose to cover MH/SU, MHPAEA does not require coverage of specific diagnoses.

MHPAEA also requires us to examine trends in coverage for MH/SU. For this study, we report on: (1) the extent to which employers cover MH/SU through private health insurance plans, and how this coverage has changed since MHPAEA was passed in 2008; and (2) what is known about the effect of health insurance coverage for MH/SU on enrollees' health care expenditures; access to, or use of, MH/SU services; and health status.

To determine the extent to which employers cover MH/SU both currently and in 2008, we surveyed a stratified random sample of small, medium, large, and very large employers about their most popular health plans for the most current plan year—either 2011 or 2010—as well as for 2008. We conducted a survey of employers because we were unable to identify a published national employer survey that included specific detailed information about employers' MH/SU benefits prior to and following MHPAEA—namely, information about diagnoses included in or excluded from coverage. We fielded our web-based survey between May 18, 2011, and July 1, 2011, to 707 employers, selected from the sampling frame we developed using the Lexis Nexis corporate database.<sup>8</sup> We received usable responses from 168 employers, after following up with nonrespondents to encourage their participation, for a 24 percent response rate. All 168 employers offered coverage of mental health conditions, substance use disorders, or both, in either the current plan year, 2008 plan year, or both plan years. Of the 168 employers that provided usable survey responses, a subset of employers answered at least one detailed benefits question for only one plan year—the current plan year or the 2008 plan year. As a result, the denominator for our calculations varied depending on the question we analyzed. Given our overall response rate of 24 percent, our survey results are not generalizable. Rather, the survey responses provide information limited to responding employers' coverage of MH/SU in the current plan year and

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<sup>8</sup>To develop our sampling frame, we used the Dossier function of the Lexis Nexis corporate database to select 32,431 U.S.-based companies on January 18, 2011. We selected privately held and publicly traded parent companies with between 51 to 100,000 employees that were headquartered in the United States. We drew our random sample of employers from this sampling frame. We excluded employers from our survey that had 50 or fewer employees because MHPAEA did not apply to them.

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2008 plan year. We did not verify the accuracy of the employers' responses or assess compliance with MHPAEA.

To supplement the data collected from our survey, we reviewed the results of published national employer surveys from the Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET) and Mercer. These surveys provided generalizable information on employers' coverage of MH/SU. We also conducted interviews with agency officials from DOL and HHS who had expertise in MH/SU issues, as well as with other experts, to learn about the implementation of MHPAEA and trends in employers' coverage of MH/SU. We did not interview Treasury officials because the focus of this engagement did not relate to that agency's scope of responsibility. Lastly, we conducted detailed interviews with a nongeneralizable sample of four employer survey respondents to obtain more detailed information about the employers' coverage of MH/SU, and their reasons for making or not making changes to coverage after MHPAEA took effect.<sup>9</sup>

To describe what is known about the effect of health insurance coverage for MH/SU on enrollees' health care expenditures, access to, or use of, MH/SU services, and health status, we conducted a literature review of peer-reviewed journals and other periodicals published between January 1, 2000, and March 11, 2011. We also included articles in our literature review that were suggested to us by the experts we interviewed, as well as studies that were referenced in the articles found during our initial search. In total, we reviewed 34 studies as part of our literature review.

Appendix I provides more details about our scope and methodology. Appendix II provides a list of articles we reviewed as part of our literature review.

We conducted our work from December 2010 to September 2011 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We

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<sup>9</sup>Unless otherwise specified, these studies examined the effect of health insurance coverage for MH/SU in general and were not specific to examining the effects of federal or state parity laws, including MHPAEA.



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believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings in this product.

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## Background

Most Americans obtain their health insurance coverage through the workplace. Employers typically offer health insurance coverage for employees on an annual basis through one or more health plans. Each plan year, employers can decide how many health plans to offer, whether to include coverage for MH/SU in the health plans offered, and what type of benefits<sup>10</sup> those plans can include as part of their coverage.<sup>11,12</sup> Additionally, employers may determine if their plans' MH/SU benefits will be managed by the same health insurer that manages their medical/surgical benefits, or if they will be managed by a separate organization that specializes in MH/SU benefits—known as a managed behavioral health organization (MBHO).

Health insurance benefits commonly include cost-sharing provisions requiring enrollees to pay for a portion of their health care. These provisions can be applied to both MH/SU and medical/surgical benefits, and include:

- **Deductibles:** Required payments of a specified amount made by enrollees for services before the health insurer begins to pay.
- **Copayments:** Payments made by enrollees of a specified flat dollar amount, usually on a per-unit-of-service basis, with the health insurer

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<sup>10</sup>Benefits are provisions or services included in a health insurance plan's coverage.

<sup>11</sup>A plan year refers to the 12-month period during which yearly plan design features such as the deductible, out-of-pocket maximum, and specific benefit maximums accumulate. A plan year is often, but not always, January 1 through December 31.

<sup>12</sup>Within the coverage of MH/SU that employers may offer, the types of MH/SU treatment services and the settings in which MH/SU treatment services are provided vary widely, so that a patient may receive care appropriate to the severity of the symptoms. Types of MH/SU services can include: counseling, case management, partial hospitalization, inpatient treatment, vocational rehabilitation, and a variety of residential programs. MH/SU treatment may also include prescription drugs. In addition, patients with acute symptoms may be treated by personnel in emergency rooms and hospital units, and by MH/SU crisis and outreach specialists. Patients with more subacute symptoms are treated by personnel in hospitals, day treatment programs, mental health center programs, and by different types of individual practitioners. Patients with long-term symptoms are often treated in mental health centers, residential units, and practitioners' offices.

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reimbursing some portion of the remaining charges. The payment is made after the deductible is met and until the out-of-pocket expense maximum is reached—that is, the maximum amount that enrollees have to pay per year for all covered medical expenses.

- **Coinsurance:** A percentage payment made by enrollees after the deductible is met and until the out-of-pocket expense maximum is reached.

Prior to the implementation of MHPAEA, private health insurance plans offered through employers that covered MH/SU typically provided lower levels of coverage for the treatment of these illnesses than for the treatment of physical illnesses.<sup>13</sup> Employers often limited the coverage of MH/SU through the use of plan design features that were more restrictive for MH/SU benefits than for medical/surgical benefits. Prior to MHPAEA, MH/SU benefits were commonly subject to higher cost-sharing features such as deductibles, copayments, or coinsurance; more restrictive treatment limitations such as the number of covered hospital days or outpatient office visits; and limited out-of-network providers.<sup>14</sup> Also, there were concerns that employers would limit the MH/SU treatment enrollees could receive by excluding specific MH/SU diagnoses, such as eating disorders, from their benefits.

For example, prior to MHPAEA, an employer's plan could cover unlimited hospital days and outpatient office visits and require 20 percent coinsurance for outpatient office visits for medical/surgical treatment while, for MH/SU, that same plan could cover only 30 hospital days and 20 outpatient office visits per year and impose 50 percent coinsurance for outpatient office visits. Additionally, an employer's plan might limit the MH/SU diagnoses for which treatment was covered.

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<sup>13</sup>The Mental Health Parity Act of 1996 established requirements with respect to lifetime and annual limits that were later supplemented by MHPAEA, enacted in 2008. This report focuses on MHPAEA's effects on parity and coverage.

<sup>14</sup>Out-of-network providers are providers not included in a group of designated providers with whom the plan has an agreement to provide care to enrollees—called in-network providers. Enrollees' costs are generally lower if they obtain care from in-network providers, rather than out-of-network providers.

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Employers provided more limited coverage of MH/SU prior to MHPAEA primarily because of concerns about the cost of providing coverage for individuals with MH/SU.<sup>15</sup> Concerns about the high costs associated with long-term, intensive psychotherapy and extended hospital stays, particularly for some diagnoses such as schizophrenia or major depression, could have prompted employers to impose treatment limitations on outpatient office visits and hospital days, and limits on annual or lifetime dollar amounts for treatment of MH/SU.

To help address the discrepancies in health care coverage between mental illnesses and physical illnesses, Congress passed MHPAEA which strengthened federal parity requirements.<sup>16</sup> MHPAEA requires that coverage terms for MH/SU—when those services are offered—be no more restrictive than coverage terms for medical/surgical services.

