Trends in employer-provided mental health and substance abuse benefits

Traditionally, employer-provided coverage for mental disorders and substance abuse treatment has been more restrictive than for other medical care benefits; recent data from the BLS National Compensation Survey show substantive changes in narrowing some of those differences, primarily as a result of State and federally-mandated benefits.

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Employer-provided mental health coverage has experienced dramatic changes over the last decade. Prior to the passage of the Mental Health Parity Act (MHPA) of 1996, nearly all employer-financed health insurance plans covered mental disorders, but benefits were traditionally more restrictive than for other illnesses.[1] Coverage for mental disorders, for example, was usually for shorter periods, and plans generally provided lower annual and lifetime maximum dollar benefits. This was particularly true for outpatient care. The primary impact of the MHPA on mental health provisions was the requirement that coverage for lifetime and annual dollar limits for mental health benefits be the same as those for medical and surgical benefits. Data from the Bureau of Labor Statistics' National Compensation Survey (NCS) show recent changes in mental healthcare provisions that affect most participants.[2] For example, the incidence of employees in medical plans imposing more restrictive dollar limits on mental healthcare has decreased from 41 percent in 1997 to 7 percent in 2002 for inpatient care and from 55 percent to 7 percent for outpatient care.[3] In contrast, the incidence of employees covered by medical plans that provide for fewer inpatient days of care for mental illness than for other medical conditions has increased from 61 percent in 1997 to 77 percent in 2002.

According to current estimates, at least one in five people has a diagnosable mental disorder during the course of a year. Approximately 15 percent of those with mental disorders also suffer from a substance abuse disorder.[4] Similar to mental health benefits, substance abuse benefits have typically been subject to separate and more restrictive limits than benefits for other illnesses. Employer-provided substance abuse benefits have shown changes since 1997, although these changes have not always been as pronounced as those for mental healthcare benefits. The MHPA of 1996 did not affect substance abuse treatment benefits. The incidence of employees in medical care plans with day limits for inpatient detoxification, for example, has only increased from 53 percent in 1997 to 58 percent in 2002. In contrast, the incidence of plans imposing dollar limits for inpatient detoxification has dropped from 37 percent to 17 percent over the same period. This article presents and compares data from the Bureau's 1997 Employee Benefits Survey and the 2000 and 2002 NCS[5] and provides brief background, historical, and economic perspectives on the topics of mental health and substance abuse care.

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Mental healthcare in perspective

The Surgeon General describes mental disorders as health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning. The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) reported that, in 2002, an estimated 27.3 million Americans aged 18 or older (13 percent of adults) received treatment for a mental illness in the 12 months prior to the study.[6] An estimated 17.5 million Americans aged 18 or older (8.3 percent of adults) had a serious mental illness, and slightly less than one-half of these received treatment in the prior 12 months. Of those whose treatment needs were unmet, more than two-fifths said they could not afford treatment, and about one-fifth said they did not know where to go to receive treatment.

In 2003, the President's New Freedom Commission on Mental Health reported that "mental illnesses rank first among illnesses that cause disability in the United States, Canada, and Western Europe."[7] In 1997, the latest year for which comparable data are available, the Commission reports that the United States spent more than $1 trillion on healthcare, including almost $71 billion associated with the direct costs of providing diagnosis and treatment of mental illnesses. About 57 percent of those direct mental health expenditures were publicly funded, compared with 46 percent for overall healthcare expenditures.[8] In addition to direct costs, the annual economic indirect cost to the U.S. economy was estimated in 1990 at $79 billion. Most of that indirect cost, about $63 billion, reflects the loss of productivity for workers suffering from mental illnesses. The indirect costs also include an estimated $12 billion in lost productivity due to mortality, and nearly $4 billion in lost time for incarcerated individuals and those providing family care. Between 1986 and 1996, mental health spending did not keep pace with the levels of general healthcare spending due to declines in private health spending under managed care programs and cutbacks in hospital expenditures.[9]

In the workplace, several studies have consistently found that workers who report symptoms of mental disorders have higher absenteeism and lower earnings than otherwise similar coworkers.[10] Depending on the specific study, findings indicate that anywhere from one-seventh to one-fourth of U.S. workers suffer from mental disorders during a given year. The most common mental disorder in employee populations is depression. As in the general population, many workers suffer from multiple disorders such as depression and substance abuse problems.

Prior to World War II, treatment of mental disorders was primarily in the purview of State mental hospitals.[11] Early insurance carriers, which emerged in the late 1930s, limited benefits to nonpsychiatric illness and injury. In the late 1940s, general hospitals began to include psychiatric clinics and staff psychiatrists. Commercial insurance carriers followed suit by including hospitalization coverage for mental illness. Eventually, State laws mandated inclusion of mental health benefits in commercial health insurance policies, and about one-half of States had such mandated benefits by 1984. Blue Cross and Blue Shield followed the commercial carrier lead and by 1971, all Blue Cross and Blue Shield plans provided mental health coverage for member hospitals and medical benefits. Outpatient coverage for mental health benefits, first introduced in the 1950s by commercial carriers, was a common benefit by the 1960s. Insurers soon began to place limits on outpatient mental health benefits to avoid paying for treatments of indefinite duration.

This early pattern of mental health coverage essentially remained the same throughout the 1980s and early 1990s. While coverage for outpatient mental healthcare rose modestly through the 1980s, restrictions such as day and dollar limits became more prevalent. Separate day limits for inpatient benefits, which provided fewer days of care for mental healthcare than for other illnesses, also became common in an effort to curb the skyrocketing costs of healthcare. Such restrictions on mental healthcare peaked in the early 1990s when States began to mandate that insurers provide comparable benefit levels for inpatient mental healthcare. These mandates, while beneficial to some healthcare subscribers, did not provide widespread relief primarily due to these mandates' typically limited scope.[12] Congress expressed their concern regarding the disparity of coverage for treatment of mental disorders with the passage of the Mental Health Parity Act of 1996.

