CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

August 22, 2001

S. 543
Mental Health Equitable Treatment Act of 2001

As ordered reported by the Senate Committee on Health, Education, Labor, and Pensions on August 1, 2001

SUMMARY

The Mental Health Equitable Treatment Act of 2001 would prohibit group health plans and group health insurance issuers that provide both medical and surgical benefits and mental health benefits from imposing treatment limitations or financial requirements for coverage of mental health benefits that are different from those used for medical and surgical benefits.

The bill would affect the federal budget because it would result in higher premiums for employer-sponsored health benefits. Higher premiums, in turn, would result in more of an employee's compensation being received in the form of nontaxable employer-paid premiums, and less in the form of taxable wages. As a result of this shift, federal income and payroll tax revenues would decline. The Congressional Budget Office (CBO) estimates that the proposal would reduce federal tax revenues by $230 million in 2002 and by $5.4 billion over the 2002-2011 period. Because S. 543 would affect receipts, pay-as-you-go procedures would apply to the bill.

S. 543 would preempt state laws that have less stringent requirements for mental health coverage than those in this bill. That preemption would be an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA). However, because the preemption only would prohibit the application of state regulatory law, CBO estimates that the costs of the mandate would not be significant and thus would not exceed the threshold established by UMRA ($56 million in 2001, adjusted annually for inflation). As a result of this legislation, some state, local, and tribal governments would pay higher health insurance premiums for their employees. However, these costs would not result from intergovernmental mandates, but would be costs passed on to them by private insurers who would face a private-sector mandate to comply with the requirements of the bill.

The bill would impose a private-sector mandate on group health plans and group health insurance issuers by prohibiting them from imposing treatment limitations or financial requirements for mental health benefits that differ from those placed on medical and surgical

benefits. Under current law, the Mental Health Parity Act of 1996 requires a more limited form of parity between mental health and medical and surgical coverage. That mandate is set to expire at the end of fiscal year 2001. Thus, S. 543 would both extend and expand the existing mandate requiring mental health parity. CBO estimates that the direct costs of the private-sector mandate in the bill would equal about $3 billion in 2002, and would grow in later years. That amount would significantly exceed the annual threshold established by UMRA ($113 million in 2001, adjusted for inflation) in each of the years that the mandate would be effective.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of the bill is shown in Table 1.

TABLE 1. ESTIMATED BUDGETARY EFFECTS OF S. 543

	By Fiscal Year, in Millions of Dollars										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
CHANGES IN REVENUES											
On-budget	0	-150	-290	-330	-360	-370	-390	-410	-430	-450	-500
Off-budget[a]	0	-70	-140	-160	-170	-180	-190	-200	-210	-220	-230
Total changes	0	-230	-430	-490	-520	-550	-580	-600	-630	-660	-730

a. Revenues from Social Security payroll taxes are designated as "off-budget."

BASIS OF ESTIMATE

This bill would prohibit group health plans and group health insurance issuers who offer mental health benefits from imposing treatment limitations or financial requirements for mental health benefits that are different from those used for medical and surgical benefits. For plans that offer mental health benefits through a network of mental health providers, the requirement for parity of benefits would apply to those benefits provided by members of the plan's network of health providers, not to benefits provided by health professionals outside of the plan's network. The provision would apply to benefits for any mental health condition listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders,

but would not apply to benefits for substance abuse treatment. The bill would not require group health plans to offer mental health benefits, but laws in some states require that plans cover those benefits.

The provision would apply to both self-insured and fully insured group health plans. Small employers (those employing between 2 and 50 employees in a year) would be exempt from the bill's requirements, as would individuals purchasing insurance in the individual market. In states with laws that are more stringent than the provisions of S. 543, fully insured group health plans would be required to comply with the state law, while self-insured plans would be required to comply with the provisions of S. 543.

CBO's estimate of the cost of this bill is based in part on published results of a model developed by the Hay Group. That model relies on data from several sources, including the claims experience of private health insurers participating in the Federal Employees Health Benefits (FEHB) program and the Medical Expenditure Panel Survey. CBO adjusted those results to account for the current and future use of managed care arrangements for providing mental health benefits and the increased use of prescription drugs that mental health parity would be likely to induce. Also, CBO took account of the effects of existing state and federal rules that place requirements similar to those in the bill on certain entities. (For example, the Office of Personnel Management implemented mental health and substance abuse parity in the FEHB program in January 2001).

CBO estimates that S. 543, if enacted, would increase premiums for group health insurance by an average of 0.9 percent, before accounting for the responses of health plans, employers, and workers to the higher premiums under the bill. Those responses would include reductions in the number of employers offering insurance to their employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered, and reductions in the scope or generosity of health insurance benefits, such as increased deductibles or higher copayments. CBO assumes that these behavioral responses would offset 60 percent of the potential impact of the bill on total health plan costs.

