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Lessons for Health Reform from the Hard-won Success of Behavioral Health Insurance Parity

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As federal efforts to enact a major health care overhaul heat up, it is tempting to look to history for guidance on how to negotiate a successful path to reform. We have ample cautionary tales to draw upon – almost 100 years and counting of failed attempts at health reform. Proponents of reform have paid considerable attention to avoiding the mistakes of the 1993–94 Clinton era effort, for example. There has been less consideration given to whether policy successes offer lessons for reformers. The sheer scale of an effort aiming to rearrange 17 percent of the U.S. economy defies easy analogy. Nonetheless, a recent success on a long-standing health policy issue may be worth reflecting on at this key junction in health reform.

In autumn of 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity (MHPAE) Act was enacted into law. Efforts to achieve parity in insurance benefits for mental health and substance abuse date back almost 50 years to the John F. Kennedy administration. The intent of the MHPAE Act is to end historical differences in coverage provisions in private health insurance by equalizing behavioral and general medical benefits. Parity has long been viewed as a means of improving efficiency and fairness by reducing insurers' ability to select patients based on their risk in private health insurance markets.

Historical analogies are imperfect. One can easily come up with more differences than similarities when comparing parity to health reform. Health reform involves many more groups and dollars and, unlike parity, is highly salient with the public. Parity does not expand coverage to the uninsured, will have no real impact on the federal budget or Medicare, and includes an escape clause for businesses that experience a two percent premium increase attributable to the policy, a provision with no analogy in health reform. Despite these and numerous other differences, the successful enactment of parity by Congress after many failed attempts offers three lessons of relevance to health reform architects.

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First, the parity experience suggests that reformers' ability to identify a strategy to address cost concerns can create the political leverage necessary to allow policymakers to seriously contemplate insurance expansion. During the 1990s, actuarial estimates of the cost impact of parity produced widely disparate projections ranging from a 1 percentage point to an 11 percentage point increase in total premiums that led Congress to believe that there was unknown financial risk. Failure to enact parity during this period was largely attributed to uncertainty over the cost of parity legislation. This concern was addressed as newer evidence emerged on the cost of parity in the context of managed care. Research on states' experiences with parity and on the effects of a parity directive in the Federal Employee Health Benefits Program consistently demonstrated that the policy had little impact on spending under managed care but did increase consumer risk protection by lowering family out-of-pocket costs.¹ This new evidence resulted in the Congressional Budget Office (CBO) scoring parity legislation at a much lower cost than in the past beginning in 2001. It also convinced employers and insurers that comprehensive parity would not break the bank.

Albeit on a much larger scale, current uncertainty in Congress about how to pay for health reform is reminiscent of early cost concerns related to expanding mental health coverage. The market shift from indemnity insurance to managed care created a readily available method for enacting parity without driving up costs; resolving the dilemma of how to assemble a viable combination of financing and cost containment provisions poses a more daunting challenge for health reformers. However, the parity experience suggests that the sooner congressional architects can agree upon a strategy for financing reform, the sooner attention will shift back to negotiating the contours of insurance expansion.

Second, ironing out the most acrimonious differences among stakeholders early in the legislative process and behind closed doors can improve the odds of successful reform. A great achievement of parity is that it is viewed as a legislative triumph both by mental health and addiction treatment advocates and by the business community that had opposed it for decades. Its passage is the product of successful efforts within the Senate to bring competing interests into dialogue in a private venue rather than engaging in the more common process of "shuttle diplomacy" with congressional staff serving as intermediaries. At the behest of longtime parity champion Senator Pete Domenici (R-NM), the ranking majority and minority Health, Education, Labor and Pensions (HELP) Committee members Senators Edward Kennedy (D-MA) and Michael Enzi (R-WY) invited business and insurance groups to participate in closed-door meetings to explore promising areas of compromise on parity. Provider and consumer groups eventually joined these discussions with the goal of crafting a joint bill that most groups could support. This process was instrumental to the shape of the parity bill that emerged from the Senate HELP committee, clearing the way for passage by the full Senate and eventual agreement on a Senate-House conference bill, which, in an unexpected 11th hour legislative maneuver, became the vehicle for the \$700 billion financial bailout law signed by President Bush in October 2008.

Despite the rhetorical appeal of transparency in the current reform debate, our view is that a similar process of resolving contentious issues with interest groups behind closed doors could prove instrumental to improving the odds of successful health reform. There are some encouraging signs that this lesson is being heeded in the Senate. Based in some part on the success of the process leading to enactment of parity described above, this model of negotiating with interest groups in private was replicated on a larger scale in the form of the Workhorse Group, a set of stakeholders invited to participate in closed-door sessions on health reform in the Senate HELP Committee. These negotiations were critical to shaping the bill language adopted by the committee. While one of the great failures of the 1993–94 health reform debate was the inability of a single committee of jurisdiction in the Senate or the House to find sufficient common ground to successfully vote a bill out of committee, the Senate HELP

Committee voted its bill out in July. This sign of progress is due in part to efforts to confront heated issues with interest groups early on and, to the extent possible in the context of the media frenzy over health reform, in a manner shielded from intense public scrutiny.

Finally, parity enactment provides a sobering reminder that the implementation phase matters. Given the major hurdles to moving health reform through Congress, some may argue that it is premature to worry about implementation. Yet, the experience with parity suggests that health reform architects ignore the rulemaking process at their peril. Rulemaking involves federal agencies making administrative determinations about how to interpret legislative language. In the case of parity, this process involved a request for comments posted in the *Federal Register* in late April 2009 from the three regulatory agencies charged with implementing the law, to be followed this fall by the issuance of proposed and final rules.

After observing the collaborative process among interest groups over the final shape of the parity law, one might have anticipated a united front in the rulemaking phase. Instead, groups' public comment letters have been focused narrowly on advancing self-interested and often conflicting aims. Provider groups have raised concerns about fees. Business groups want clarification that they have both latitude in managing care and the option of offering separate (but equal) deductibles and catastrophic limits for behavioral health benefits. Consumer groups are seeking the broadest interpretation of parity that extends to benefit management as well as treatment settings. In essence, the rulemaking process has created a contentious second bite at the apple for groups that had been temporarily united under a shaky alliance to win passage of the law.

Political scientists have long observed this tendency of interest groups to re-fight policy battles at the rulemaking stage,² and this phenomenon is familiar to those who have studied the politics of Medicare coverage policy³ or Medicare payment reform,⁴ for example. Given the way health reform is taking shape, a best guess is that many key legislative provisions will be skeletal in their detail. This suggests that implementation will be even more important in the context of health reform, and anticipating and nailing down potential areas of contention ahead of time will be crucial.

In sum, we contend that three key lessons from parity are relevant, albeit on a larger scale, to health reform. First, the sooner congressional leaders can reach agreement on a package of provisions to finance proposed reforms, the better chance they will have to gain buy-in on the structure of insurance expansions. Second, resolving key conflicts with interest groups early and in private could improve the odds of successful reform. Finally, anticipating the issues likely to come up in implementation prior to bill passage could be helpful in averting a second round of political wrangling and uncertainty in the rulemaking phase.

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