CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

March 20, 2007

S. 558
Mental Health Parity Act of 2007

As ordered reported by the Senate Committee on Health, Education, Labor, and Pensions on February 14, 2007

SUMMARY

The Mental Health Parity Act of 2007 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 both federal revenues and direct spending for Medicaid, beginning in 2009. The bill 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 $1 billion over the 2009-2012 period and by $3 billion over the 2009-2017 period. Social Security payroll taxes, which are off-budget, would account for about 35 percent of those totals.

The bill's requirements for issuers of group health insurance would apply to managed care plans in the Medicaid program. CBO estimates that enacting S. 558 would increase federal direct spending for Medicaid by $280 million over the 2009-2012 period and by $790 million over the 2009-2017 period. In addition, assuming appropriation of the necessary amounts, CBO estimates that implementing S. 558 would have discretionary costs of $20 million in 2008, $143 million over the 2008-2012 period, and $322 million over the 2008-2017 period.

S. 558 would preempt state laws governing mental health coverage that are different than those in this bill and that apply to firms with 50 or more employees. 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 to state, local, or tribal

governments would not be significant and thus would not exceed the threshold established by UMRA ($66 million in 2007, 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 2007. Thus, S. 558 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 total about $1.5 billion in 2009, and would grow in later years. That amount would significantly exceed the annual threshold established by UMRA ($131 million in 2007, adjusted for inflation) in each of the years that the mandate would be in effect.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 558 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

ESTIMATED BUDGETARY EFFECTS OF S. 558

	By Fiscal Year, in Millions of Dollars											
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017
CHANGES IN REVENUES												
Income and HI Payroll Taxes (on-budget)	0	-90	-160	-190	-210	-230	-250	-260	-280	-300	-650	-1,970
Social Security Payroll Taxes (off-budget)	0	-50	-90	-100	-110	-120	-130	-140	-150	-160	-350	-1,050
Total Changes	0	-140	-250	-290	-320	-350	-380	-400	-430	-460	-1,000	-3,020
CHANGES IN DIRECT SPENDING												
Medicaid												
Estimated Budget Authority	0	60	70	70	80	90	90	100	110	120	280	790
Estimated Outlays	0	60	70	70	80	90	90	100	110	120	280	790
CHANGES IN SPENDING SUBJECT TO APPROPRIATION												
Implementation costs for DHHS and DOL												
Estimated Authorization Level	25	30	30	30	35	35	35	35	35	40	150	330
Estimated Outlays	20	29	30	30	34	35	35	35	35	39	143	322

NOTE: DHHS = Department of Health and Human Services, DOL = Department of Labor, HI = Hospital Insurance (Part A of Medicare).

BASIS OF ESTIMATE

The bill would prohibit group health plans and group health insurance issuers who offer mental health benefits (including benefits for substance abuse treatment) from imposing treatment limitations or financial requirements for those 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 be established by comparing in-network medical and surgical benefits with in-network mental health benefits, and comparing out-of-network medical and surgical benefits with out-of-network mental health benefits. The provision would apply to benefits for any mental health condition that is covered under the group health plan. The bill would not require plans to offer mental health benefits, nor would it require that those plans cover all types of mental health services or ailments if the plan covered any mental health services or ailments. Laws in some states, however, require that plans cover those benefits, which would affect the potential impact of this bill on health plan premiums.

Revenues

The provisions of the bill 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. The bill also would exempt group health plans for whom the cost of complying with the requirements would increase total plan costs (for medical and surgical benefits and mental health benefits) by more than 2 percent in the first plan year following enactment, and 1 percent in subsequent plan years. In general, S. 558 would preempt state laws regarding parity of mental health benefits. The bill would not affect the application of state law for firms with fewer than 50 employees. In addition, because state parity laws and the proposed federal law are very similar, S. 558 would not have a significant impact on people already affected by state parity laws.

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 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 Federal Employees Health Benefits Program in January 2001.)

CBO estimates that S. 558, if enacted, would increase premiums for group health insurance by an average of about 0.4 percent, before accounting for the responses of health plans, employers, and workers to the higher premiums that would likely be charged 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 (including eliminating coverage for mental health benefits and/or substance benefits), and reductions in the scope or generosity of health insurance benefits, such as increased deductibles or higher copayments. CBO expects that those 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—less than 0.2 percent of group health insurance premiums—would occur in the form of higher spending 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 $2 billion in 2009 to $4.5 billion in 2017.

Those reductions in workers' taxable compensation would lead to lower federal tax revenues. CBO estimates that federal tax revenues would fall by $140 million in 2009 and by $3 billion over the 2009-2017 period if S. 558 were enacted. Social Security payroll taxes, which are off-budget, would account for about 35 percent of those totals.

Direct Spending

The bill's requirements for issuers of group health insurance would apply to managed care plans in the Medicaid program. CBO estimates that enacting S. 558 would increase Medicaid payments to managed care plans by about 0.2 percent. That is less than the 0.4 percent increase in the estimated increase in spending for employer-sponsored health insurance because Medicaid programs offer broader coverage of mental health benefits than the private sector. CBO estimates that enacting S. 558 would increase federal spending for Medicaid by $280 million over the 2009-2012 period and $790 million over the 2009-2017 period.

Spending Subject to Appropriation

S. 558 would require the Secretary of Labor and the Secretary of Health and Human Services to each designate an individual to serve as ombudsman to group health plans, and would require the departments to conduct random audits of plans to ensure that they are in compliance with the requirements of the bill. Based on the costs of implementing the Health Insurance Portability and Accountability Act of 1996, and assuming appropriation of the necessary amounts, CBO estimates that implementing S. 558 would increase spending by $20 million in 2008 and by $30 million to $40 million annually in subsequent years.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

S. 558 would preempt state laws governing mental health coverage that are different than those in this bill and that apply to firms with 50 or more employees. The 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 (PHSA) would allow state, local, and tribal governments, as employers that provide health benefits to their employees, to opt out of the requirements of this bill. Consequently, the bill's requirements for mental health parity 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. CBO estimates that state, local, and tribal governments would face additional costs of about $100 million in 2009, increasing to about $155 million in 2012. This estimate reflects the assumption that governments would shift roughly 25 percent of the additional costs to their employees.

Because the bill's requirements would apply to managed care plans in the Medicaid program, CBO estimates that state spending for Medicaid also would increase by about $210 million over the 2008-2012 period.

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 (including benefits for substance abuse treatment). S. 558 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. For plans that offer mental health benefits through a network of mental health providers, the requirement for parity of benefits would be established by comparing in-network medical and surgical benefits with in-network mental health benefits, and comparing out-of-network medical and surgical benefits with out-of-network mental health benefits.

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 calendar year 2007. Consequently, S. 558 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. 558 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 0.4 percent of employer-sponsored health insurance premiums compared to having no mandate at all.

CBO estimates that the direct costs of the mandate in S. 558 would be $1.5 billion in 2009, rising to $3.4 billion in 2013. Those costs would exceed the threshold specified in UMRA ($131 million in 2007, adjusted annually for inflation) in each year the mandate would be in effect.

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