



Heterogeneity and the effect of mental health parity mandates on the labor market[☆]



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ABSTRACT

Health insurance benefit mandates are believed to have adverse effects on the labor market, but efforts to document such effects for mental health parity mandates have had limited success. I show that one reason for this failure is that the association between parity mandates and labor market outcomes vary with mental distress. Accounting for this heterogeneity, I find adverse labor market effects for non-distressed individuals, but favorable effects for moderately distressed individuals and individuals with a moderately distressed family member. On net, I conclude that the mandates are welfare increasing for moderately distressed workers and their families, but may be welfare decreasing for non-distressed individuals.

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1. Introduction

Mental illness is associated with a significant reduction in the labor market performance of individuals with mental illness (Bartel and Taubman, 1986, 1979; Ettner et al., 1997; Chatterji et al., 2007, 2011; Frank and Gertler, 1991). Although treatment is effective at improving productivity on the job (Berndt et al., 1998), it is unclear if mentally ill workers receive these productivity gains as higher wages. Even though treatment for mental illness is associated with improvements in productivity, many employers have been reluctant to provide coverage for mental illness because of stigma, concerns about adverse selection, and the large demand elasticity for mental health care (Gruber, 1994b; McGuire and Montgomery,

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1982; Newhouse, 1993). In order to increase coverage of mental health benefits, many states have laws mandating coverage of mental illness in most or all state-regulated health insurance plans, with the number of states mandating that health insurance plans cover mental illness rising from 5 states in 1996 to 26 states in 2008. The federal government also mandates that all health insurance plans provide mental health coverage through the Affordable Care Act and the Mental Health Parity and Addiction Equity Act.

Despite the significant increase in the number of states with parity mandates and the universal reach of the federal mental health parity mandate, there is little research on the labor market effects of parity mandates and all of that research is focused on employees of firms with fewer than 100 employees. Cseh (2008) provides the most recent and comprehensive study of the labor market effects of mental health parity mandates using data from the 1999 through 2004 March CPS on workers at firms with fewer than 100 employees. His work finds no evidence that parity mandates affect insurance coverage, hours worked, or wages. Earlier work by Kaestner and Simon (2002) reached broadly similar conclusions studying parity mandates and a number of other state laws affecting health insurance benefits using data from the 1989 through 1998 March CPS, again on workers at firms with fewer than 100 employees.

In this paper, I use data from the National Health Interview Survey and the Medical Expenditure Panel Survey to study the effect

of parity mandates on employment, insurance coverage, earnings, and hours worked. Because these mandates are intended to help individuals in poor mental distress, I extend the previous literature by allowing for differential effects by mental distress.¹ When I do not account for heterogeneity by mental distress, I find, as in Cseh (2008) and Kaestner and Simon (2002), that parity mandates have no effect on any of these outcomes. However, the average masks significant and important heterogeneity in the effect of the mandate—I consistently find that parity mandates are associated with a higher probability of insurance coverage, higher wages, and longer working hours for individuals with moderate mental distress. These results would imply either an increase in the productivity of mentally distressed workers or an outward shift in the labor demand curve, with ambiguous effects on labor supply. When I study the effect of parity mandates on family members of individuals for whom I observe mental distress, I find that parity mandates increase hours worked, but not average wages, for individuals with a moderately distressed family member, indicating that there is an increase in labor supply associated with parity mandates. I interpret these results as evidence that parity mandates increase social welfare for moderately distressed workers and their families and argue that the wage increase I find for moderately distressed individuals in my main analysis arises from a productivity effect (Berndt et al., 1998).

