Health Plans Respond to Parity: Managing Behavioral Health Care in the Federal Employees Health Benefits Program

M. SUSAN RIDGELY, M. AUDREY BURNAM,
COLLEEN L. BARRY, HOWARD H. GOLDMAN,
and KEVIN D. HENNESSY

*RAND Corporation; Yale University School of Medicine; University
of Maryland School of Medicine; Substance Abuse and Mental Health
Services Administration*

The government often uses the Federal Employees Health Benefits (FEHB) Program as a model for both public and private health policy choices. In 2001, the U.S. Office of Personnel Management (OPM) implemented full parity, requiring that FEHB carriers offer mental health and substance abuse benefits equal to general medical benefits. OPM instructed carriers to alter their benefit design but permitted them to determine whether they would manage care and what structures or processes they would use. This article reports on the experience of 156 carriers and the government-wide BlueCross and BlueShield Service Benefit Plan. Carriers dropped cost-restraining benefit limits. A smaller percentage also changed the management of the benefit, but these changes affected the care of many enrollees, making the overall parity effect noteworthy.

Key Words: Parity, managed care, behavioral health, health insurance.

FOR DECADES, HEALTH PLANS OFFERED COVERAGE FOR behavioral health disorders at significantly lower levels than for other medical conditions. The reason was the concern that lowering out-of-pocket costs through insurance would result in greater utilization and that individuals with mental health problems would be more likely to select plans that provided more generous coverage and therefore place those plans at a competitive disadvantage in the marketplace.

Address correspondence to: M. Susan Ridgely, RAND Corporation, 1776 Main Street, Santa Monica, CA 90407-2138 (email: ridgely@rand.org).

The Milbank Quarterly, Vol. 84, No. 1, 2006 (pp. 201–218)
© 2006 Milbank Memorial Fund. Published by Blackwell Publishing.

Many insurers, including those in the Federal Employees Health Benefits Program, limited insurance coverage by creating a restrictive benefit design that discouraged the enrollment of high-cost individuals and limited the enrollees' use of behavioral health services. Currently, the typical private-sector insurance benefit requires from the insured higher copayments for mental health services than for other medical services, and it imposes special limits on the use of behavioral health services (Barry et al. 2003). These limits have an efficiency rationale, and before the emergence of managed care, benefit design was the only way that insurers could restrict the use of behavioral health services. Employers, insurers, and others have argued that it is necessary to keep the current system of restricting behavioral health care through benefit design.

On the other side of the debate, advocates argue that special benefit limits on behavioral health care impede access to care, especially for adults and children with severe mental disorders. Rigid benefit limits (such as a limit of twenty outpatient treatment encounters per year) affect all insured persons equally, regardless of the severity of their illness. Advocates use the term *parity* to refer to a policy that specifies that mental health and substance abuse insurance benefits must be equal to the benefits for general medical care. Typically, this means expanding the coverage for behavioral health services by removing special limits on care (such as annual or lifetime limits on the number of outpatient visits or inpatient days) or by reducing copayments or deductibles for behavioral health care. Advocates of parity argue that limiting coverage for "diseases of the brain" while allowing full coverage for other diseases is a form of discrimination that should not be countenanced by federal and state policymakers. Advocates believe that full parity will increase access to behavioral health care and reduce out-of-pocket costs for people with mental illnesses. Parity initiatives focus on benefit design ("nominal benefits") rather than how health benefits are administered ("effective benefits").

Parity advocates have succeeded in getting a number of parity initiatives enacted into law at the federal and state levels. In 1996, Congress passed the Mental Health Parity Act, which prohibited annual or lifetime dollar limits on mental health coverage but did not provide full parity because it did not address day or visit limits or copayment requirements. Thirty-eight states also have enacted state parity laws that, though they differ substantially in scope, still fall short of providing full parity for all diagnoses. Full parity for behavioral health benefits nationally has not

been achieved due to limitations in the reach of state law (i.e., state insurance mandates are preempted by ERISA for self-insured health plans) and the advocates' failure, despite repeated attempts, to enact a full federal parity law.

