CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

November 21, 2007

H.R. 1424
Paul Wellstone Mental Health and Addiction Equity Act of 2007

As ordered reported by the House Committee on Energy and Commerce on October 16, 2007

SUMMARY

H.R. 1424 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 (including benefits for substance abuse treatment) that are different from those used for medical and surgical benefits.

Enacting the bill would affect both federal revenues and direct spending for Medicaid, beginning in 2008. 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 estimates that the proposal would reduce federal tax revenues by $1.1 billion over the 2008-2012 period and by $3.1 billion over the 2008-2017 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 H.R. 1424 would increase federal direct spending for Medicaid by $310 million over the 2008-2012 period and by $820 million over the 2008-2017 period.

CBO has reviewed the non-tax provisions of the bill (sections 2, 3, and 5) and has determined that sections 2 and 3 contain intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). The bill would preempt state laws governing mental health coverage that conflict with those in this bill. 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 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, H.R. 1424 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 $1.3 billion in 2008, 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 H.R. 1424 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

ESTIMATED BUDGETARY EFFECTS OF H.R. 1424

	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)	-20	-120	-170	-190	-210	-230	-250	-260	-280	-300	-710	-2,030
Social Security Payroll Taxes (off-budget)	-10	-70	-100	-100	-110	-120	-130	-140	-150	-160	-390	-1,090
Total Changes	-30	-190	-270	-290	-320	-350	-380	-400	-430	-460	-1,100	-3,120
CHANGES IN DIRECT SPENDING												
Medicaid												
Estimated Budget Authority	30	60	70	70	80	90	90	100	110	120	310	820
Estimated Outlays	30	60	70	70	80	90	90	100	110	120	310	820

Note: HI = Hospital Insurance (Part A of Medicare)

BASIS OF ESTIMATE

H.R. 1424 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. It would, however, amend the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (IRC) to require mental health benefits of plans that choose to offer such benefits to be at least as generous as the Federal Employees Health Benefits Plan (FEHBP) with the highest average enrollment as of the beginning of the most recent plan year involved. It also would amend the Public Health Service Act (PHSA) to require that the mental health benefits of plans that choose to offer such benefits cover treatments for any mental health condition or substance-related disorder included in the most recent edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric

Association (APA). Finally, the bill would limit plans' methods for managing utilization of mental health and substance abuse services to those that are based on valid medical evidence and relevant to the patient whose medical treatment is under review.

Revenues

The provisions of the bill would apply to both self-insured and fully insured group health plans. Small employers (those employing fewer than 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, H.R. 1424 would not preempt state laws regarding parity of mental health benefits except to the extent that state laws prohibit the application of a requirement of the bill.

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 FEHBP in January 2001.)

CBO estimates that the requirement to cover all conditions contained in the DSM combined with the limitation on plans' use of utilization management would probably result in an increase in employer-sponsored health insurance premiums that would be larger than if the requirement was for a minimum scope of benefits alone. However, because the provision only applies to those plans that would be affected by the PHSA, its impact on costs would likely be small. In addition, existing laws in some states require that plans cover all types of mental health services or ailments, which would reduce the potential impact of this bill on health plan premiums.

CBO estimates that H.R. 1424, 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—about 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 $400 million in 2008 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 $30 million in 2008 and by $3.1 billion over the 2008-2017 period if H.R. 1424 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 H.R. 1424 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 H.R. 1424 would increase federal spending for Medicaid by $310 million over the 2008-2012 period and by $820 million over the 2008-2017 period.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 1424 would preempt state laws governing mental health coverage that conflict with 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 laws that conflict with the new federal standards, CBO estimates that the mandate would impose no significant costs on state, local, or tribal governments.

An existing provision in the 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 $10 million in 2008, 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 $235 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). H.R. 1424 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.

The bill further amends the PHSA by limiting plans' methods for managing utilization of mental health and substance abuse services to those that are based on valid medical evidence and relevant to the patient whose medical treatment is under review. Because the provision applies only to those plans who would be affected by the PHSA, its impact on costs would likely be small.

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, H.R. 1424 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 H.R. 1424 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 H.R. 1424 would be $1.3 billion in 2008, rising to $3.0 billion in 2012. 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.

PREVIOUS CBO ESTIMATES

On March 20, 2007, CBO transmitted a cost estimate for S. 558, the Mental Health Parity Act of 2007, as ordered reported by the Senate Committee on Health, Education, Labor, and Pensions on February 14, 2007. On September 7, 2007, CBO transmitted a cost estimate for H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007, as ordered reported by the House Committee on Education and Labor on July 18, 2007. On October 4, 2007, CBO transmitted a cost estimate for H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007, as ordered reported by the House Committee on Ways and Means on September 26, 2007.

All three versions of H.R. 1424 differ from S. 558 in several ways. H.R. 1424 would: (1) require mental health benefits of plans that choose to offer such benefits to meet a minimum benefits requirement; (2) exempt group health plans with collective bargaining agreements from the requirements of the bill until the later of the expiration of such agreements or January 1, 2010; (3) make conforming modifications to the Internal Revenue Code; and (4) apply to group health plans beginning January 1, 2008 (while S. 558 specified that the policy would be effective more than one year after the date of the enactment, affecting plans beginning on or after January 1, 2009).

CBO estimates the minimum benefit requirement and exception for the collective bargaining agreements under H.R. 1424 would have no significant budgetary effect, while the difference in the effective dates would affect our estimate for 2008 and 2009. CBO and the Joint Committee on Taxation estimate that conforming modifications to the IRC would result in a negligible impact on excise tax revenue collected from employers who fail to comply with the requirements of the bill.

The Ways and Means and Energy and Commerce Committees' versions differ from the Education and Labor Committee's version in that they would not include a mechanism for auditing group health plans or for providing assistance to beneficiaries of such plans. In addition, the Ways and Means and Energy and Commerce Committees' versions would amend the PHSA to require mental health benefits of plans that choose to offer such benefits to include benefits that are included in the most recent edition of the DSM of Mental Disorders published by the APA. Because this change alone would not be materially different from the requirement that such benefits be at least as generous as the FEHBP with the highest average enrollment as of the beginning of the most recent plan year, CBO estimated that the estimated budgetary effects of the Ways and Means Committee's version would be identical to those of the Education and Labor Committee's version.

The Energy and Commerce Committee's version differs from the other two versions in that it would impose a restriction on plans' methods for managing utilization of mental health and substance abuse services to those that are based on valid medical evidence and are relevant to the patient whose medical treatment is under review. However, because the provision applies only to those plans that would be affected by the changes to the Public Health Service Act, its impact on costs would probably be small.

ESTIMATE PREPARED BY:

Federal Costs: Jeanne De Sa and Shinobu Suzuki
Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum
Impact on the Private Sector: Stuart Hagen

ESTIMATE APPROVED BY:

Keith J. Fontenot
Deputy Assistant Director for Health and Human Resources,
Budget Analysis Division