2. Background

2.1. Effects of mental health and potential benefits of parity mandates

Poor mental health is strongly associated with worse labor market outcomes, including lower earnings, reduced labor supply, and a lower likelihood of being employed. Evidence for this adverse impact comes from a variety of studies employing different datasets and methods. Bartel and Taubman (1986, 1979) study a sample of twins and find that worse mental health, based on physician diagnoses, was associated with lower wages, working fewer hours, and a lower likelihood of employment, which aggregate up to a 50% decline in earnings due to poor mental health. Frank and Gertler (1991) consider how measurement of mental health affects the association with earnings; two different indicators of mental distress, including a population-based survey measure that is similar to the measure I use, indicate that poor mental health was associated with a 22% reduction in log earnings (in separate regressions). Subsequent research, using instrumental variable models of psychiatric distress in the National Comorbidity Survey (Ettner et al., 1997), has found smaller adverse associations between poor mental health and labor market outcomes, implying that poor mental health is associated with 10–30% lower earnings than peers in good mental health. Chatterji et al. (2007, 2011) use data from the National Latino and Asian American Study and the National Comorbidity Survey–Replication to estimate the adverse consequences of a diagnosed mental illness and mental distress. Their estimates indicate that a diagnosed psychiatric disorder reduces the probability of employment by 5–20 percentage points, but they find no evidence that mental illness or distress affects wages or hours worked.

Despite the previous literature, it is not clear that mental health causes worse labor market outcomes. This concern is not allayed by instrumental variable research designs since many of the instruments use either family history or the early onset of mental health problems as instruments, which are likely to be correlated with human capital (Fletcher and Wolfe, 2008; Fletcher, 2014; Currie and Stabile, 2006).² Cseh (2008), using the NLSY79, finds that poor mental health is correlated with worse labor market outcomes in models without fixed effects, but this result goes away when he includes fixed effects in his models. He argues that these results imply that any correlation between mental health and labor market outcomes actually reflects differences in personality, rather than mental health.

Just as poor mental health is associated with worse labor market outcomes, there is suggestive evidence that treatment for mental illnesses may improve productivity on the job. Berndt et al. (1998) uses data from a clinical trial of a depression treatment and obtains suggestive evidence that individuals report improved work performance following treatment and that this improvement is correlated with reductions in the severity of their symptoms. However, it is unclear if these changes in work performance translate into higher earnings for treated individuals.

These adverse correlates of mental illness, and the improvement in productivity from treatment, imply that there may be significant welfare gains for workers in poor mental health (and, potentially, their employers) from mental health treatment, yet employers have historically been reluctant to cover mental illness. There are a variety of reasons given for the differential treatment of mental and physical health conditions including stigma, beliefs that mental illnesses are somehow less “real” than physical illnesses, employer fears of adverse selection (McGuire and Montgomery, 1982), and more elastic demand for mental health treatment (Newhouse, 1993).

Beginning in the 1970s, state policymakers responded with requirements that insurance companies at least offer mental health benefits and in most cases these mandates neither applied to employers nor regulated cost-sharing and other aspects of the mental health benefit. Since the early 1990s, states have taken a more aggressive stand on mental health benefits by passing mandates that affect both employers and insurers and regulate the financial terms of the mental health benefit, often by requiring equal cost-sharing for mental and physical health benefits (referred to as “mental health parity”).

In order for these benefit mandates to improve the well-being of individuals in poor mental health, there must be an effect of parity on mental health treatment. Several single firm case studies indicate that mental health parity has a modest, if any, effect on mental health treatment. For example, when the Federal government implemented mental health parity in its employee benefit plan, there was no evidence of an increase in mental health utilization after the implementation of parity, relative to before, when compared to a control group of commercial insurance plans (Goldman et al., 2006). Zuvekas et al. (2002) presents a second case-study from implementing mental health parity in an employer setting, finding that parity combined with managed behavioral health care was associated with a large reduction in spending on mental health and substance abuse services, compared to firms that did not implement parity. It is not entirely clear that results from either of these case studies generalizes to the population because in both cases there was the potential for contamination from the implementation of

¹ Previous studies of benefit mandates (e.g. Gruber, 1994a; Lahey, 2012; Bitler and Schmidt, 2012) interacted the mandate with a gender dummy since the mandates being studied (maternity coverage and infertility treatment) were likely to yield benefits for women but not for men included in their samples. Other studies of mental health parity have included interactions with mental distress (e.g. Busch and Barry, 2008), but this is the first paper to take this approach to study the labor market effects of mental health parity mandates.

² Conditioning on an imperfect measure of human capital, such as education, does not solve the problem since measurement error in education is likely to be correlated with either family history or the presence of early mental health problems.

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