Since the mid-1990s, when Congress was considering full parity at the federal level, research has accumulated suggesting that a restrictive benefit design is not the only way to constrain the costs of behavioral health care. Alternatives, including the use of "carve-outs," can achieve the same goals. The term *carve-out* refers to an arrangement in which a specific health benefit (in this case, behavioral health) is managed separately from the general medical benefit. Although other health benefits also are subject to carve-outs (e.g., dental benefits), the term is most often used in the behavioral health context. A number of studies have shown the effectiveness of carve-outs in constraining behavioral health treatment costs (Goldman et al. 1999; Goldman, McCulloch, and Sturm 1998; Ma and McGuire 1998; Sturm 1997). Studies of large employer groups that implemented both parity and managed care concurrently also found that even though the demand for mental health services sometimes rose, managed care more than offset any parity-related increases in demand (and therefore costs) for behavioral health treatment (Sturm, Goldman, and McCulloch 1998; Zuvekas et al. 2002). These findings suggest that parity can be achieved without "breaking the bank."

Some of these studies also found that health plans often respond to parity by carving out, but said little about what techniques these plans or carve-out vendors used to manage care. Beyond the decision of whether to carve out, do health plans put their carve-out vendors at financial risk (e.g., through the use of capitation contracts that pay a specified amount regardless of the quantity of services rendered)? Do they share risk with providers? Do they alter provider networks in order, for example, to control more tightly the use of certain types of providers? Do they, in fact, employ any of the specific techniques that have previously been associated with controlling the costs of behavioral health care?

Ours is the first national study to examine the implementation of parity by describing, in detail, the health plans' actual response. A study of the impact of parity in the Federal Employees Health Benefits (FEHB) Program, the nation's largest employer-sponsored health insurance program, offers an opportunity to understand how parity may affect the operation of health plans if Congress should decide to enact comprehensive national parity legislation. The FEHB Program serves 8.5 million

persons and has served explicitly as a model for Congress and various administrations to experiment with both public and private health care policy choices.

The Federal Employees Health Benefits (FEHB) Program

Public Law 86-382, enacted by Congress on September 28, 1959, created the FEHB Program to provide health coverage to federal employees, annuitants (retirees), and their dependents. The U.S. Office of Personnel Management (OPM) has administrative responsibility, which includes approving carriers¹ for participation; negotiating benefit and rate changes; receiving, depositing, and remitting premiums; auditing the carriers' operations; and evaluating the administration of the statute and the health plans the program offers (OPM 2004).

Currently, carriers offer more than 350 health benefits plans² under the FEHB Program. Fourteen of these are fee-for-service plans, seven of which are open to all enrollees, while another seven are limited to specific categories of federal employees (e.g., postal workers, Secret Service personnel). The largest fee-for-service plan is the government-wide Service Benefit Plan administered by the BlueCross BlueShield Association. The Service Benefit Plan covers approximately 50 percent of all enrollees, annuitants, and their dependents. Unions and employee organizations have other fee-for-service plans. Most fee-for-service plans are preferred provider organizations (PPO), and many require a preauthorization of expensive services (e.g., inpatient care). In addition, carriers offer health maintenance organizations (HMO) and point of service (POS) products at the regional, state, or local level.³

Carriers compete for market share. Enrollees have a choice of health plans and are given information about both their price and performance. Price information is important because enrollees face cost-sharing provisions (i.e., enrollees must pay at least 25 percent of the premium, and even more for plans with above-average premiums).

Parity in the FEHB Program

In an address at the 1999 White House Conference on Mental Health, President Bill Clinton directed OPM to implement parity by 2001. OPM

defined the goal of parity as coverage for mental health and substance abuse “identical with regard to traditional medical care deductibles, co-insurance, co-pays, and day and visit limitations” (OPM 2000, 2). According to the policy guidance, parity was to be applied by carriers to services provided by in-network providers. For out-of-network benefits, carriers were allowed to keep cost sharing, day/visit limits, and catastrophic maximums at year 2000 levels.

OPM anticipated that carriers would eliminate special deductibles, copayments, and other benefit limits that previously applied only to behavioral health benefits. OPM’s instructions specifically encouraged carriers to manage benefits by, for example, contracting with a carve-out vendor, employing utilization management techniques, and limiting networks of providers (OPM 2000). Rather than imposing explicit requirements, it was left largely to the carriers to determine what policies and procedures they would institute to control the possibly higher costs from the expected removal of benefit limits.