Under MHPAEA, employers are not required to offer MH/SU coverage. However, those plans that do offer mental health or substance use disorder coverage were required to comply with MHPAEA's parity requirements for their health plan year that began on or after October 3, 2009.<sup>17</sup>

On February 2, 2010, DOL, HHS, and Treasury issued the *Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (IFR), which contain provisions regarding coverage of MH/SU as a result of MHPAEA.<sup>18</sup> The provisions in the IFR, which employers had to implement for the plan year beginning on or after July 1, 2010, address various aspects of implementing parity

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<sup>15</sup>See GAO, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited*, [GAO/HEHS-00-95](#) (Washington, D.C.: May 10, 2000).

<sup>16</sup>States may also pass laws requiring that mental health coverage sold in the state be offered on par with medical/surgical, and these requirements may be more stringent than those required by federal law. According to the National Conference of State Legislatures, state parity laws regulating mental health coverage have been passed in 49 states and the District of Columbia as of May 2011. See National Conference of State Legislatures, "State Laws Mandating or Regulating Mental Health Benefits" (Washington, D.C.: May 2011), accessed June 13, 2011, <http://www.ncsl.org/default.aspx?tabid=14352>.

<sup>17</sup>Beginning in 2014, certain health plans will be required to offer MH/SU coverage as part of the Patient Protection and Affordable Care Act's essential health benefits requirements.

<sup>18</sup>75 *Fed. Reg.* 5410 (Feb. 2, 2010).

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for coverage of MH/SU, including classifications of benefits and nonquantitative treatment limitations (NQTL).

The IFR specifies six classifications of benefits within which parity must be applied: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs. The IFR further specifies that plans choosing to cover MH/SU benefits must offer the MH/SU benefits within any one classification when medical/surgical benefits are offered at that same classification. Thus, for plans that cover MH/SU benefits, if medical/surgical services are covered for in-patient, out-of-network care, the plan must also cover MH/SU services for in-patient, out-of-network care.

An NQTL is a treatment limitation that is not expressed numerically but still limits the scope or duration of benefits for treatment under a health plan.<sup>19</sup> Examples of NQTLs, some of which are noted in the IFR include: standards for provider admission to participate in a network; plan methods for determining usual, customary, and reasonable charges; pre-authorization of services; and utilization review.<sup>20</sup> The IFR stipulates that employers must ensure that NQTLs are comparable across benefit classifications. Generally, if an NQTL is used for MH/SU services within a classification, it is to be applied no more stringently than an NQTL for medical/surgical services within that same classification.<sup>21</sup>

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<sup>19</sup>Conversely, quantitative treatment limitations are expressed numerically and include number of covered outpatient office visits or hospital days.

<sup>20</sup>Pre-authorization of services is the requirement that an enrollee receives prior approval for care. Utilization review is the evaluation of the use of hospital services, including the appropriateness of the admission, length of stay, and ancillary services.

<sup>21</sup>However, this requirement allows variations to the extent that recognized clinically appropriate standards of care may permit a difference.

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## Employers Continued to Offer Coverage or Enhanced Benefits for Mental Health Conditions and Substance Use Disorders Since the Enactment of MHPAEA

Most employers that responded to our survey continued to offer coverage of MH/SU through private insurance plans following the implementation of MHPAEA. The types of diagnoses and treatments included in employers' MH/SU benefits remained largely unchanged, and some employers enhanced their MH/SU benefits by removing coverage limits as a result of MHPAEA requirements. After the issuance of the final regulations implementing MHPAEA, employers may make additional changes to their MH/SU benefits.

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## Most Employers Continued to Offer Coverage for Mental Health Conditions and Substance Use Disorders

Most employers that responded to our survey offered coverage of MH/SU both in their most current plan year—2011 or 2010—and in 2008, before MHPAEA was passed. Of the employers that responded to our survey about their coverage of MH/SU for both plan years, about 96 percent offered coverage for MH/SU for the current plan year and for 2008.<sup>22,23</sup> Approximately 2 percent of employers reported that they offered coverage for only mental health conditions in 2008 but not substance use disorders, and continued to offer coverage for only mental health conditions in the current plan year.

Conversely, a small percentage of employers—about 2 percent of those employers that responded to our survey about their coverage of MH/SU for both plan years—reported discontinuing their coverage of both MH/SU or only substance use disorders in the current plan year. One employer that discontinued offering coverage of mental health reported that it did so to control health insurance costs. Another employer reported that it ceased to offer coverage of substance use disorders because it did not want to cover these disorders without treatment limitations. Under

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<sup>22</sup>Of the 168 employers that provided usable responses to our survey, 160 employers responded to the survey question about offering MH/SU for the current plan year and for the 2008 plan year. The remaining 8 employers reported that they offered coverage for either MH/SU or for mental health conditions only for the current year and did not provide an answer about their coverage of MH/SU for the 2008 plan year.

<sup>23</sup>One employer that reported continuing to offer mental health coverage in the current plan year enhanced its coverage by adding substance use disorder coverage in the current plan year.

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MHPAEA, if substance use disorders are covered, any treatment limitations for the substance use benefits must be used on par with those used in medical/surgical benefits.

Published employer surveys also reported that few employers discontinued coverage of MH/SU since MHPAEA was passed. According to Kaiser/HRET's *Employer Health Benefits 2010 Annual Survey*, less than 2 percent of employers reported eliminating coverage for MH/SU as a result of MHPAEA.<sup>24</sup> Mercer reported in its *National Survey of Employer-Sponsored Health Plans* that the percentage of employers surveyed that reported offering coverage for MH/SU was consistent from 2008 to 2010. Specifically, about 90 percent of employers surveyed in 2008 and 92 percent of employers surveyed in 2010 reported offering coverage for MH/SU.<sup>25</sup> According to both Mercer's 2008 survey and 2010 survey, offering coverage of MH/SU was most common among employers with 500 or more employees, at about 97 percent. Additionally, about 90 percent of employers with fewer than 500 employees surveyed in 2008 and 92 percent of employers with fewer than 500 employees surveyed in 2010 indicated that they offered coverage for MH/SU.

Agency officials also told us that based on their review of trend data and information on employer's coverage of MH/SU, employers appeared to continue to offer coverage of MH/SU since MHPAEA was passed. In addition, representatives from large insurance companies, a health benefits consulting firm, and an MBHO told us that most employers with whom they interact continued to offer coverage of MH/SU since MHPAEA was passed. According to other health benefits experts, most employers they knew of generally experienced minimal challenges in complying with the MHPAEA requirements. Representatives from medium, large, and very large employers with whom we spoke told us that the process for making changes to their health plans to comply with MHPAEA was relatively easy for them because they relied on their insurance brokers or

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<sup>24</sup>Specifically, the survey found that of the 31 percent of employers that made changes to their mental health benefits as a result of MHPAEA, 5 percent reported eliminating coverage for MH/SU. See Kaiser Family Foundation and the Health Research & Educational Trust (Kaiser/HRET), *Employer Health Benefits 2010 Annual Survey*, September 2010.

<sup>25</sup>Mercer, *National Survey of Employer-Sponsored Health Plans: 2010 Survey Report* (New York, N.Y.: Mercer, LLC, 2011), and Mercer, *National Survey of Employer-Sponsored Health Plans: 2008 Survey Report* (New York, N.Y.: Mercer, LLC, 2009).

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health benefits consultants to inform them of the requirements and assist them in making necessary changes.

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**Diagnoses and Treatments Included in Benefits Remained Largely Unchanged and Some Employers Enhanced Benefits by Removing Coverage Limits**

Employers have not substantially changed the diagnoses and treatments that are included in their MH/SU benefits. However, fewer employers reported excluding at least one broad MH/SU diagnosis and more employers reported excluding a treatment related to MH/SU in the current plan year than for 2008. Some employers enhanced their MH/SU benefits by removing coverage limits and modifying cost-sharing for MH/SU in response to MHPAEA requirements.

**Diagnoses and Treatments**

The types of MH/SU diagnoses included and excluded from employers' MH/SU benefits remained consistent between the current plan year and 2008.<sup>26</sup> About 91 percent of employers that responded to the question in our survey about the diagnoses included in their MH/SU benefits for both the current plan year and 2008 plan year<sup>27</sup> reported their MH/SU benefits included the same broad diagnoses in their most popular health plan in the current plan year and in 2008. The other 9 percent of employers reported including more broad diagnoses in their MH/SU benefits for the current plan year than in the 2008 plan year. Most employers that provided information about diagnoses included in MH/SU benefits for both years reported that they included all types of broad mental health diagnoses in their MH/SU benefits for both plan years. Five of these broad diagnoses were covered by over 90 percent of employers for both the current plan year and 2008—mental disorders due to a general medical condition, substance-related disorders, schizophrenia and other psychotic disorders, mood disorders, and anxiety disorders (see fig. 1).