Parity statutes force changes in coverage

Traditionally, more restrictions have been placed on health insurance coverage for mental disorders than on coverage for other illnesses.[13] Efforts have been undertaken to enact legislation requiring that insurance coverage for mental health services be comparable to coverage for medical and surgical services. On September 26, 1996, President Clinton signed the Mental Health Parity Act of 1996.[14] Mental health parity refers to the effort to treat the financing of mental healthcare benefits provided through a health insurance plan on the same basis as the financing of general health services.

The MHPA reduces differences in the way medical care plans treat mental health benefits and medical and surgical benefits in terms of lifetime and annual dollar benefit limits. It does not, however, mandate employers to offer mental health coverage and is limited to employers who offer health insurance that includes mental health coverage. The MHPA still allows day limits for inpatient or outpatient care, higher

deductibles or coinsurance, and restrictions on prescription drugs.[15]

The MHPA was followed by similar parity acts in many States. Prior to passage of the Act in 1996, only five States had parity laws, and those provisions varied. Since enactment of the MHPA, 33 States have passed laws prohibiting discrimination in insurance and managed care coverage of mental illness.[16] Some of these State laws are even stricter on mental health discrimination than the Federal law. Most of these differences fall in the categories of type of mental health mandate, definition of mental illness, the inclusion of substance abuse coverage, small employers' coverage, and cost-increase exceptions. Several economic factors may affect a State's decision to enact legislation beyond that required by the MHPA, among them: "higher levels of per-capita mental health spending; a higher proportion of the population under managed care; a higher level of mandated health benefits; and higher levels of education."[17] Also, States with a higher percent of small business firms may be less likely to adopt stricter mental health parity laws.[18]

Implementation of the MHPA is not expected to have a huge impact on the costs of medical care. A study conducted by the National Advisory Mental Health Council (NAMHC) Parity Workgroup, the National Institute of Mental Health (NIMH), other Federal agencies, and nonfederal consultants has predicted that the cost increase in health benefits as a result of the MHPA is 1.4 percent. This cost was previously estimated at 3.6 percent.[19] This study uses recent data from the Hay model, actuarial data from the Federal Employees Health Benefit Program, data from large managed behavioral healthcare companies, and information about large State employees' health plans. The study cautions, however, that this 1.4 percent may be overestimated because it does not take into consideration recent changes in mental health treatment programs.

New look for employer-provided plans

The effect of the Mental Health Parity Act on mental health coverage can be examined by comparing mental health benefits provided by employer-sponsored medical plans before and after January 1, 1998, the day the MHPA took effect. BLS data show the percent of workers covered by mental healthcare benefits and the percent whose plans impose more restrictions on mental healthcare benefits than other illnesses. (See tables 1 and 2.)

Table 1. Medical care benefits: coverage for selected services, by type of plan, private industry, 1997, 2000, and 2002

Service	1997 All employees	2000 All employees	2002 All employees	2002 1 – 99 workers	2002 100 workers or more
Total with medical care	100	100	100	100	100
Inpatient mental health	96	93	93	92	93
Outpatient mental health	95	93	92	90	93
Inpatient alcohol detoxification[1]	98	94	95	95	94
Inpatient alcohol rehabilitation[2]	80	80	83	83	84
Outpatient alcohol rehabilitation[2]	84	85	87	86	87
Inpatient drug detoxification[1]	97	94	94	94	95
Inpatient drug rehabilitation[2]	80	79	83	82	84
Outpatient drug rehabilitation[2]	83	84	87	86	87
Indemnity					
Inpatient mental health	97	93	93	92	94
Outpatient mental health	93	90	91	89	92
Inpatient alcohol detoxification[1]	97	92	93	92	93
Inpatient alcohol rehabilitation[2]	84	81	86	87	85
Outpatient alcohol rehabilitation[2]	85	84	87	88	86
Inpatient drug detoxification[1]	96	92	93	92	93
Inpatient drug rehabilitation[2]	84	81	86	86	86
Outpatient drug rehabilitation[2]	84	83	87	87	86
Prepaid					
Inpatient mental health	95	91	92	92	92
Outpatient mental health	99	97	95	92	97
Inpatient alcohol detoxification[1]	99	98	98	99	98
Inpatient alcohol rehabilitation[2]	72	76	78	77	79
Outpatient alcohol rehabilitation[2]	82	87	87	83	89
Inpatient drug detoxification[1]	98	98	98	99	98
Inpatient drug rehabilitation[2]	72	76	78	75	80
Outpatient drug rehabilitation[2]	81	87	86	83	89

[1] Detoxification is the systematic use of medication and other methods under medical supervision to reduce or eliminate the effects of substance abuse.

[2] Rehabilitation is designed to alter abusive behavior in patients once they are free of acute physical and mental complications.