Evaluation of FEHB Parity

As part of a national evaluation funded by the U.S. Department of Health and Human Services and in collaboration with OPM, we studied the parity implementation experience of the carriers in the FEHB Program. The purpose of our study was to document the extent to which carriers responded to the parity mandate by changing the benefit design and adopting managed care strategies (e.g., carving out) intended to restrain use or cost. We expected that the carriers would remove deductible, copay, and coinsurance limits on behavioral health benefits in order to bring those benefits in line with general medical benefits, as directed by the OPM.⁴ In order to control the costs of providing behavioral health services under this more generous benefit design, we also expected that the carriers would be more likely to use managed care strategies.

Carriers could expand the behavioral health care benefit in a number of ways without greatly raising the cost. We expected that the carriers might conclude that in order to detect overutilization and to restrict care in a clinically appropriate way, they would need the assistance of vendors with experience in behavioral health care. Most health plans that carve out put their vendors at risk (e.g., through the use of capitation contracts), as a way of aligning their vendors’ financial incentives with their own. Often

these vendors “push the risk downstream” by changing the financial incentives for the providers in their networks. Unlike a fee-for-service reimbursement environment, in which the providers’ revenue rises with greater utilization, putting vendors and providers at risk ensures that they have a stake in managing utilization. Thus, we expected that both the number of carriers contracting with carve-out vendors and the use of at-risk contracts would increase and that we might even see changes in the use of financial incentives at the provider level.

We also anticipated that we might see changes in the provider networks. Costs can be controlled by limiting access to certain providers if the carriers refer certain patients to providers who have agreed to discount fees or whose practice patterns conform with the health plan’s preferences. Or carriers can respond to parity by expanding their provider networks in anticipation of more demand for behavioral health services.

Finally, we expected that care might be managed more intensely, so we examined the extent to which carriers changed the number and/or types of utilization controls they employed. For example, the use of primary care physicians as gatekeepers might be expected to reduce the use of expensive specialist care. Requiring prior authorization for services, or the submission of treatment plans, could be expected to have a dramatic impact on the use of services, by forcing providers to inform carriers in advance about their plans for treatment, especially for expensive treatment such as inpatient care. This article describes the carriers’ responses to parity by comparing benefits and the management of those benefits, both before and after parity.

Methods

We collaborated with the U.S. Office of Personnel Management to create a parity reporting requirement (PRR) that would be included in the annual reporting requirements for carriers. We developed closed-ended, fixed-choice survey items and tested them with nine carriers selected to achieve a mix of plan type, size, and geographic area. We also sought and received feedback from government project officers and other government-funded investigators working in the field of managed behavioral health care. The final version of the reporting requirement incorporated these revisions. RAND’s institutional review board reviewed and approved the data collection plan. OPM staff fielded the reporting

TABLE 1
Research Questions Addressed in the PRR

Research Questions	Respondents
Did the plans change the nominal benefit design?	
• Change the amount, scope and duration of benefits?	Carriers
• Remove the deductibles, copays, and coinsurance limits?	Carriers
• Add new mental health/substance abuse benefits?	Carriers
Did plans change the effective benefit design?	
• Contract with carve-out vendors?	Carriers and Blues plans
• Shift the risk to vendors (risk-based contracting)?	Carriers and Blues plans
• Change the financial incentives for providers?	Carriers
• Expand or limit the provider networks?	Carriers
• Increase the use of utilization management controls?	Carriers and Blues plans

requirement for the carriers active in 2002 and 2003, but the data collection was handled somewhat differently for the BlueCross and BlueShield Service Benefit Plan because it is a national plan administered both nationally and locally (described later).

PRR for Carriers

The PRR collected information about benefit design and management, including items designed to determine whether carriers were altering policy and procedures related to the management of the behavioral health benefit (the so-called effective benefit). Table 1 outlines the research questions addressed in the PRR.