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<sup>26</sup>According to most employers that responded to our survey, the *Diagnostic and Statistical Manual of Mental Disorders* is considered to be the standard basis of their coverage for MH/SU. Experts also told us that the *Diagnostic and Statistical Manual of Mental Disorders* is the most commonly used basis of coverage for MH/SU. The *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, lists 16 broad diagnostic classes of MH/SU. Each of the 16 broad diagnostic classes are comprised of subcategories. An example of a broad diagnostic class would be Mood disorders, and a diagnosis subcategory within that class would be Depressive disorders.

<sup>27</sup>Of the 168 employers that provided usable responses to our survey, 67 employers responded to the survey question about which diagnoses were included in the MH/SU benefits for both the current plan year and 2008 plan year.

**Figure 1: Percentage of Employers Including Broad MH/SU Diagnoses in Their Most Popular Plan, 2008 Plan Year and Current Plan Year**

Diagnosis	2008 plan year	Current plan year
Disorders usually diagnosed in infancy, childhood, or adolescence	87%	88%
Delirium, dementia, and amnesic and other cognitive disorders	88%	93%
Mental disorders due to a general medical condition	93%	96%
Substance-related disorders	97%	97%
Schizophrenia and other psychotic disorders	94%	94%
Mood disorders	93%	91%
Anxiety disorders	97%	97%
Somatoform disorders	81%	82%
Factitious disorders	81%	81%
Dissociative disorders	85%	85%
Sexual and gender identify disorders	70%	70%
Eating disorders	88%	88%
Sleep disorders	87%	88%
Impulse-control disorders	82%	84%
Adjustment disorders	81%	81%
Personality disorders	84%	85%

 Less than 90 percent of employers included this diagnosis in their most popular plan  
 Ninety percent or more of employers included this diagnosis in their most popular plan

Source: GAO employer survey of mental health and substance use coverage.

Note: Of the 168 employers that provided usable responses to our survey, 67 employers responded to the survey question about which diagnoses were included in the MH/SU benefits for both the employer's 2008 plan year and current plan year—either 2011 or 2010.

Of the employers that responded to our survey question about the diagnoses included in their MH/SU benefits for both the current plan year and 2008 plan year,<sup>28</sup> 34 percent reported that their most popular plan in their current plan year excluded at least one broad MH/SU diagnosis from their benefits, and 39 percent reported this for the 2008 plan year.<sup>29</sup> Approximately 9 percent of employers that answered detailed benefits questions in our survey reported that their most popular plan for the

<sup>28</sup>Of the 168 employers that provided usable responses to our survey, 67 employers responded to the survey question about which diagnoses were included in the MH/SU benefits for both the current plan year and 2008 plan year.

<sup>29</sup>Our survey asked employers to select from a list of 16 broad diagnostic classes of MH/SU, those diagnostic classes for which the company covered treatment in the current plan year and 2008 plan year.



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current plan year excluded at least one specific mental health diagnosis subcategory within a broader mental health diagnosis and 2 percent excluded at least one specific substance use disorder subcategory. Similarly, approximately 10 percent reported excluding at least one specific mental health diagnosis subcategory and 2 percent excluded at least one specific substance use disorder subcategory for the 2008 plan year.<sup>30</sup> Examples of specific diagnosis subcategories excluded by our survey respondents included developmental disorders, learning disorders, mental retardation, sexual deviation and dysfunction, and relational disorders, such as marriage or family problems.

Similarly, according to Mercer's 2010 *National Survey of Employer-Sponsored Health Plans*, 1 percent of employers with 500 or more employees and less than 1 percent of employers with fewer than 500 employees reported excluding additional diagnoses from their MH/SU benefits as a result of MHPAEA. Representatives from a large health insurer, a health benefits consulting firm, an insurance broker organization, and an advocacy group also reported that employers with whom they interact generally included the same number and type of diagnoses in their MH/SU benefits for the current plan year as they did prior to MHPAEA's implementation.

In addition to exclusions of diagnoses, some employers also choose to exclude specific treatments from their MH/SU benefits. Of the employers that responded to the question in our survey about excluding a specific treatment for MH/SU, approximately 41 percent reported excluding a specific treatment for MH/SU from their most popular health plan in the current plan year, while 33 percent reported doing so for their most popular health plan in the 2008 plan year.<sup>31</sup>

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<sup>30</sup>Of the 168 employers that provided usable responses to our survey, 130 employers responded to the detailed benefits questions of the survey for the current plan year, and 123 employers responded to the detailed benefits questions of the survey for the 2008 plan year.

<sup>31</sup>Of the 168 employers that provided usable responses to our survey, 96 employers responded to the question about whether the most popular health plan for the current year excluded coverage for any specific treatments related to MH/SU, and 81 employers responded to this question for the 2008 plan year.

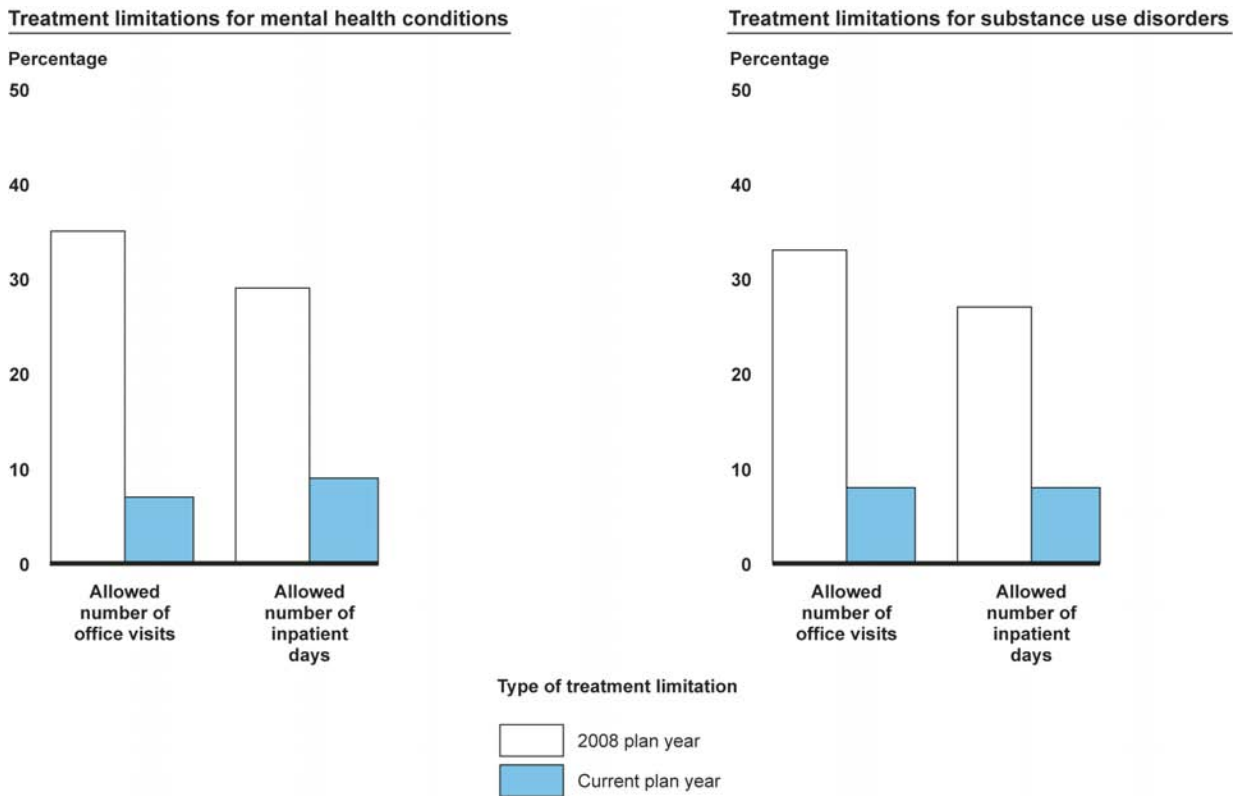
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According to representatives from an advocacy organization and an institution that conducts employer-based surveys on health insurance coverage, some employers choose to exclude specific treatments related to certain MH/SU diagnoses from their MH/SU benefits than to exclude the diagnosis itself. For example, representatives from an MBHO, a health benefits consulting firm, and an institution that conducts employer-based surveys on health insurance coverage told us that employers may exclude the treatment of “applied behavioral analysis” for autism, citing concerns about the treatment’s effectiveness, rather than excluding coverage for autism.