Table 2. Mental healthcare and alcohol abuse treatment benefits: relationship to coverage for other illnesses, private industry, 1997, 2000, and 2002

Relationship to coverage for other illnesses	1997 All employees	2000 All employees	2002		
			All employees	1 – 99 workers	100 workers or more
Mental healthcare					
Inpatient care					
Total covered	100	100	100	100	100
Covered the same	12	13	11	14	9
Covered differently	88	87	89	86	91
Outpatient care[1]					
Total covered	100	100	100	100	100
Covered the same	2	6	7	10	6
Covered differently	98	94	93	90	94
Alcohol abuse					
Inpatient detoxification[2]					
Total covered	100	100	100	100	100
Covered the same	25	26	20	26	15
Covered differently	75	74	80	74	85
Inpatient rehabilitation[3]					
Total covered	100	100	100	100	100
Covered the same	7	7	8	14	4
Covered differently	93	93	92	86	96
Outpatient rehabilitation					
Total covered	100	100	100	100	100
Covered the same	6	8	8	12	6
Covered differently	94	92	92	88	94

[1] Includes treatment in one or more of the following: outpatient department of a hospital, residential treatment center, organized outpatient clinic, day-night treatment center, or doctor's office. If benefits differed by location of treatment, the location offering the most beneficial coverage was tabulated.

[2] Detoxification is the systematic use of medication and other methods under medical supervision to reduce or eliminate the effects of substance abuse.

[3] Rehabilitation is designed to alter the abusive behavior in patients once they are free of acute physical and mental complications.

Although there was little difference from 1997 to 2002 in the extent to which medical plans imposed more restrictive limits on mental healthcare benefits than other illnesses, there were changes in the specific limitations. (See table 3.) There was a significant decrease, for example, in the percent of workers with restrictions on dollar limits for care received. For inpatient care, the percent of covered workers who had a dollar limit imposed on services received dropped from 41 percent in 1997 to 7 percent in 2002. Outpatient care saw an even greater decline in the percent of those with a limit placed on dollars, from 55 percent in 1997 to 7 percent in 2002.

Table 3 also shows that there was an increase in restrictions on the number of inpatient and outpatient days of mental healthcare available from 1997 to 2002: the Mental Health Parity Act does not prohibit plans from imposing such limits. An example of a more restrictive day limit for mental healthcare would be a plan where patients are limited to 30 days of inpatient mental healthcare, but unlimited days of inpatient care for other medical conditions. The percent of covered workers whose plan imposed more restrictive limits on the number of days covered for hospital room and board increased from 61 percent in 1997 to 77 percent in 2002. Similarly, the percent subject to a limit on the number of days covered for outpatient visits increased from 53 percent in 1997 to 75 percent in 2002. There was virtually no change in the percentage of employees with medical care plans that imposed a less generous coinsurance rate for mental health inpatient care than for other illnesses.[20] Those subject to a less generous coinsurance rate for outpatient care, on the other hand, decreased to 18 percent in 2002 from 36 percent in 1997. While there was generally little difference in the 2002 NCS data between establishments employing 1–99 workers and those employing 100 workers or more, workers in the larger establishments were more likely to be subject to more restrictive limits on the number of days for both inpatient and outpatient mental healthcare.

Furthermore, separate data for prepaid plans and indemnity[21] plans show a decreasing trend in the dollar limits provisions for both inpatient and outpatient coverage. For example, between 1997 and 2002, inpatient coverage for prepaid plans showed an 8-percentage-point drop in the number of workers in plans with dollar limits (from 12 percent to 4 percent). (See table 4.) Workers in plans with dollar limits for outpatient coverage dropped from 19 percent to 4 percent during the same period. Indemnity plans showed the same pattern. (See table 5.) Workers in indemnity plans with

Table 3. Mental healthcare benefits: separate limits on coverage, private industry, 1997, 2000, and 2002

Coverage limitation	1997 All employees	2000 All employees	2002		
			All employees	1 – 99 workers	100 workers or more
Inpatient care					
Total with mental healthcare benefits	100	100	100	100	100
No separate limits[1]	14	15	15	19	12
Subject to separate limits[2]	86	85	85	81	88
Days	61	76	77	71	81
Dollars	41	10	7	9	6
Coinsurance	13	13	11	11	12
Copayment	7	3	12	12	12
Other[3]	1	4	4	4	5
Outpatient care[4]					
Total with mental healthcare benefits	100	100	100	100	100
No separate limits[1]	4	7	10	13	9
Subject to separate limits[2]	96	93	90	87	91
Days	53	72	75	70	79
Dollars	55	15	7	8	6
Coinsurance	36	20	18	20	17
Copayment	30	30	29	27	31
Other[3]	2	16	9	11	8

[1] These include plans that provide coverage without any separate limits; they also include plans that provide coverage subject to only the major medical limits of the plan.

[2] Separate limitations indicate that mental healthcare benefits are more restrictive than benefits for other treatments. For example, if a plan limits inpatient mental healthcare to 30 days per year, but the limit on inpatient care for any other type of illness is greater than 30 days per year, the plan contains separate limits. The total is less than the sum of the individual items because many plans had more than one type of limitation.

[3] These are plans where comparisons were made between copayments and coinsurances for mental healthcare and all other illnesses. For example, outpatient mental healthcare had a 50 percent coinsurance payment, while office visits for other illnesses had a $10 copayment.

[4] Includes treatment in one or more of the following: outpatient department of a hospital, residential treatment center, organized outpatient clinic, day-night treatment center, or doctor's office. If benefits differed by location of treatment, the location offering the most beneficial coverage was tabulated.

NOTE: Sum of individual items is greater than total because some participants were in plans with more than one type of limit.