The PRR was distributed electronically by email attachment. Data were collected at two points in time. In January 2002, the carriers were asked to provide pre- (2000) and post-parity (2001) implementation data, and in January 2003, the carriers were asked to describe current policy and procedures.⁵ Copies of all responses were forwarded to RAND for data entry and analysis. The response rate in 2002 was 98 percent ($n = 175$) and in 2003 was 99 percent ($n = 159$), for a total of 156 participating carriers responding at two points in time.

PRR for the Service Benefit Plan

The Service Benefit Plan was handled somewhat differently. As mentioned earlier, the Service Benefit Plan is a national fee-for-service plan administered by the BlueCross BlueShield Association. A national contract is negotiated between OPM and the association, and local plans share the risk with the association. Because the plans assume risk, decisions about policy and procedures (particularly about whether to carve out) are local decisions. Although the association is subject to OPM's regular reporting requirements, those plans participating in the Service Benefit Plan do not report individually to OPM.

In collaboration with the association and OPM, we constructed a short form of the PRR to be administered to the Blues plans at a single point in time (2003). The questions on this form asked only about the use of carve-outs and the use of various forms of utilization management. The form was sent by email attachment with instructions to send the response directly to OPM. All copies were forwarded to RAND for data entry and analysis. The response rate for the Blues plans was 100 percent, largely as the result of the association staff's active follow-up. Sixty-two plans are included in the analyses we reported.⁶ The responses from Blues plans are discussed separately in the relevant findings.

Results

Changes in the Nominal Benefit Design in Response to Parity

As Table 2 shows, the carriers did change their nominal benefit design, as expected, by removing amount, scope, and duration limits and by changing deductible, copay, or coinsurance limits on the behavioral health benefit, rather than by changing the physical health benefit or adding new benefits. Some carriers did not report changes because the pertinent parts of their nominal benefit already were in compliance with parity. As of January 2001 all carriers were in compliance.⁷ The loosening of these sorts of benefit limits is likely to increase access to services, because under parity, enrollees do not face predetermined limits on particular types of services, and their out-of-pocket expenditures presumably will be lower under parity. But because greater management of the benefit

TABLE 2
Changes in Nominal Benefits

FEHB Carriers (<i>n</i> = 141) ^a	Yes, 2001 Only	Yes, 2003 Only	Yes, 2001 & 2003	No
Changed amount, scope, or duration limits: MH				
% of plans	80.9	0.0	2.8	16.3
% of enrollees	75.9	0.0	0.8	23.3
Changed amount, scope, or duration limits: SA				
% of plans	70.2	0.0	2.8	27.0
% of enrollees	63.7	0.0	8.0	28.3
Changed amount, scope, or duration limits: PH				
% of plans	7.8	9.2	0.7	82.3
% of enrollees	1.2	7.9	4.3	86.6
Changed deductibles, copays, or co-ins.: MH				
% of plans	39.7	10.6	24.8	24.8
% of enrollees	36.8	2.8	52.0	8.4
Changed deductibles, copays, or co-ins.: SA				
% of plans	34.8	12.1	17.0	36.2
% of enrollees	28.4	3.4	47.5	20.6
Changed deductibles, copays, or co-ins.: PH				
% of plans	4.3	40.4	5.7	49.7
% of enrollees	10.2	52.1	13.1	24.6

Notes: ^aReporting only 141 of 156 carriers due to item nonresponse.

MH = Mental Health

SA = Substance Abuse

PH = Physical Health

could have an offsetting effect, we also looked carefully at the effective benefit design under parity.

Changes in the Effective Benefit Design in Response to Parity

The account of changes to the effective benefit design is a little more complicated because many carriers were managing behavioral health benefits in the preparity period.

Contracting with Carve-Out Vendors. The PRR included a question about the use of carve-out vendors such as managed behavioral health organizations. If the carrier responded in the affirmative, OPM asked whether this arrangement was a preexisting (preparity) or a new

TABLE 3
Contracts with Behavioral Health (BH) Vendor (Carve-Outs)

	Preexisting BH Vendor	Preexisting, in Anticipation of Parity	New Vendor in Response to Parity	New Vendor Other than Parity	No BH Other Vendor
FEHB Carriers (n = 156) in 2001					
% of plans	51.9	1.3	6.4	6.4	34.0
% enrollees	28.7	0.8	45.9	5.7	18.9
BCBS Service Benefit Plans (n = 62) in 2001					
% of plans	33.9	1.6	24.2	4.8	1.6 33.9
% enrollees	31.6	1.4	27.0	5.6	1.6 32.9

(postparity) arrangement and whether the arrangement was a response to the implementation of parity.