### Coverage Limits

The most common change to MH/SU benefits reported among those that responded to our survey was enhancing benefits through the removal of treatment limitations, such as the number of allowed office visits or inpatient days. About 7 percent of employers that answered detailed benefits questions in our survey reported limits on the number of allowed office visits for mental health conditions in the current plan year, compared to 35 percent in 2008; and 9 percent reported limits on the number of allowed inpatient days for treatment of mental health conditions, compared to 29 percent in 2008. Similarly, 8 percent of employers that answered detailed benefits questions in our survey reported limits on the number of allowed office visits for substance use disorders, compared to 33 percent in 2008; and 8 percent reported limits on the number of allowed inpatient days for treatment of substance use disorders, compared to 27 percent in 2008 (see fig. 2).

**Figure 2: Percentage of Employers Including Treatment Limitations for MH/SU in Their Most Popular Plan, 2008 Plan Year and Current Plan Year**



Source: GAO employer survey of mental health and substance use coverage.

Note: The calculations for the 2008 plan year are based on 123 employer responses and the calculations for the employer’s current plan year—either 2011 or 2010—are based on 130 employer responses.

Reported use of lifetime dollar limits on MH/SU treatments also declined from 2008 to the current plan year.<sup>32</sup> About 5 percent of employers that answered detailed benefits questions in our survey reported lifetime dollar

<sup>32</sup>Some of the reduction in lifetime dollar limits may be attributable to employers’ implementation of the Patient Protection and Affordable Care Act, which prohibits lifetime limits on the dollar value of essential health benefits, including MH/SU services for plan years beginning on or after September 23, 2010. The act also requires health insurers to phase-out annual limits on these benefits, including MH/SU benefits, starting with plan years beginning on or after September 23, 2010, with the elimination of annual limits occurring with plan years that begin on January 1, 2014.

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limits on treatments for MH/SU for the current plan year, compared to 20 percent in 2008.<sup>33</sup> Employers that reported lifetime dollar limits on mental health treatments for the current plan year generally told us that these limits applied to all treatments for MH/SU or that they applied to all treatments covered by the plan—including both MH/SU and medical/surgical.

Kaiser/HRET's *Employer Health Benefits 2010 Annual Survey* reported that of the 31 percent of employers surveyed that made changes in their mental health benefits as a result of MHPAEA, two-thirds of these employers reported eliminating coverage limits on mental health treatments, the most common change made by employers. Mercer's 2010 *National Survey of Employer-Sponsored Health Plans* also found that the elimination of treatment limitations and annual or lifetime dollar limits were common changes made by employers, reporting that 35 percent of employers with 500 or more employees and 15 percent of employers surveyed with fewer than 500 employees removed limits on the number of allowed office visits or dollar limits in response to parity requirements.

Several experts with whom we spoke told us that it was common for employers to eliminate treatment limitations and annual or lifetime dollar limits for MH/SU in response to parity requirements.<sup>34</sup> For example, representatives from an insurance broker organization and a trade association told us that employers with which they interacted removed limits on the number of allowed office visits for mental health conditions from their plans. A representative from a large insurance company told us that the employers with whom they work removed all limits on the number of allowed inpatient hospital days from plans to which MHPAEA applies, and a representative from an insurance broker organization also reported that employers with whom they consulted removed lifetime dollar limits on substance use disorders from their plans.

## Cost-Sharing

Among employers who reported information on cost-sharing, copayments and coinsurance amounts for office visits with in-network providers

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<sup>33</sup>Of the 168 employers that provided usable responses to our survey, 130 employers responded to the detailed benefits questions of the survey for the current plan year, and 123 employers responded to the detailed benefits questions of the survey for the 2008 plan year.

<sup>34</sup>Our study did not address employers' compliance with MHPA's lifetime and annual limit requirements.

generally stayed about the same, fluctuating minimally from 2008 to the current plan year, while copayments and coinsurance amounts for outpatient services with in-network providers decreased slightly from 2008 to the current plan year (see table 1).

**Table 1: Average Cost-Sharing for In-Network Office Visits and Outpatient Services in the 2008 Plan Year and in the Current Plan Year**

Response	Mental health conditions		Substance use disorders	
	2008	Current plan year	2008	Current plan year
Office visit copayment	\$25	\$26	\$25	\$27
Office visit coinsurance	21%	19%	22%	19%
Outpatient services copayment	\$39	\$33	\$39	\$33
Outpatient services coinsurance	24%	19%	26%	19%

Source: GAO employer survey of mental health and substance use coverage.

Note: The calculations for the 2008 plan year are based on 123 employer responses and the calculations for the employer's current plan year—either 2011 or 2010—are based on 130 employer responses.

Mercer's 2010 *National Survey of Employer-Sponsored Health Plans* found that 3 percent of employers surveyed decreased their cost-sharing requirements for MH/SU in response to MHPAEA, and larger employers were more likely to change their cost-sharing requirements than smaller employers. Specifically, according to Mercer, 20 percent of employers with 20,000 or more employees and 6 percent of employers with 500 to 999 employees reported decreasing their MH/SU copayments or coinsurance to comply with MHPAEA.

## Employers May Continue to Modify Benefits as Agencies Refine Parity Requirements

Employers may continue to modify certain nonfinancial requirements—such as changes to the services they cover (the scope of services)<sup>35</sup> and NQTLs—in their MH/SU benefits in response to agencies' issuance of final implementing regulations for MHPAEA. Agency officials reported that the final regulations may provide additional detail on the required scope of services and on using NQTLs.

<sup>35</sup>The scope of services—also known as the continuum of care—is the types of services that a plan offers to treat a condition.

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## Scope of Services

The IFR does not specifically address the scope of services offered within each classification of benefits,<sup>36</sup> and agency officials recognize that achieving parity in coverage is complicated by the fact that not all treatments or treatment settings for MH/SU correspond well to those for medical/surgical. Some commenters requested clarification about whether an employer would be required to cover a particular treatment or treatment setting for a mental health condition or substance use disorder that is otherwise covered in a plan, if benefits for the treatment or treatment settings are not provided for medical/surgical conditions—for example, counseling, an outpatient service used for treatment of MH/SU but not medical/surgical. As part of its issuance of the IFR, the agencies requested public comments on whether, and to what extent, the final regulations should address the scope of services provided by a group health plan or health insurance coverage. Agency officials from HHS’s Office of the Assistant Secretary for Planning and Evaluation (ASPE) and DOL are conducting research on the costs to employers that are associated with scope of services for MH/SU and intend to use the results to inform potential final regulations on the issue.

Experts reported that some employers are unclear what types of services for MH/SU they must offer within the IFR’s six classifications to be in compliance with MHPAEA and its implementing regulations. These employers may modify their MH/SU benefits in response to the final regulations.

## Nonquantitative Treatment Limitations

As part of the process of developing final regulations, DOL, HHS, and Treasury are researching NQTLs for MH/SU, including convening a panel of experts to discuss how health plans use NQTLs—for example, use of pre-authorization for MH/SU benefits within certain classifications, as compared to use of pre-authorization for medical/surgical benefits within the same classification. The agencies may use this research to provide more detailed guidelines on how NQTLs for MH/SU services can be used on par with NQTLs used for medical/surgical services. Currently, the IFR does not specify the steps employers can take to achieve parity with NQTLs across classifications for coverage of MH/SU and medical/surgical services. For example, the IFR generally requires that any processes or other factors used in applying the NQTLs should be “comparable to” and

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<sup>36</sup>The six classifications of benefits, as defined in the IFR, are (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

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used “no more stringently” for MH/SU benefits in a certain classification than they are for medical/surgical benefits at that same classification, but these qualitative terms may be interpreted or applied inconsistently by employers.<sup>37</sup>

A representative from an MBHO told us that the IFR requirements for NQTLs could be interpreted in different ways, and the MBHO has seen variation in how employers are applying NQTLs in their plans. Representatives from an advocacy group reported that, in some cases, employers appear to be applying NQTLs more stringently to MH/SU benefits than to medical/surgical benefits. For example, according to the advocacy group, some plans require pre-authorization for inpatient care for MH/SU services for every 2-day period the care is expected to be given, but require pre-authorization for inpatient services for medical/surgical benefits less frequently.<sup>38</sup> The final regulations, which will be informed by the agencies’ findings, may result in employers’ further modification of their use of NQTLs in their benefit packages in order to comply with any new or modified requirements.