Table 4. Mental healthcare benefits: separate limits on coverage in prepaid plans, private industry, United States, 1997, 2000, and 2002

Coverage limitation	1997 All employees	2000 All employees	2002		
			All employees	1 – 99 workers	100 workers or more
Inpatient care					
Total with mental healthcare benefits	100	100	100	100	100
No separate limits[1]	10	15	16	19	14
Subject to separate limits[2]	90	85	84	81	86
Days	84	77	77	72	82
Dollars	12	7	4	6	3
Coinsurance	10	10	8	7	9
Copayment	16	5	14	15	13
Other[3]	1	2	3	2	4
Outpatient care[4]					
Total with mental healthcare benefits	100	100	100	100	100
No separate limits[1]	3	9	7	8	6
Subject to separate limits[2]	97	91	93	92	94
Days	83	77	84	82	85
Dollars	19	8	4	5	2
Coinsurance	13	6	10	8	12
Copayment	61	44	44	40	48
Other[3]	1	8	7	9	5

[1] These include plans that provide coverage without any separate limits; they also include plans that provide coverage subject to only the major medical limits of the plan.

[2] Separate limitations indicate that mental healthcare benefits are more restrictive than benefits for other treatments. For example, if a plan limits inpatient mental healthcare to 30 days per year, but the limit on inpatient care for any other type of illness is greater than 30 days per year, the plan contains separate limits. The total is less than the sum of the individual items because many plans had more than one type of limitation.

[3] These are plans where comparisons were made between copayments and coinsurances for mental healthcare and all other illnesses. For example, outpatient mental healthcare had a 50 percent coinsurance payment, while office visits for other illnesses had a $10 copayment.

[4] Includes treatment in one or more of the following: outpatient department of a hospital, residential treatment center, organized outpatient clinic, day-night treatment center, or doctor's office. If benefits differed by location of treatment, the location offering the most beneficial coverage was tabulated.

NOTE: Sum of individual items is greater than total because some participants were in plans with more than one type of limit.

Table 5. Mental healthcare benefits: separate limits on coverage in indemnity plans, private industry, United States, 1997, 2000, and 2002

Coverage limitation	1997 All employees	2000 All employees	2002		
			All employees	1 – 99 workers	100 workers or more
Inpatient care					
Total with mental healthcare benefits	100	100	100	100	100
No separate limits[1]	16	15	14	19	11
Subject to separate limits[2]	84	85	86	81	89
Days	50	75	77	70	81
Dollars	55	11	9	11	8
Coinsurance	15	15	13	13	13
Copayment	3	2	10	10	11
Other[3]	2	5	5	5	5
Outpatient care[4]					
Total with mental healthcare benefits	100	100	100	100	100
No separate limits[1]	4	7	12	15	9
Subject to separate limits[2]	96	93	88	85	91
Days	38	70	70	62	76
Dollars	74	19	9	10	8
Coinsurance	47	28	22	27	19
Copayment	14	20	21	19	23
Other[3]	2	22	11	13	10

[1] These include plans that provide coverage without any separate limits; they also include plans that provide coverage subject to only the major medical limits of the plan.

[2] Separate limitations indicate that mental healthcare benefits are more restrictive than benefits for other treatments. For example, if a plan limits inpatient mental healthcare to 30 days per year, but the limit on inpatient care for any other type of illness is greater than 30 days per year, the plan contains separate limits. The total is less than the sum of the individual items because many plans had more than one type of limitation.

[3] These are plans where comparisons were made between copayments and coinsurances for mental healthcare and all other illnesses. For example, outpatient mental healthcare had a 50 percent coinsurance payment, while office visits for other illnesses had a $10 copayment.

[4] Includes treatment in one or more of the following: outpatient department of a hospital, residential treatment center, organized outpatient clinic, day-night treatment center, or doctor's office. If benefits differed by location of treatment, the location offering the most beneficial coverage was tabulated.

NOTE: Sum of individual items is greater than total because some participants were in plans with more than one type of limit.

inpatient care dollar limits dropped from 55 percent to 9 percent from 1997 to 2002, while indemnity plans with outpatient care dollar limits also dropped from 74 percent to 9 percent over the same period.

NCS data for mental healthcare shows differences between prepaid plans and indemnity plans for limits on days of care. For example, the incidence of prepaid plans with more restrictive day limits for inpatient care declined modestly from 84 percent to 77 percent from 1997 to 2002, but prepaid plans with day limits for outpatient care showed little net change over the same period. Indemnity plans, in contrast, present a different scenario — the incidence of indemnity plans with day limits increased for both inpatient care and outpatient care. Indemnity plans with day limits for inpatient care rose from 50 percent to 77 percent from 1997 to 2002, while indemnity plans with day limits for outpatient care increased from 38 percent to 70 percent over the same period. Also, differences in 2002 NCS incidence data on workers in plans subject to separate day limits by size of establishment were more pronounced for indemnity plans. Seventy percent of workers in establishments employing 1–99 workers were in plans subject to separate limits for inpatient care compared with 81 percent in larger establishments. The differences for outpatient care followed a similar pattern.

Substance abuse

According to the 2002 National Survey on Drug Use and Health (NSDUH), an estimated 120 million Americans, or slightly more than one-half of those surveyed, aged 12 or older reported being drinkers of alcohol.[22] About 54 million (22.9 percent) participated in binge drinking at least once in the 30 days prior to the survey, and about 6.7 percent of survey respondents reported being heavy drinkers. An estimated 19.5 million Americans, representing 8.3 percent of the population aged 12 or older, were current illicit drug users. An estimated 22 million Americans (9.4 percent of the population aged 12 or older) were classified with substance abuse problems in 2002. In the 12 months prior to being interviewed for the 2002 study, an estimated 3.5 million people aged 12 or older (1.5 percent of the population) received some kind of treatment related to the use of alcohol, illicit drugs, or both. Of these, about 2.2 million received treatment for alcohol during their most recent treatment.