As Table 3 indicates, about half of the carriers had already carved out before the implementation of parity and continued those relationships in the postparity period. A third reported no carve-outs in either the pre- or the postparity period. Although most carriers made no change in carve-out status before and after parity, a small percentage of carriers did report that parity affected their decision to carve out. It is important to note that these carriers represent about half of all carrier enrollments. Most of the plans that carved out in response to parity were fee-for-service plans.

In addition, parity affected the largest fee-for-service plan. Because the Service Benefit Plan represents more than 50 percent of the total program enrollment, a parity effect on this national plan would be felt by a significant percentage of enrollees. The BlueCross BlueShield Association did not make a national policy decision about the issue of carving out. Instead, each Blues plan made its own decision. About a third of the Blues plans had preexisting carve-outs, and another third reported no carve-outs either before or after parity. In contrast to the carriers, 25 percent of the Blues plans reported that they carved out in anticipation of, or in response to, the implementation of parity. Together, these changes represent a strong response to the parity directive. Parity had an even larger effect on enrollees. Among those in the Blues plans, one-third had their behavioral health benefits managed by a carve-out organization before parity, which increased to two-thirds after parity. The carve-out effect on the Service Benefit Plan did erode somewhat over time, and by 2003, the Blues plans reported a loss of three carve-outs.

The Use of Risk-Based Contracts. Generally, parity had little effect on the use of risk-based contracting. The vast majority of carriers used at-risk contracts with vendors both before and after parity. Interestingly, although more Blues plans carved out after parity, they did not place their vendors at risk. Most Blues plans employed administrative services only (ASO) contracts with their vendors.

Financial Incentives for Providers. The PPR included questions about whether the carrier or its vendor had changed financial incentives (e.g., level of payment, withholds, bonuses) for specialty providers. While we thought that the vendors might use either withholds or bonuses to share risk with providers (in order to manage utilization), as Table 4 shows,

TABLE 4
Changes in Provider Networks

FEHB Carriers (<i>n</i> = 149) ^a	Changes in 2001	Changes in 2003
Financial incentives for individual MH providers		
% of plans	6.3	17.3
% of enrollees	15.9	13.8
Financial incentives for individual SA providers		
% of plans	5.6	12.6
% of enrollees	15.9	9.7
Financial incentives for institutional MH providers		
% of plans	6.3	16.3
% of enrollees	15.9	17.1
Financial incentives for institutional SA providers		
% of plans	6.3	12.6
% of enrollees	15.9	15.2
MH specialty providers in network increased > 5%		
% of plans	27.0	32.6
% of enrollees	47.0	24.1
SA specialty providers in network increased > 5%		
% of plans	17.0	23.4
% of enrollees	30.5	19.1
Geographic area of network expanded		
% of plans	17.0	15.9
% of enrollees	54.6	16.1

Notes: ^aReporting only 149 of 156 carriers due to item nonresponse.

MH = Mental Health

SA = Substance Abuse

TABLE 5
Use of Behavioral Health Utilization Controls by FEHB Carriers ($n = 152$)^a

	No in 2000, 2001, 2003	Yes in 2000, 2001, 2003	No in 2000, Yes in 2001 and/or 2003	Yes in 2000, No in 2001 and/or 2003
PCP gatekeeping				
% of plans	61.2	10.5	11.2	17.1
% of enrollees	77.1	3.9	12.7	6.3
Provider treatment plan				
% of plans	15.1	58.6	9.9	16.5
% of enrollees	8.7	36.4	46.4	8.5
Prior authorization				
% of plans	4.0	80.3	9.2	6.6
% of enrollees	8.7	49.0	41.0	1.3
Concurrent review				
% of plans	1.3	80.9	11.9	5.9
% of enrollees	0.3	49.9	48.8	1.1
Retrospective review				
% of plans	17.1	42.1	21.1	19.7
% of enrollees	11.4	21.1	51.9	15.5
Closed or preferred provider panels				
% of plans	18.4	52.0	17.1	12.5
% of enrollees	9.0	40.9	45.7	4.3
Disease management programs				
% of plans	34.2	34.9	15.8	15.1
% of enrollees	43.0	24.1	24.1	8.8