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<sup>37</sup>Specifically, the IFR states that any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in a classification must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification except to the extent that recognized clinically appropriate standards of care may permit a difference. 75 *Fed. Reg.* 5410 (Feb. 2, 2010).

<sup>38</sup>Requiring more frequent pre-authorization can affect use of services. According to a study on the impact of pre-authorization on the use of mental health services, when an enrollee must obtain pre-authorization more frequently for outpatient mental health treatments, they are more likely to terminate treatment earlier. See X. Liu, et al., “The Impact of Prior Authorization on Outpatient Utilization in Managed Behavioral Health Plans,” *Medical Care Research and Review*, vol. 57, no. 2 (2000).

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## Research Suggests That Coverage for Mental Health Conditions and Substance Use Disorders Has a Varied Effect on Enrollees

Research indicates that enhanced coverage for MH/SU has generally led to reduced enrollee expenditures. Research also indicates that health insurance coverage for MH/SU has had mixed effects on access to, and use of, MH/SU services. In addition, little research has explored the effect of health insurance coverage for MH/SU on health status.

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## Research Indicates That Enhanced Health Insurance Coverage for Mental Health Conditions and Substance Use Disorders Reduces Enrollee Expenditures

Of the nine studies we reviewed that focused on the effect of health insurance coverage for MH/SU on enrollee expenditures, six studies generally found that the implementation of parity requirements led to reduced enrollee expenditures.<sup>39</sup> Specifically, four of the nine studies examined mental health parity requirements in the Federal Employees Health Benefits Program (FEHBP) and found that implementing parity resulted in reductions in enrollee out-of-pocket costs. For example, one of these studies compared specific MH/SU benefits offered in FEHBP plans before and after the implementation of parity, and found that copayments and coinsurance for MH/SU services decreased by 50 percent or more after parity was implemented.<sup>40</sup> Two of the nine studies examined the impact of state parity laws on expenditures and found that parity generally reduced enrollee expenditures.<sup>41</sup> For example, one of these studies found

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<sup>39</sup>Additionally, a recently published study examining the effect of Oregon's parity requirements on expenditures for MH/SU services found that increases in spending on MH/SU services after implementation of Oregon's parity law were almost entirely the result of a general trend observed among individuals with and without parity. See J.K. McConnell, et al., "Behavioral Health Insurance Parity: Does Oregon's Experience Presage the National Experience With the Mental Health Parity and Addiction Equity Act?" *American Journal of Psychiatry* (2011).

<sup>40</sup>C.L. Barry and M.S. Ridgely, "Mental Health and Substance Abuse Insurance Parity for Federal Employees: How Did Health Plans Respond?" *Journal of Policy Analysis and Management*, vol. 27 (2008).

<sup>41</sup>See C.L. Barry and S.H. Busch, "Do State Parity Laws Reduce the Financial Burden on Families of Children with Mental Health Care Needs?" *Health Services Research*, vol. 42, no. 3, Part I (2007), and M. Rosenbach et al., *Effects of the Vermont Mental Health and Substance Abuse Parity Law*. A special report prepared at the request of the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2003.



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that families with children in need of mental health services in parity states were more likely to have lower annual out-of-pocket costs than families with children in need of mental health services in nonparity states.<sup>42</sup>

Three of the nine studies examined other aspects of how health insurance coverage for MH/SU may impact enrollee expenditures that were unique to the scenarios or targeted populations studied. For example, one study examined differences in out-of-pocket spending among various populations and found that among individuals who use mental health services, out-of-pocket expenses were highest for those who were uninsured or enrolled in Medicare, compared with those who had private health insurance or were enrolled in Medicaid.<sup>43</sup>

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### Research Found Mixed Effects on Access to, and Use of, Services for Mental Health Conditions and Substance Use Disorders

Available research on access to, and use of, MH/SU services, as affected by health insurance coverage, was mixed. Of the 30 studies we reviewed on these topics, 17 studies found health insurance coverage for MH/SU—or enhanced insurance coverage through parity requirements—had some effect on access to, or use of, MH/SU services, whereas 13 studies found little to no effect.<sup>44</sup>

Of the 17 studies finding some effect of health insurance coverage on access to, or use of, MH/SU services:

- Six studies looked at a specific aspect of health insurance coverage—cost-sharing requirements, pre-authorization requirements, or the way MH/SU benefits are structured—and found that restricting coverage had a negative effect on enrollees’ use of services. Specifically, one study found that as cost-sharing increased among privately insured

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<sup>42</sup>Barry and Busch, “Do State Parity Laws Reduce the Financial Burden on Families of Children with Mental Health Care Needs?”

<sup>43</sup>J.S. Ringel and R. Sturm, “Financial Burden and Out-of-Pocket Expenditures for Mental Health Across Different Socioeconomic Groups: Results From HealthCare for Communities,” *The Journal of Mental Health Policy and Economics*, vol. 4 (2001).

<sup>44</sup>Some study authors have noted that several factors may affect access to, or use of, MH/SU services, including the use of techniques such as pre-authorization or utilization review, and stigma associated with MH/SU that may prevent enrollees from seeking needed services.

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patients, the rate of substance use disorder treatment decreased.<sup>45</sup> Another study found that when health plans increased the number of treatment sessions approved at a time, patients were less likely to prematurely terminate treatment.<sup>46</sup> A third study found that as private health plans increased the use of managed care mechanisms, such as utilization review and prior authorization, children decreased their use of MH/SU services.<sup>47</sup>

- Five studies indicated that plans with more comprehensive coverage were associated with a positive effect on access to, or use of, MH/SU services. For example, one study examined a large U.S.-based company that reduced copayments and made efforts to destigmatize mental illness, and found that the benefit design change led to an 18 percent increase in the probability of enrollees initiating mental health treatment.<sup>48</sup>
- Four studies examined the effect of state parity requirements and, as a group, found a mixed effect on enrollees' access to, or use of, MH/SU services. For example, one of these studies examined the effect of a state parity requirement within the first 3 years following implementation of parity requirements, and found that the implementation of parity requirements resulted in increased access to, and use of, mental health services; however, the implementation of parity resulted in reduced access to substance use disorder services.<sup>49</sup> Another study found that state parity requirements increased access to, or use of, MH/SU services for individuals with mild to moderate mental health needs, but that state parity

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<sup>45</sup>B.D. Stein and W. Zhang, "Drug and Alcohol Treatment Among Privately Insured Patients: Rate of Specialty Substance Abuse Treatment and Association with Cost-Sharing," *Drug and Alcohol Dependence*, vol. 71 (2003).

<sup>46</sup>Liu et al., "The Impact of Prior Authorization on Outpatient Utilization in Managed Behavioral Health Plans."

<sup>47</sup>D.L. Leslie, R.A. Rosenheck, and S.M. Horwitz, "Patterns of Mental Health Utilization and Costs Among Children in a Privately Insured Population," *Health Services Research*, vol. 36, no.1, Part I (2001).

<sup>48</sup>R.C. Lindrooth, A.T. Lo Sasso, and I.Z. Lurie, "The Effect of Expanded Mental Health Benefits on Treatment Initiation and Specialist Utilization," *Health Services Research*, vol. 40, no. 4 (2005).

<sup>49</sup>M. Rosenbach et al., *Effects of the Vermont Mental Health and Substance Abuse Parity Law*.

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requirements had no effect on access to, or use of, MH/SU services for individuals with severe mental health needs.<sup>50</sup> The remaining two studies found that state parity requirements increased access to, or use of, MH/SU services.<sup>51</sup>

- Two studies found that being uninsured or having a certain type of insurance was associated with lower access to MH/SU services.<sup>52</sup> For example, one study assessed the extent to which psychiatrists were accepting new patients with different types of insurance—Medicaid, Medicare, and private insurance—and with different types of care plans.<sup>53</sup> This study found that psychiatrists were less likely to accept new patients in managed care plans and Medicaid than patients in nonmanaged private insurance plans and Medicare, indicating that the type of coverage patients have may affect their access to available providers.<sup>54</sup>

In contrast, 13 of the 30 studies we reviewed found little to no effect:

- Three studies examined the effect of mental health parity requirements in the FEHBP and found that enhanced coverage did not increase access to, or use of, MH/SU services.
- Six studies examined the effect of state mental health parity requirements on access to, or use of, MH/SU services and found little to no effect. One of these studies found a difference in the effect of

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<sup>50</sup>K.M. Harris, C. Carpenter, and Y. Bao, “The Effects of State Parity Laws on the Use of Mental Health Care,” *Medical Care*, vol. 44, no. 6 (2006).