Of the 18.6 million persons (7.9 percent of the total population) who reported needing treatment for alcohol problems, only about 8 percent of these received treatment at a specialized facility. Of those who did not receive treatment, about 35 percent sought treatment, but were unable to get it. The other 65 percent did not seek treatment for whatever reason. Similarly, of the 7.7 million people (3.3 percent of the total population) who needed treatment for an illicit drug problem, only 1.4 million (18 percent of those in need) received treatment from a specialized treatment facility. Of the 6.3 million people who reported needing drug treatment but did not receive it, about one-fourth sought treatment but did not receive it, and three-fourths did not seek treatment.

The economic costs of substance abuse are enormous. The overall economic cost of alcohol abuse has been steadily increasing through the 1990s, and in 1998 was estimated to be $184.6 billion.[23] Similarly, the Office of National Drug Control Policy estimated that the overall cost of drug abuse to society in the United States in 1998 added another $143.4 billion annually.[24] This represents a steady increase of 5.9 percent annually since 1992. These costs are projected to continue to rise in the foreseeable future. About 70 percent of the economic costs for substance abuse were attributed to lost productivity, most of which resulted from substance abuse-related illness or premature death.

Several bills have been introduced in Congress to bring parity to substance abuse benefits, similar to what has been done for general mental healthcare benefits. Mental healthcare and substance abuse treatment are strongly connected. Thus, as mental healthcare parity laws continue to pass, an increasing number of States are adopting parity laws for substance abuse treatment as well. Parity laws aim at getting the same type of treatment and limitations for mental healthcare or substance abuse treatment as for other illnesses.

Within the States that have adopted some kind of substance abuse parity law, there are different levels of provisions. For example, some States have adopted full parity laws for mental health and substance abuse. Others have adopted minimum mandated benefits, which require mental health treatment benefits at levels that are not equal to other illnesses, but have some similarities. [25]

Substance abuse benefits data

BLS data presented in table 1 show that nearly all workers with medical care are covered by alcohol and drug abuse benefits. The modest difference in coverage between prepaid plans and indemnity plans is attributed to the requirement that Federally-qualified prepaid plans must cover inpatient detoxification. About three-fourths of participants with substance abuse benefits in 1997 and 2000 were in plans that covered alcohol and drug abuse treatment together. (See table 6.) Benefits provided under substance abuse care usually included both detoxification and rehabilitation. Detoxification requires supervised care by medical personnel designed to reduce or eliminate the symptoms of chemical dependency. Rehabilitation provides a variety of services intended to alter the behavior of substance abusers; such services are generally provided once a person has completed detoxification.

In 2002, virtually all participants covered by a medical care plan were eligible for inpatient (inhospital) detoxification, and four-fifths received inpatient rehabilitation cover-

Table 6. Alcohol and drug abuse treatment benefits: relationship between provisions, private industry, 1997, 2000, and 2002

Relationship to coverage	1997 All employees	2000 All employees	2002		
			All employees	1 – 99 workers	100 workers or more
Total with medical care coverage	100	100	100	100	100
Covered together[1]	78	78	68	66	69
Covered separately but with same limits[2]	1	1	5	8	4
Other[3]	19	14	21	21	21
Alcohol and drug abuse treatment not covered	–	–	2	2	2
Not determinable	2	7	4	4	3

[1] These are plans where all limits that apply to alcohol abuse treatment also apply to drug abuse treatment. When care is received for one of these types of treatment, it reduces the availability of care from the other. For example, if alcohol and drug abuse treatments are limited to 30 days per year, and 20 days are used for alcohol abuse treatment, then there are 10 days left for drug abuse treatment.

[2] These are plans where alcohol and drug abuse treatments are subject to separate but identical limits. For example, alcohol abuse treatment is limited to 30 days per year, and drug abuse treatment is limited to a separate 30 days per year.

[3] Includes plans where alcohol abuse treatment coverage differs from drug abuse treatment coverage.

NOTE: Because of rounding, sum of individual items may not equal totals. Dash indicates data not available.

age. Detoxification is considered medically necessary, and thus nearly all medical plans include it. There is a greater tendency to exclude inpatient rehabilitation, because it requires less constant and less immediate care. Outpatient alcohol abuse treatment, generally rehabilitative care, was available to nearly 9 out of 10 employees with alcohol treatment coverage. Because BLS data show that coverage for alcohol abuse treatment was nearly identical to coverage for drug abuse treatment, only the data for alcohol abuse treatment is discussed in this article.

Similar to provisions for mental illnesses, table 2 shows that medical care plans typically place more restrictions on coverage for alcohol abuse treatment services than for medical and surgical services.[26] Participants were more likely to have inpatient detoxification treated the same as any other inpatient confinement than to have inpatient rehabilitation covered the same as any other illness. Only 8 percent of the participants with alcoholism treatment coverage had outpatient care treated the same as that for other conditions in 2002.