Note: ^aReporting only 152 of 156 carriers due to item nonresponse.

parity had little effect on the use of financial incentives in 2001. The 2003 data suggest, however, that the incentives may have been “tweaked” after two years under parity.⁸

Changing Provider Networks. A number of carriers reported that they expanded their provider networks in the postparity period and continued to expand them significantly through 2003 (see Table 4). In addition to having dropped benefit limits, having more specialty providers in health plan networks was likely to improve access to care. While carriers were enlarging the size and geographic base of their provider networks, they were not changing the disciplinary mix of providers. Most of the

carriers reported no changes in disciplinary mix for either mental health or substance abuse providers in either 2001 or 2003 (not shown).

The Number and Mix of Utilization Controls. Carriers and Blues plans were using a variety of techniques to manage care even before parity. Managing the benefit with utilization measures such as prior authorization and review of treatment plans is at least theoretically preferable to rigid benefit limits because it allows for clinically sensitive decisions about the appropriateness of care. OPM clearly expected that the carriers and Blues plans would adopt appropriate care management measures. In the PRR, carriers reported on their use of seven methods of controlling utilization.

TABLE 6
Use of Behavioral Health Utilization Controls by BCBS Service Benefit
Plans ($n = 62$)

	No in 2000, 2001, 2003	Yes in 2000, 2001, 2003	No in 2000, Yes in 2001 and/or 2003	Yes in 2000, No in 2001 and/or 2003
PCP gatekeeping				
% of plans	85.5	8.1	6.5	0.0
% of enrollees	89.2	5.1	5.7	0.0
Provider treatment plan				
% of plans	6.5	35.5	51.6	6.5
% of enrollees	7.5	25.4	66.5	0.6
Prior authorization				
% of plans	6.5	54.8	30.7	8.1
% of enrollees	2.8	55.7	39.3	2.2
Concurrent review				
% of plans	4.8	74.2	12.9	8.1
% of enrollees	2.3	81.9	13.8	2.0
Retrospective review				
% of plans	24.2	58.1	9.7	8.1
% of enrollees	27.5	57.9	11.7	2.9
Closed or preferred provider panels				
% of plans	19.4	53.2	27.4	0.0
% of enrollees	7.6	56.0	36.4	0.0
Disease management programs				
% of plans	79.0	12.9	8.1	0.0
% of enrollees	83.8	7.1	9.2	0.0

The effect of parity on the number and mix of utilization techniques used by the carriers and Blues plans is mixed. To a large extent, the carriers were already using utilization management techniques before parity (see Table 5). While relatively few carriers reported changes in 2001 and 2003, those carriers making changes represented a high percentage of enrollees, and therefore their changes affected a significant proportion of enrollees. The effect of parity on utilization management strategies also was apparent in the Blues plans (see Table 6). The BlueCross BlueShield Association's recommendation to institute a standard treatment planning requirement across its licensees appeared to lead to the adoption of such

TABLE 7
Association between Carve-Outs and Use of Behavioral Health Utilization Controls in 2001

	Carriers ^a No Carve-Out (<i>n</i> = 50)	Carriers ^a Carve-Out (<i>n</i> = 102)	BCBS Plans No Carve-Out (<i>n</i> = 21)	BCBS Plans Carve-Out (<i>n</i> = 41)
PCP gatekeeping				
# of plans	22	8	2	7
% of plans	44.0	7.8	9.5	17.0
Provider treatment plan				
# of plans	33	85	16	37
% of plans	66.0	83.3	76.2	90.2
Prior authorization				
# of plans	39	96	14	36
% of plans	78.0	94.1	66.7	87.8
Concurrent review				
# of plans	39	100	16	39
% of plans	78.0	98.0	76.2	95.1
Retrospective review				
# of plans	35	64	13	29
% of plans	70.0	62.7	61.9	70.7
Closed or preferred provider panels				
# of plans	28	72	15	30
% of plans	56.0	70.6	71.4	73.1
Disease management programs				
# of plans	25	55	2	7
% of plans	50.0	53.9	9.5	17.1

Note: ^aReporting on a total of 152 of 156 carriers due to item nonresponse.

strategies by the majority of Blues plans. In addition, the Blues plans increasingly reported the use of controls such as prior authorization and closed or preferred provider panels.