<sup>51</sup>See D. Dave and S. Mukerjee, “Mental Health Parity Legislation, Cost-Sharing and Substance-Abuse Treatment Admissions,” *Health Economics*, vol. 20 (2011); and S.H. Zuvekas, A.E. Rupp, and G.S. Norquist, “The Impacts of Mental Health Parity and Managed Care in One Large Employer: a Reexamination,” *Health Affairs*, vol. 24, Iss. 6 (2005).

<sup>52</sup>See K.B. Wells et al., “Alcohol, Drug Abuse and Mental Health Care for Uninsured and Insured Adults,” *Health Services Research*, vol. 37, no. 4 (2002); and J.E. Wilk et al., “Access to Psychiatrists in the Public Sector and in Managed Health Plans,” *Psychiatric Services*, vol. 56, no. 4 (2005).

<sup>53</sup>Wilk et al., “Access to Psychiatrists in the Public Sector and in Managed Health Plans.”

<sup>54</sup>The study sample was limited to 1,203 psychiatrists. While psychiatrists were less willing to accept patients with certain types of coverage which affects access, it does not preclude patients from obtaining services from another provider.

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state mental health parity requirements by employer size. Specifically, after implementation of state mental health parity requirements, enrollees from smaller employers—comprised of 50 to 100 employees—increased the use of mental health services after parity, while there was little or no effect on the use of mental health services for enrollees from larger employers—comprised of 100 or more employees.<sup>55</sup>

- Four studies focused on the effect of health insurance coverage on access to, or use of, MH/SU services for a specific population, and also found that health insurance coverage had little to no effect on access to, or use of, MH/SU services. For example, two studies examined the effect of health insurance coverage on specific populations—children with special mental health service needs living in a rural area, or low-income, minority groups—and found that having private health insurance had little to no effect on use of services for either of these populations.<sup>56</sup>

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### Little Research Has Explored the Relationship between Health Insurance Coverage and Health Status

Of the studies we reviewed, two studies examined the effect of health insurance coverage for MH/SU on health status of the general population. One study compared suicide rates among states with different parity requirements and found that state mandates did not have an effect on suicide rates.<sup>57</sup> The other study found that increasing copayments was associated with an increased likelihood of the reoccurrence of substance use treatment. Specifically, each 10 percent increase in copayment was associated with a 1 percent increase in the probability of returning to

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<sup>55</sup>S.H. Busch and C.L. Barry, “New Evidence on the Effects of State Mental Health Mandates,” *Inquiry*, vol. 45 (2008).

<sup>56</sup>See E.J. Costello, W. Copeland, A. Cowell, and G. Keeler, “Service Costs of Caring for Adolescents with Mental Illness in a Rural Community, 1993-2000,” *The American Journal of Psychiatry*, vol. 164 (2007); and K.C. Thomas and L.R. Snowden, “Minority Response to Health Insurance Coverage for Mental Health Services,” *The Journal of Mental Health Policy and Economics*, vol. 4 (2001).

<sup>57</sup>J. Klick and S. Markowitz, “Are Mental Health Insurance Mandates Effective? Evidence From Suicides,” *Health Economics*, vol. 15 (2006).

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begin a new course of substance use disorder treatment within 180 days.<sup>58</sup>

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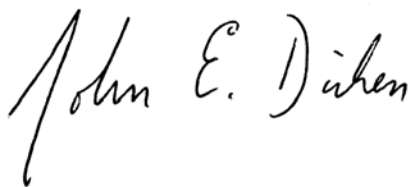
## Agency Comments

DOL and HHS reviewed a draft of this report and provided technical comments, which we incorporated as appropriate.

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We are sending copies of this report to the Secretaries of the Department of Labor and the Department of Health and Human Services and appropriate congressional committees. In addition, the report will be available at no charge on GAO's website at <http://www.gao.gov>.

If you or your staff have any questions regarding this report, please contact me at (202) 512-7114 or [dickenj@gao.gov](mailto:dickenj@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.



John E. Dicken  
Director, Health Care

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<sup>58</sup>A.T. Lo Sasso and J.S. Lyons, "The Effects of Copayments on Substance Abuse Treatment Expenditures and Treatment Reoccurrence," *Psychiatric Services*, vol. 53, no. 12 (2002).

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*List of Committees*

The Honorable Max Baucus  
Chairman

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Ranking Member  
Committee on Finance  
United States Senate

The Honorable Tom Harkin  
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The Honorable Dave Camp  
Chairman

The Honorable Sander Levin  
Ranking Member  
Committee on Ways and Means  
House of Representatives

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# Appendix I: Scope and Methodology

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To determine the extent to which employers cover mental health conditions and substance use disorders (MH/SU) both currently and in 2008, we surveyed a stratified random sample of small, medium, large, and very large employers about the MH/SU covered in their most popular health plans for the most current plan year—either in 2011 or 2010—as well as for 2008. We defined most popular health plan as the plan that covered the greatest number of lives. We fielded a web-based survey between May 18, 2011, and July 1, 2011, to 707 employers, selected from a sampling frame we developed using the Lexis Nexis corporate database.<sup>1</sup>

Our survey was designed to collect information about trends in employer coverage of MH/SU benefits, and included questions about coverage for MH/SU in the most current plan year—2011 or 2010—and in 2008. We conducted a survey of employers because we were unable to identify a published national employer survey that included specific detailed information about employers' MH/SU benefits prior to and following MHPAEA—namely, information about diagnoses included in or excluded from coverage. For our survey, employers had the option of either completing the entire survey, including detailed questions about their most popular health plans' cost-sharing requirements, or completing a portion of the survey and submitting to us their most popular health plans' summary plan documents (SPD), which included information on the plans' cost-sharing requirements.<sup>2</sup>

As part of the survey development process, we asked experts to review a draft version of the survey and we pretested the survey. We incorporated feedback from experts and the pretests into the survey.

We selected a stratified random sample of 1,000 employers from our sampling frame. Our stratification divided employers into groups based on the number of employees—small employers had 51-199 employees; medium employers had 200-999 employees; large employers had 1,000-

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<sup>1</sup>To develop our sampling frame, we used the Dossier function of the Lexis Nexis corporate database to select 32,431 U.S.-based companies on January 18, 2011. We selected privately held and publicly traded parent companies with between 51 to 100,000 employees that were headquartered in the United States.

<sup>2</sup>Employers had the option of submitting their summary plan documents—or other documents detailing their coverage, such as a plan certificate of coverage—for either the current plan year, for the 2008 plan year, or both plan years.

4,999 employees; and very large employers had 5,000 or more employees.<sup>3</sup> We obtained working e-mail addresses for 707 employers, which received the survey on May 18, 2011. The distribution of employer sizes among the final group of employers was similar to that in the original sample.

When we closed the survey on July 1, 2011, after following up with nonrespondents by phone and e-mail to encourage their participation, 168 employers had submitted usable survey responses, for a response rate of 24 percent. Given the response rate, our survey results are not generalizable. Rather, the survey responses provide information limited to responding employers' coverage of MH/SU in the current plan year and 2008 plan year. Specifically, we received usable survey responses from 91 small employers, 50 medium employers, 19 large employers, and 8 very large employers. All 168 employers offered coverage of mental health conditions, substance use disorders, or both, in either the current plan year, 2008 plan year, or both plan years. We expected all employers to respond to a key set of questions; however, not every employer that responded to our survey answered the key questions in their entirety. In addition, our survey included a series of detailed benefits questions which employers were expected to respond to only if the question applied to them.<sup>4</sup> For all the survey questions to which we expected a response, the percentage of employers that did not respond to a question ranged from zero to 46 percent, depending on the question. We did not verify the accuracy of the employers' responses or assess compliance with MHPAEA.