The 2002 NCS data in table 2 also show that workers in establishments employing 1–99 workers were somewhat less likely than those in the larger establishments to have their inpatient detoxification, inpatient rehabilitation, and outpatient rehabilitation covered more restrictively than for other illnesses. There are pronounced differences in the incidence of separate limits by establishment size. (See table 7.) Sixty-

Table 7. Alcohol abuse treatment benefits: separate limits on coverage, private industry, 1997, 2000, and 2002

Coverage limitation	1997 All employees	2000 All employees	2002		
			All employees	1 – 99 workers	100 workers or more
Inpatient detoxification[1]					
Total with coverage	100	100	100	100	100
No separate limits[2]	26	27	26	33	20
Subject to separate limits[3]	74	73	74	67	80
Days	53	53	58	48	66
Dollars	37	27	17	17	17
Coinsurance	12	7	10	10	10
Copayment	4	3	10	11	10
Other[4]	2	5	6	5	6
Inpatient rehabilitation[5]					
Total with coverage	100	100	100	100	100
No separate limits[2]	7	8	12	20	6
Subject to separate limits[3]	93	92	88	80	94
Days	69	67	70	60	77
Dollars	45	32	20	20	19
Coinsurance	15	11	12	12	11
Copayment	6	5	12	12	11
Other[4]	2	7	7	7	8
Outpatient rehabilitation[6]					
Total with coverage	100	100	100	100	100
No separate limits[2]	7	9	11	14	8
Subject to separate limits[3]	93	91	89	86	92
Days	49	61	66	62	69
Dollars	51	34	20	20	19
Coinsurance	26	16	16	18	14
Copayment	23	21	24	24	24
Other[4]	2	17	10	10	11

[1] Detoxification is the systematic use of medication and other methods under medical supervision to reduce or eliminate the effects of substance abuse.

[2] These include plans that provide coverage without any separate limits; they also include plans that provide coverage subject to only the major medical limits of the plan.

[3] Separate limitations indicate that alcohol abuse treatment benefits are more restrictive than benefits for other treatments. For example, if a plan limits inpatient rehabilitation care to 30 days per year, but the limit on inpatient care for any other type of illness is greater than 30 days per year, the plan contains separate limits. The total is less than the sum of the individual items because many plans had more than one type of limitation.

[4] These are plans where comparisons were made between copayments and coinsurances for alcohol abuse treatment and all other illnesses. For example, outpatient alcohol abuse treatment had a 50 percent coinsurance payment, while office visits for other illnesses had a $10 copayment.

[5] Rehabilitation is designed to alter abusive behavior in patients once they are free of acute physical and mental complications.

[6] Includes treatment in one or more of the following: outpatient department of a hospital, residential treatment center, organized outpatient clinic, day-night treatment center, or doctor's office. If benefits differed by location of treatment, the location offering the most beneficial coverage was tabulated.

seven percent of workers in establishments with 1–99 employees, for example, were subject to more restrictive limits for inpatient detoxification compared with 80 percent in the larger establishments. Nearly all of this difference is attributed to differences in plans subject to day limits. There were similar differences in limits by size of establishment for inpatient rehabilitation. Note that while table 7 also shows virtually no change between 1997 and 2002 in the number of employees in healthcare plans with separate limits on alcohol abuse treatment, the incidence of employees in plans with more restrictive dollar limits has dropped from 37 percent in 1997 to 17 percent in 2002.

Among workers covered by a prepaid medical care plan, BLS data for the 2002 NCS show that about three-fifths could receive hospital room and board services for any type of illness without any restrictions on the amount of coverage or without any required patient payment. In contrast, in 2002 only 39 percent of those covered by prepaid plans could receive inpatient alcohol detoxification treatment without any restrictions or required payments. (See table 8.) Plans with

Table 8. Alcohol abuse treatment benefits: separate limits on coverage in prepaid plans, private industry, 1997, 2000, and 2002

Coverage limitation	1997 All employees	2000 All employees	2002		
			All employees	1 – 99 workers	100 workers or more
Inpatient detoxification[1]					
Total with coverage	100	100	100	100	100
No separate limits[2]	42	40	39	45	34
Subject to separate limits[3]	58	60	61	55	66
Days	50	43	48	37	57
Dollars	14	15	8	9	7
Coinsurance	9	4	7	9	5
Copayment	10	5	13	15	11
Other[4]	1	5	4	4	4
Inpatient rehabilitation[5]					
Total with coverage	100	100	100	100	100
No separate limits[2]	12	11	17	23	12
Subject to separate limits[3]	88	89	83	77	88
Days	79	68	69	58	78
Dollars	20	22	9	11	8
Coinsurance	13	10	9	11	8
Copayment	14	10	16	19	15
Other[4]	2	7	6	7	6
Outpatient rehabilitation[6]					
Total with coverage	100	100	100	100	100
No separate limits[2]	12	17	12	12	11
Subject to separate limits[3]	88	83	88	88	89
Days	70	61	72	66	76
Dollars	21	22	10	12	9
Coinsurance	9	6	8	12	5
Copayment	42	32	37	39	35
Other[4]	1	10	5	4	5

[1] Detoxification is the systematic use of medication and other methods under medical supervision to reduce or eliminate the effects of substance abuse.

[2] These include plans that provide coverage without any separate limits; they also include plans that provide coverage subject to only the major medical limits of the plan.

[3] Separate limitations indicate that alcohol abuse treatment benefits are more restrictive than benefits for other treatments. For example, if a plan limits inpatient rehabilitation care to 30 days per year, but the limit on inpatient care for any other type of illness is greater than 30 days per year, the plan contains separate limits. The total is less than the sum of the individual items because many plans had more than one type of limitation.

[4] These are plans where comparisons were made between copayments and coinsurances for alcohol abuse treatment and all other illnesses. For example, outpatient alcohol abuse treatment had a 50 percent coinsurance payment, while office visits for other illnesses had a $10 copayment.

[5] Rehabilitation is designed to alter abusive behavior in patients once they are free of acute physical and mental complications.

[6] Includes treatment in one or more of the following: outpatient department of a hospital, residential treatment center, organized outpatient clinic, day-night treatment center, or doctor's office. If benefits differed by location of treatment, the location offering the most beneficial coverage was tabulated.