The remaining 40 percent of the potential increase in costs, or about 0.4 percent of group health insurance premiums, would occur in the form of increased outlays for health insurance. Those costs would be passed through to workers, reducing both their taxable compensation and other fringe benefits. For employees of private firms, CBO assumes that all of that increase would ultimately be passed through to workers. State, local, and tribal governments are assumed to absorb 75 percent of the increase and to reduce their workers' taxable income and other fringe benefits to offset the remaining one-quarter of the increase.

CBO estimates that the resulting reduction in taxable income would grow from $1.0 billion in calendar year 2002 to $2.3 billion in 2011.

Those reductions in workers' taxable compensation would lead to lower federal tax revenues. CBO estimates that federal tax revenues would fall by $230 million in 2002 and by $5.4 billion over the 2002-2011 period if S. 543 were enacted. Social Security payroll taxes, which are off-budget, would account for about 30 percent of those totals.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net change in governmental receipts that are subject to pay-as-you-go procedures are shown in the Table 2. (Only the changes in on-budget revenues are subject to pay-as-you-go procedures.) For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

TABLE 2. ESTIMATED EFFECTS OF S. 543 ON RECEIPTS AND DIRECT SPENDING

	By Fiscal Year, in Millions of Dollars										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Change in Receipts	0	-150	-290	-330	-360	-370	-390	-410	-430	-450	-500
Change in Outlays	Not applicable										

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

S. 543 would preempt state laws that have less stringent requirements for mental health coverage than those in this bill. That preemption would be an intergovernmental mandate as defined in UMRA. However, because the preemption would simply prohibit the application of state regulatory law, CBO estimates that the mandate would impose no significant costs on state, local, or tribal governments.

An existing provision in the Public Health Service Act would allow state, local, and tribal governments that operate group health plans for the benefit of their employees to opt out of the requirements of this bill. Consequently, those requirements would not be intergovernmental mandates as defined in UMRA, and the bill would affect the budgets of

those governments only if they choose to comply with the requirements on group health plans. Roughly two-thirds of employees in state, local, and tribal governments are enrolled in self-insured plans.

The remaining governmental employees are enrolled in fully insured plans. Governments purchase health insurance for those employees through private insurers and would face increased premiums as a result of higher costs passed on to them by those insurers. The increased costs, however, would not result from intergovernmental mandates. Rather, they would be part of the mandate costs initially borne by the private sector and then passed on to the governments as purchasers of insurance. Assuming that in the absence of this legislation all mental health parity requirements would expire, CBO estimates that state, local, and tribal governments would face additional costs of $150 million in 2002, increasing to about $260 million in 2006. This estimate reflects the assumption that governments would shift roughly 25 percent of the additional costs to their employees.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill would impose a private-sector mandate on group health plans and issuers of group health insurance that provide medical and surgical benefits as well as mental health benefits. S. 543 would prohibit those entities from imposing treatment limitations or financial requirements for mental health benefits that differ from those placed on medical and surgical benefits. The requirements would not apply to coverage purchased by employer groups with fewer than 50 employees. Health plans that provided mental health benefits through a network of mental health providers would have to comply with the parity requirements for benefits provided by the network of providers but not for benefits provided by mental health professionals outside the network.

Under current law, the Mental Health Parity Act of 1996 prohibits group health plans and group health insurance issuers from imposing annual and lifetime dollar limits on mental health coverage that are more restrictive than limits imposed on medical and surgical coverage. The current mandate is set to expire at the end of fiscal year 2001. Consequently, S. 543 would both extend and expand the current mandate requiring mental health parity.

CBO's estimate of the direct costs of the mandate assumes that affected entities would comply with S. 543 by further increasing the generosity of their mental health benefits. Many plans currently offer mental health benefits that are less generous than their medical and surgical benefits. We estimate that the direct costs of the additional services that would be newly covered by insurance because of the mandate would equal about 0.9 percent of employer-sponsored health insurance premiums compared to having no mandate at all.

The Unfunded Mandates Reform Act is unclear about how to measure the costs of extending an expiring mandate that has not yet expired. On the one hand, UMRA may be interpreted as requiring the direct costs to be measured relative to a case that assumes the current mandate will not exist beyond its expiration date. On the other hand, it also may be interpreted as requiring the direct costs to be measured relative to the cost of the existing mandate. CBO's estimate of the direct costs under each of those interpretations is displayed in Table 3.

Under the first interpretation, CBO estimates that the direct costs of the mandate in S.543 would be $3.1 billion in 2002, rising to $5.5 billion in 2006. Under the second interpretation, the direct costs would be $2.8 billion in 2002, rising to $5.0 billion in 2006. In both cases, those costs would significantly exceed the threshold specified in UMRA ($113 million in 2001, adjusted annually for inflation) in each year the mandate would be effective.

TABLE 3. ESTIMATED DIRECT COSTS OF THE PRIVATE-SECTOR MANDATES IN S. 543

	By Fiscal Year, in Millions of Dollars				
	2002	2003	2004	2005	2006
Direct costs compared with no mandate	3,100	4,500	4,800	5,100	5,500
Direct costs compared with the mandate in the Mental Health Parity Act of 1996	2,800	4,000	4,400	4,700	5,000

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