Of the 168 employers that provided usable survey responses, 130 employers answered at least one of the detailed benefits questions—detailed survey questions about the limitations and cost-sharing requirements of their MH/SU benefits—for the current plan year, and 123 employers answered at least one of the detailed benefits questions for the 2008 plan year. As a result, when we analyzed the total survey data, we used 168 as the denominator for our calculations. However, we used 130

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<sup>3</sup>Our stratification was informed by the stratification used by other published national employer surveys such as Kaiser Family Foundation and the Health Research and Educational Trust's (Kaiser/HRET) *Employer Health Benefits Annual Survey*.

<sup>4</sup>The questions in the survey asking about treatment limitations, lifetime dollar limits, and cost-sharing amounts were open-ended responses. Employers could leave these questions blank if their most popular plans lacked these features.



as the denominator for our calculations for responses to the detailed benefits questions for the current plan year, and used 123 as the denominator for our calculations for responses to the detailed benefits questions for the 2008 plan year. In instances where we analyzed responses from a smaller number of respondents, we noted this in the text.

To supplement the data collected from our survey, we reviewed the results of published national employer surveys from the Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET) and Mercer. These surveys provided generalizable information on employers' coverage of MH/SU.

Since 1999, Kaiser/HRET has surveyed a sample of employers each year through telephone interviews with human resource and benefits managers and published the results in its annual report—*Employer Health Benefits*. Kaiser/HRET selects a random sample from a Survey Sampling International list of private employers and from the Census Bureau's Census of Governments list of public employers with three or more employees. Kaiser/HRET then stratifies the sample by industry and employer size. It attempts to repeat interviews with employers that responded in prior years. For the most recently completed annual survey—conducted from January to May 2010 and published in September 2010—2,046 employers responded to the full survey, giving the survey a 47 percent response rate.<sup>5</sup> Using statistical weights, Kaiser/HRET projected its results nationwide. Kaiser/HRET used the following definitions for employer size: (1) small—3 to 199 employees—and (2) large—200 and more employees. In some cases, Kaiser/HRET reported information for additional categories of small and large employer sizes.

Since 1993, Mercer has surveyed a stratified random sample of employers each year through mail questionnaires and telephone interviews and published the results in its annual report—*National Survey of Employer-Sponsored Health Plans*. Mercer selects a random sample of private sector employers from a Dun & Bradstreet database, stratified into eight categories, and randomly selects public sector employers—state,

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<sup>5</sup>Kaiser Family Foundation and the Health Research & Educational Trust, *Employer Health Benefits 2010 Annual Survey*, September 2010.

county, and local governments—from the Census of Governments. The random sample of private sector and government employers represents employers with 10 or more employees. For the 2010 survey, which was published in 2011, Mercer mailed questionnaires to employers with 500 or more employees in July 2010 along with instructions for accessing a web-based version of the survey instrument, another option for participation.<sup>6</sup> Employers with fewer than 500 employees, which historically have been less likely to respond using a paper questionnaire, were contacted to be given the option of responding to the survey by phone or by using the web-based survey. Telephone follow-up was conducted with employers with 500 or more employees in the random sample and some mail and web respondents were contacted by phone to clear up inconsistent or incomplete data. A total of 2,833 employers responded to the survey. By using statistical weights, Mercer projected its results nationwide and for four geographic regions. The Mercer survey report contains information for large employers—500 or more employees—and for categories of large employers with certain numbers of employees as well as information for small employers—those with fewer than 500 employees. Mercer used the same methodology for its 2008 survey, which was published in 2009.<sup>7</sup> A total of 2,873 employers responded to the survey. According to a Mercer representative, in any given year, Mercer typically obtains a 25 percent response rate to its survey.

We conducted interviews with agency officials and experts to learn about the implementation of MHPAEA and trends in employers' coverage of MH/SU benefits. We spoke with agency officials from the Department of Labor (DOL), Department of Health and Human Services's (HHS) Assistant Secretary for Planning and Evaluation (ASPE), and HHS's Substance Abuse and Mental Health Services Administration who had expertise in MH/SU issues. We did not interview Treasury officials because the focus of this engagement did not relate to that agency's scope of responsibility. We spoke with experts who included representatives from two large managed behavioral health organizations (MBHO); two large national insurance companies; mental health advocacy organizations; institutions that field employer-based surveys on

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<sup>6</sup>Mercer, *National Survey of Employer-Sponsored Health Plans: 2010 Survey Report* (New York, N.Y.: Mercer, LLC, 2011).

<sup>7</sup>Mercer, *National Survey of Employer-Sponsored Health Plans: 2008 Survey Report* (New York, N.Y.: Mercer, LLC, 2009).

health insurance coverage; a large benefits consulting firm; an insurance broker organization; and three trade associations. We also interviewed four employer survey respondents—one in each employer size category—to obtain more detailed information about the employers' coverage of MH/SU, and their reasons for making or not making changes to coverage after the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) took effect.

For our literature review on the effect of health insurance coverage for MH/SU on enrollees' health care expenditures,<sup>8</sup> access to, or use of, MH/SU services, and health status, we conducted a key word search of nine databases, such as Medline and EMBASE, that included peer-reviewed journals and other periodicals to capture articles published between January 1, 2000, and March 11, 2011. We searched these databases for articles with key words in their title or article subject terms related to the effect of health insurance on health care expenditures or health status,<sup>9</sup> using combinations and variations of the words "insurance coverage," "mental health," "substance use," "health cost," "health expenditure," and "health status." From these sources, we identified 246 abstracts of research articles, publications, and reports.

After reviewing the abstracts, we included 34 studies that discussed the effect of health insurance coverage on enrollee expenditures, access to, or use of, MH/SU services, or health status. We also included articles in our literature review that were suggested to us by the experts we interviewed, as well as those that were referenced in the articles found during our initial search.

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<sup>8</sup>Our review focused specifically on the effect of health insurance coverage on enrollee out-of-pocket expenditures.

<sup>9</sup>For the purposes of our literature review, we defined health insurance as one of the following: having coverage, having limited availability of coverage, or any absence of health insurance coverage. We defined health care expenditures as copayments, cost-sharing, and other out-of-pocket expenditures, and we defined health status as the quality of care an individual receives or the health outcomes of receiving care.

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# Appendix II: Articles Reviewed on the Effect of Health Insurance Coverage on Enrollees

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We conducted a review of published studies between January 2000 and March 11, 2011, that included an assessment of the effect of health insurance coverage for mental health conditions and substance use disorders (MH/SU) on enrollee expenditures, access to, or use of, MH/SU services, or health status.<sup>1</sup> We identified 34 such studies, 9 of which addressed the effect of health insurance coverage on enrollee expenditures, 30 of which discussed access to, or use of, MH/SU services, and 2 of which discussed health status. Some studies addressed more than one topic.

Tables 2 through 4 identify the 34 studies included in our review, and whether we determined them to be relevant to the effect of health insurance coverage for MH/SU on enrollees' health care expenditures, access to, or use of, MH/SU services, or health status.

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<sup>1</sup>We identified published studies included in peer reviewed journals by conducting a literature search, reviewing literature suggested to us by experts we interviewed, as well as reviewed articles referenced in the literature identified during our initial search.

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**Table 2: Studies Published between January 2000 and March 11, 2011, Addressing the Effect of Health Insurance Coverage for Mental Health Conditions and Substance Use Disorders on Enrollees' Health Care Expenditures**

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**Enrollee expenditures**

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Azrin, Susan T., Haiden A. Huskamp, Vanessa Azzone, Howard H. Goldman, Richard G. Frank, M. Audrey Burnam, Sharon-Lise T. Normand, et al., "Impact of Full Mental Health and Substance Abuse Parity for Children in the Federal Employees Health Benefits Program." *Pediatrics*, vol. 119, no. 2 (2007): e452-e459.

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Azzone, Vanessa, Richard G. Frank, Sharon-Lise T. Normand and M. Audrey Burnam, "Effect of Insurance Parity on Substance Abuse Treatment." *Psychiatric Services*, vol. 62, no. 2 (2011): 129-34.

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Barry, Colleen L. and Susan H. Busch, "Do State Parity Laws Reduce the Financial Burden on Families of Children with Mental Health Care Needs?" *Health Services Research*, vol. 42, no.3 (2007): 1061-84.

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Barry, Colleen L. and M. Susan Ridgely, "Mental Health and Substance Abuse Insurance Parity for Federal Employees: How Did Health Plans Respond?" *Journal of Policy Analysis and Management*, vol. 27 (2008): 155-70.