Table 9. Alcohol abuse treatment benefits: separate limits on coverage in indemnity plans, private industry, 1997, 2000, and 2002

Coverage limitation	1997 All employees	2000 All employees	2002		
			All employees	1 – 99 workers	100 workers or more
Inpatient detoxification[1]					
Total with coverage	100	100	100	100	100
No separate limits[2]	18	19	18	27	13
Subject to separate limits[3]	82	81	82	73	87
Days	54	60	64	54	70
Dollars	48	35	21	22	21
Coinsurance	13	10	12	11	12
Copayment	2	2	9	8	9
Other[4]	2	6	7	6	7
Inpatient rehabilitation[5]					
Total with coverage	100	100	100	100	100
No separate limits[2]	5	6	10	18	4
Subject to separate limits[3]	95	94	90	82	96
Days	64	67	70	61	77
Dollars	55	38	24	25	24
Coinsurance	15	12	13	12	13
Copayment	3	2	10	9	10
Other[4]	2	7	8	6	8
Outpatient rehabilitation[6]					
Total with coverage	100	100	100	100	100
No separate limits[2]	4	3	10	14	7
Subject to separate limits[3]	96	97	90	86	93
Days	40	61	64	60	66
Dollars	65	41	24	25	24
Coinsurance	34	23	19	21	18
Copayment	13	14	18	16	19
Other[4]	2	21	13	13	13

[1] Detoxification is the systematic use of medication and other methods under medical supervision to reduce or eliminate the effects of substance abuse.

[2] These include plans that provide coverage without any separate limits; they also include plans that provide coverage subject to only the major medical limits of the plan.

[3] Separate limitations indicate that alcohol abuse treatment benefits are more restrictive than benefits for other treatments. For example, if a plan limits inpatient rehabilitation care to 30 days per year, but the limit on inpatient care for any other type of illness is greater than 30 days per year, the plan contains separate limits. The total is less than the sum of the individual items because many plans had more than one type of limitation.

[4] These are plans where comparisons were made between copayments and coinsurances for alcohol abuse treatment and all other illnesses. For example, outpatient alcohol abuse treatment had a 50 percent coinsurance payment, while office visits for other illnesses had a $10 copayment.

[5] Rehabilitation is designed to alter abusive behavior in patients once they are free of acute physical and mental complications.

[6] Includes treatment in one or more of the following: outpatient department of a hospital, residential treatment center, organized outpatient clinic, day-night treatment center, or doctor's office. If benefits differed by location of treatment, the location offering the most beneficial coverage was tabulated.

restrictions and patient payments were even more common in indemnity plans where nearly four-fifths of employees were in such plans. (See table 9.) The types of limits placed on alcohol abuse treatment are similar to those placed on mental healthcare, such as a maximum number of days, a maximum dollar benefit, or a required patient payment. Coverage for substance abuse treatment benefits has remained stable since the early 1990s.[27] □

Notes

[1] The Mental Health Parity Act of 1996 was signed into law by President Clinton as a means of treating mental illness in the same fashion as all other illnesses. Among the Act's provisions, annual and lifetime dollar limits for mental healthcare must be the same as all other illnesses. The Federal Mental Health Parity Act took effect on January 1, 1998 and expired on September 30, 2001; since then, several extensions have passed and the law is still in effect. On December 19, 2003, President Bush signed the Mental Health Reauthorization Act of 2003, extending the expiration date to December 31, 2004. The 108th Congress extended this sunset date to December 31, 2005. Note that the MHPA exempts private establishments employing 50 workers or less.

For a more detailed description of the Mental Health Parity Act of 1996, see Haneefa T. Saleem, "New Law Moves Insurance Plans Closer To Mental Health Parity," Compensation and Working Conditions (CWC), on the Internet at **http://www.bls.gov/opub/cwc/cm20030909ar01p1.htm** (visited Sept. 22, 2003). Note that sections of this article include expansions and updates of information, analysis, and data first presented by Saleem in the 2003 CWC.

[2] Because no standard errors were calculated for the survey, none of the year-to-year comparisons made in this article could be verified by a statistical test.

[3] Inpatient care is defined as facility charges in a hospital related to an acute mental condition. Outpatient care includes treatment in one or more

of the following: outpatient department of a hospital, residential treatment center, organized outpatient clinic, day-night treatment center, or doctor's office. If outpatient benefits differed by location of treatment, the location offering the most beneficial coverage was tabulated.

[4] *Mental Health: A Report of the Surgeon General—Executive Summary* (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999) on the Internet at **www.surgeongeneral.gov/library/mentalhealth/summary.html** (visited April 11, 2005).

[5] Data for 1997 are from the BLS Employee Benefits Survey (EBS), and those for 2000 and 2002 are from the National Compensation Survey (NCS), which replaced the EBS. For more information on the change to the NCS, see *Employee benefits in private industry, 1999*, USDL 01–473 (U.S. Department of Labor), Dec. 19, 2001, especially the Technical Note. The 1997 EBS was limited to private industry establishments employing 100 or more workers; the 2000 NCS included all private industry establishments, regardless of their level of employment. Data from both surveys are restricted to full-time employees. The 2002 NCS benefits survey obtained data from 2,924 private industry establishments representing nearly 103 million workers—79 million full-time and about 24 million part-time. Of the 46.3 million workers in the 2002 NCS with medical care coverage, about 2.2 million, or about 5 percent of the total receiving medical care, were part-time employees. More complete survey results, as well as survey methodology and definitions of terms, may be found at the BLS National Compensation Survey, Benefits, website on the Internet at **http://www.bls.gov/ncs/ebs/home.htm** (visited March 15, 2004).