Was there an association between carving out and using other managed care strategies? As Table 7 shows, there were some differences in 2001 between those carriers and Blues plans that carved out and those that did not carve out. With a few exceptions, the carriers that carved out were more likely to be employing all types of utilization controls. It appears that carriers that did not carve out instead may have been using primary care physicians in their provider network to screen patients for referral to specialty care. Blues plans that carved out were more likely to be using the entire spectrum of utilization management controls.

Conclusion

In an effort to control the higher cost of the expanded insurance coverage, carriers responded to OPM's encouragement to manage behavioral health benefits. The parity effect was somewhat less pronounced than some in the field had anticipated because many carriers were already managing their benefits to deal with the secular trend of rising expenditures. Many carriers had carved out before the implementation of the parity directive. Carriers and Blues plans, especially fee-for-service plans, that had not already carved out when parity was implemented were more likely to carve out, whereas others managed the benefit in more limited ways (such as adding treatment-planning requirements for providers). Although not all chose to carve out, those that did were among the largest carriers. It is clear that the OPM parity policy directive was associated with an increase in various forms of managed care, although not so much as to put vendors and/or providers at risk.

These findings are evidence that a parity policy can be implemented as intended and, at the same time, may have a moderate effect on health plans' operations because many, if not most, health plans are already managing behavioral health care. A companion study of nine large plans suggests that carriers and Blues plans were able to control the costs of removing restrictions on the benefit whether or not they instituted their managed care structures in response to parity. That study found that the utilization of behavioral health care increased equally with secular trends, that out-of-pocket spending generally declined, and

that the quality of care improved slightly or was unaffected by parity. The study also produced no systematic evidence suggesting that the total amount of behavioral health spending under parity grew more rapidly than did the spending in a comparison set of health plans serving large privately insured populations. (For a complete discussion of the findings regarding access, utilization, quality, and cost, see <http://www.aspe.hhs.gov/daltcp/reports/parity.htm>.) These findings should be instructive to the Congress when it considers whether to enact a comprehensive federal parity statute. Much more is known now than when the Congressional Budget Office reviewed the RAND Health Insurance Experiment and suggested that implementing parity could negatively affect costs for health insurance coverage. Those analyses did not reflect spending in an era of managed care.

Our study findings reinforce the expectation that implementing parity will be associated with greater management of behavioral health care. Some advocates have characterized this association—between parity and managed care—as a Faustian bargain (Frank, Goldman, and McGuire 2001). Accepting restrictions on the benefit in the form of managed care may be seen as taking away with the left hand what parity offers with the right hand. For OPM and the carriers, however, managed care made parity possible in the real world. Our study also found that the restrictions imposed by the various forms of management selected by the carriers were not as extreme as some had feared. Furthermore, they were part of a longer-standing effort to control the secular trend of increasing health care spending that both predates and parallels the parity movement.

Endnotes

1. A *carrier* is legal entity (e.g., voluntary association, corporation, partnership, or other nongovernmental organization) that offers a health benefits plan approved by the U.S. Office of Personnel Management (OPM 2004).
2. A *health benefits plan* is a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services (OPM 2004).
3. Some BlueCross BlueShield licensees are carriers (i.e., provide an HMO and/or POS product to enrollees) and also participate in the government-wide fee-for-service Service Benefit Plan administered by the BlueCross BlueShield Association.
4. There was also a (theoretical) possibility that carriers might have achieved parity by limiting their health benefits instead of removing limits on their behavioral health benefits. Although