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Goldman, Howard H., Richard G. Frank, M. Audrey Burnam, Haiden A. Huskamp, M. Susan Ridgely, Sharon-Lise T. Normand, Alexander S. Young, et al., "Behavioral Health Insurance Parity for Federal Employees." *The New England Journal of Medicine*, vol. 354, no. 13 (2006): 1378-86.

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Grazier, Kyle L. and Harold Pollack, "Translating Behavioral Health Services Research into Benefits Policy." *Medical Care Research and Review*, vol. 57, supplement 2 (2000): 53-71.

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Lo Sasso, Anthony T., Ithai Z. Lurie, Jhee Un Lee and Richard C. Lindrooth, "The Effects of Expanded Mental Health Benefits on Treatment Costs." *The Journal of Mental Health Policy and Economics*, vol. 9 (2006): 25-33.

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Ringel, Jeanne S. and Roland Sturm, "Financial Burden and Out-of-Pocket Expenditures for Mental Health Across Different Socioeconomic Groups: Results from HealthCare for Communities." *The Journal of Mental Health Policy and Economics*, vol. 4 (2001): 141-50.

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Rosenbach, Margo, Tim Lake, Cheryl Young, Wendy Conroy, Brian Quinn, Julie Ingels, Brenda Cox, et al., *Effects of the Vermont Mental Health and Substance Abuse Parity Law*. A special report prepared at the request of the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. 2003.

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Source: GAO's review of published studies.

**Table 3: Studies Published between January 2000 and March 11, 2011, Addressing the Effect of Health Insurance Coverage for Mental Health Conditions and Substance Use Disorders on Enrollees' Access to, or Use of, MH/SU Services**

**Access to, or use of, MH/SU services**

Azrin, Susan T., Haiden A. Huskamp, Vanessa Azzone, Howard H. Goldman, Richard G. Frank, M. Audrey Burnam, Sharon-Lise T. Normand, et al., "Impact of Full Mental Health and Substance Abuse Parity for Children in the Federal Employees Health Benefits Program." <i>Pediatrics</i> , vol. 119, no. 2 (2007): e452-e459.
Azzone, Vanessa, Richard G. Frank, Sharon-Lise T. Normand and M. Audrey Burnam, "Effect of Insurance Parity on Substance Abuse Treatment." <i>Psychiatric Services</i> , vol. 62, no. 2 (2011): 129-34.
Bao, Yuhua and Roland 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." <i>Health Services Research</i> , vol. 39, no. 5 (2004): 1361-77.
Barry, Colleen L. and Susan H. Busch, "Caring for Children with Mental Disorders: Do State Parity Laws Increase Access to Treatment?" <i>The Journal of Mental Health Policy and Economics</i> , vol. 11 (2008): 57-66.
Barry, Colleen L. and Susan H. Busch, "Do State Parity Laws Reduce the Financial Burden on Families of Children with Mental Health Care Needs?" <i>Health Services Research</i> , vol. 42, no.3 (2007): 1061-84.
Busch, Susan H. and Colleen L. Barry, "New Evidence on the Effects of State Mental Health Mandates." <i>Inquiry</i> , vol. 45 (2008): 308-22.
Ciemins, Elizabeth L., "The Effect of Parity-Induced Copayment Reductions on Adolescent Utilization of Substance Use Services." <i>Journal of Studies on Alcohol</i> , vol. 65 (2004): 731-5.
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Dave, Dhaval and Swati Mukerjee, "Mental Health Parity Legislation, Cost-Sharing and Substance-Abuse Treatment Admissions." <i>Health Economics</i> , vol. 20 (2011): 161-83.
Goldman, Howard H., Richard G. Frank, M. Audrey Burnam, Haiden A. Huskamp, M. Susan Ridgely, Sharon-Lise T. Normand, Alexander S. Young, et al., "Behavioral Health Insurance Parity for Federal Employees." <i>The New England Journal of Medicine</i> , vol. 354, no. 13 (2006): 1378-86.
Grazier, Kyle L. and Harold Pollack, "Translating Behavioral Health Services Research into Benefits Policy." <i>Medical Care Research and Review</i> , vol. 57, supplement 2 (2000): 53-71.
Harris, Katherine M. Christopher Carpenter and Yuhua Bao, "The Effects of State Parity Laws on the Use of Mental Health Care." <i>Medical Care</i> , vol. 44, no. 6 (2006): 499-505.
Leslie, Douglas L., Robert A. Rosenheck and Sarah McCue Horwitz, "Patterns of Mental Health Utilization and Costs Among Children in a Privately Insured Population." <i>Health Services Research</i> , vol. 36, no.1 (2001): 113-27.
Lindrooth, Richard C., Anthony T. Lo Sasso and Ithai Z. Lurie, "The Effect of Expanded Mental Health Benefits on Treatment Initiation and Specialist Utilization." <i>Health Services Research</i> , vol. 40, no. 4 (2005): 1092-1107.
Liu, Xiaofeng, Roland Sturm, and Brian J. Cuffel, "The Impact of Prior Authorization on Outpatient Utilization in Managed Behavioral Health Plans." <i>Medical Care Research and Review</i> , vol. 57, no. 2 (2000): 182-195.
Lo Sasso, Anthony T., Richard C. Lindrooth, Ithai Z. Lurie and John S. Lyons, "Expanded Mental Health Benefits and Outpatient Depression Treatment Intensity." <i>Medical Care</i> , vol. 44, no. 4 (2006): 366-72.
Lo Sasso, Anthony T., Ithai Z. Lurie, Jhee Un Lee and Richard C. Lindrooth, "The Effects of Expanded Mental Health Benefits on Treatment Costs." <i>The Journal of Mental Health Policy and Economics</i> , vol. 9 (2006): 25-33.
Lo Sasso, Anthony T. and John S. Lyons, "The Sensitivity of Substance Abuse Treatment Intensity to Co-payment Levels." <i>The Journal of Behavioral Health Services and Research</i> , vol. 31 (2004): 50-65.
Lu, Chunling, Richard G. Frank and Thomas G. McGuire, "Demand Response of Mental Health Services to Cost Sharing under Managed Care." <i>The Journal of Mental Health Policy and Economics</i> , vol. 11 (2008): 113-25.

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**Appendix II: Articles Reviewed on the Effect of  
Health Insurance Coverage on Enrollees**

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**Access to, or use of, MH/SU services**

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Pacula, Rosalie Liccardo and Roland Sturm, "Mental Health Parity: Much Ado about Nothing?" *Health Services Research*, vol. 35 (2000): 263-275.

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Rosenbach, Margo, Tim Lake, Cheryl Young, Wendy Conroy, Brian Quinn, Julie Ingels, Brenda Cox, et al., *Effects of the Vermont Mental Health and Substance Abuse Parity Law*. A special report prepared at the request of the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. 2003.

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Schmidt, Laura A. and Constance M. Weisner, "Private Insurance and the Utilization of Chemical Dependency Treatment." *Journal of Substance Abuse Treatment*, vol. 28 (2005): 67-76.

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Stein, Bradley D. and Weiyang Zhang, "Drug and Alcohol Treatment Among Privately Insured Patients: Rate of Specialty Substance Abuse Treatment and Association with Cost-Sharing." *Drug and Alcohol Dependence*, vol. 71 (2003): 153-59.

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Wilk, Joshua E., Joyce C. West, William E. Narrow, Donald S. Rae and Darrel A. Regier, "Access to Psychiatrists in the Public Sector and in Managed Health Plans." *Psychiatric Services*, vol. 56, no. 4 (2005): 408-10.

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Source: GAO's review of published studies.

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**Table 4: Studies Published between January 2000 and March 11, 2011, Addressing the Effect of Health Insurance Coverage for Mental Health Conditions and Substance Use Disorders on Enrollees' Health Status**

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**Health status**

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Klick, Jonathan and Sara Markowitz, "Are Mental Health Insurance Mandates Effective? Evidence From Suicides." *Health Economics*, vol. 15 (2006): 83-97.

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Lo Sasso, Anthony T. and John S. Lyons, "The Effects of Copayments on Substance Abuse Treatment Expenditures and Treatment Reoccurrence." *Psychiatric Services*, vol. 53, no.12 (2002): 1605-11.

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Source: GAO's review of published studies.

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# Appendix III: GAO Contact and Staff Acknowledgments

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## GAO Contact

John E. Dicken, (202) 512-7114, [dickenj@gao.gov](mailto:dickenj@gao.gov)

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## Staff Acknowledgments

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