[6] *Results from the 2002 National Survey on Drug Use and Health: National Findings*, National Household Survey on Drug Abuse Series H–22, DHHS Publication No. SMA 03–3836 (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2003) on the Internet at **http://www.oas.samhsa.gov/nhsda/2k2nsduh/2k2SoFW.pdf** (visited March 15, 2004).

[7] *Achieving the Promise*: *Transforming Mental Health Care in America*, Final Report, DHHS Publication No. SMA–03–3832 (U.S. Department of Health and Human Services, New Freedom Commission on Mental Health, 2003) p.3.

[8] Ibid., pp. 3, 22.

[9] See *Report of the Surgeon General*, 1999, Chapter 6, p. 417 on the Internet at **http://www.surgeongeneral.gov/library/mentalhealth/home.html** (visited on March 18, 2004).

[10] Studies from various published articles included: 1) Ernst R Berndt, Howard L. Bailit, Martin B. Keller, Jason C. Verner, Stan N. Finkelstein, "Health care use and at-work productivity among employees with mental disorders, "*Health Affairs* (Chevy Chase, Maryland, July/August 2000), p.244; 2) Elyse Tanouye, "Mental Illness: A Rising Workplace Cost—One Form, Depression, Takes $70 Billion Toll Annually," *The Wall Street Journal* (Eastern Edition) June 13, 2001, p. B.1; and, 3) Michael T. French and Gary A Zarkin, "Mental Health, Absenteeism and Earnings at a Large Manufacturing Worksite," *The Journal of Mental Health Policy and Economics*, JMHPE 1, 1998, pp.161–172.

[11] For more detailed information about evolution and coverage of mental health benefits, see Allan P. Blostin, "Mental health benefits financed by employers," *Monthly Labor Review*, July 1987, reprinted in Bulletin 2362, June 1990, pp. 96–100.

[12] See Roland Sturm, "State Parity Legislation and Changes in Health Insurance and Perceived Access to Care Among Individuals with Mental Illness: 1996–1998. *The Journal of Mental Health Policy and Economics*, JMHPE 3, 2000, pp. 209–13.

[13] For more detailed information on limits imposed on mental healthcare benefits, see Blostin, "Mental health benefits," pp. 96–100.

[14] *The Mental Health Parity Act of 1996*, PL-104-204. Details of the Act and final rules effective December 31, 2004, are on the Internet at **http://www.efast.dol.gov/ebsa/newsroom/pr012304.html** (visited April 11, 2005).

[15] Detailed information about key provisions of the Mental Health Parity Act of 1996 can be found at the National Association of Mental Illnesses - The Mental Health Parity Act of 1996, on the Internet at **http://web.nami.org/update/parity96.html** (visited March 18, 2004).

[16] "It's Time to Pass Comprehensive Health Insurance Parity," National Mental Health Association (NMHA) on the Internet at **http://www.nmha.org/state/parity/index.cfm** (visited March 18, 2004).

For more information about mental health see NMHA publications. NMHA is a nonprofit organization dealing with mental health and mental illnesses issues.

[17] Richard M. Scheffler and Daniel P. Gitterman conducted an econometric analysis that identifies factors that affect the passage of State parity legislation. Cited in Ruth L. Kirschtein, "Insurance Parity for Mental Health: Cost, Access, and Quality," Final Report to Congress (National Advisory Mental Health Council, National Institutes of Health, 2000) pp. 8–9.

[18] Ibid.

[19] More information about the Hay Group simulation models for estimating effects on premium increases caused by the parity law is included in Ruth L. Kirschtein, "Insurance Parity for Mental Health," p. 10.

[20] Coinsurance is the percentage of authorized expenses paid by the medical plan. For example, the plan may have a coinsurance rate of 80 percent. In this case, the plan pays 80 percent of covered medical expenses and the participant (employee) pays the remaining 20 percent. In some plans, the coinsurance rate is lower for outpatient mental healthcare than for other services.

[21] Prior to 2003, prepaid plans were referred to as health maintenance organizations (HMOs) and indemnity plans were referred to as fee-for-service plans or Non-HMOs.

[22] *Results from the 2002 National Survey*, on the Internet at **http://www.oas.samhsa.gov/nhsda/2k2nsduh/2k2SoFW.pdf** (visited March 15, 2004).

[23] *10th Special Report to the U.S. Congress on Alcohol and Health*: *Highlights from Current Research*, (U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, June 2000), p. xi.

[24] *The Economic Costs of Drug Abuse in the United States, 1992–1998*, Publication No. NCJ–190636 (Office of National Drug Control Policy, Executive Office of the President, 2001) on the Internet at **http://www.whitehousedrugpolicy.gov** (visited March 15, 2004).

[25] Greg Martin, "Substance Abuse Parity: State Actions," December 2002, on the Internet at **http://www.ncsl.org/programs/health/forum/pmsap.htm** (visited June 22, 2004).

[26] The designation of alcohol abuse coverage as more restrictive than that for other illnesses results from a comparison of types of coverage. For instance, if a plan limits inpatient alcohol abuse care to 30 days per year, but the limit on inpatient care for any other illness exceeds 30 days per year, that plan contains separate, more restrictive, limits.

[27] For historical perspective and detailed discussion of employer-provided substance abuse benefits, see Marc E. Kronson, "Substance abuse coverage provided by employer medical plans," *Monthly Labor Review*, April 1991, pp.3–10. In addition, see, *Substance Abuse Provisions in Employee Benefit Plans*, Bulletin 2412 (Bureau of Labor Statistics, August 1992).