- this was not specifically prohibited by OPM, it apparently was not considered or was considered and rejected.
5. The response categories for one of the questions were modified slightly in the 2003 version of the PRR. Another question was dropped because it yielded little useful information in 2002. Otherwise, the items on the 2002 and 2003 PRRs were identical.
 6. Responses from two of the sixty-four Blues plans were dropped from the analysis because those plans share responsibility for covering enrollees with other association licensees in their jurisdictions.
 7. Using data from health plan brochures, Hennessey and Barry (2004) documented that all carriers, as well as the Service Benefit Plan, were in full compliance with the parity directive in January 2001. They also offered data on preparity behavioral health benefit limits.
 8. These effects could have been the result of secular trends, although the PRR asked carriers and Blues Plans to report on the implementation of parity. Unless the respondent specifically indicated otherwise (i.e., the change being reported was not related to parity), we attributed these changes to parity. In a separate but related study (Ridgely et al. 2005), we conducted in-depth interviews on parity implementation with respondents from nine carriers and Blues plans. These interviews suggested that plans might be concerned about the response of federal employees to managed care. Some respondents told us that they made only minor changes in 2001, with the expectation that they could "tweak" their benefit management in later years if costs rose rapidly under the expanded benefit.

References

- Barry, C., J. Gabel, R. Frank, S. Hawkins, H. Whitmore, and J. Pickreign. 2003. Design of Mental Health Benefits: Still Unequal after All These Years. *Health Affairs* 22(5):127–37.
- Frank, R.G., H.H. Goldman, and T.G. McGuire. 2001. Will Parity in Coverage Result in Better Mental Health Care? *New England Journal of Medicine* 345(23):1701–4.
- Goldman, W., J. McCulloch, B. Cuffel, and D. Kozma. 1999. More Evidence for the Insurability of Managed Behavioral Health Care. *Health Affairs* 18(5):172–81.
- Goldman, W., J. McCulloch, and R. Sturm. 1998. Costs and Use of Mental Health Services before and after Managed Care. *Health Affairs* 17(2):40–52.
- Hennessey, K., and C. Barry. 2004. Parity in the Federal Employees Health Benefits Program: An Overview in *Mental Health, United States 2002*. Rockville, Md.: National Institute for Mental Health.
- Ma, C., and T. McGuire. 1998. Costs and Incentives in a Mental Health Carve Out. *Health Affairs* 17:53–69.
- Ridgely, M.S., S. Teleki, M.A. Burnam, H. Huskamp, and M. Rosenthal. 2005. "Effective" Benefit Design in Eight Large Health Plans: Implementation of Parity in the Federal Employees Health Benefits Program. Unpublished manuscript.

- Sturm, R. 1997. How Expensive Is Unlimited Mental Health Coverage under Managed Care? *Journal of the American Medical Association* 278(18):1533–37.
- Sturm, R., W. Goldman, and J. McCulloch. 1998. Mental Health and Substance Abuse Parity: A Case Study of the Ohio State Employees Program. *Journal of Mental Health Policy and Economics* 1(2):129–34.
- U.S. Office of Personnel Management (OPM). 2000. Call Letter for Contract Year 2001—Policy Guidance. FEHB Program Carrier Letter no. 2000-17. Washington, D.C., April 11.
- U.S. Office of Personnel Management (OPM). 2004. *Federal Employees Health Benefits Handbook*. Available at <http://www.opm.gov/insure/handbook/fehb01> (accessed April 10, 2004).
- Zuvekas, S.H., D.A. Regier, D.S. Rae, A. Rupp, and W.E. Narrow. 2002. The Impacts of Mental Health Parity and Managed Care in One Large Employer Group. *Health Affairs* 21(3):148–59.

Acknowledgments: The research reported in this article was conducted under contract to the Office of the Assistant Secretary of Planning and Evaluation of the U.S. Department of Health and Human Services (Contract Number HHS-100-00-0025, Northrop Grumman Information Technology, Inc., prime contractor). The authors would like to acknowledge the valuable guidance and assistance of colleagues at the U.S. Office of Personnel Management, in particular, Abby Block, Janet Pfleger, Anne Easton, and Michael Kaszynski, as well as the BlueCross BlueShield Association, in particular, Bonnie Wagman and Catherine VanVonno.