MENTAL HEALTH PARITY

Definition and History

Over the past ten years, mental health parity has become a topic of great interest at both the state and federal levels. It has been argued that lack of knowledge and social stigmas have lead to the differential treatment of mental illness in many insurance plans. As the issue continues to be on legislative agendas, vast arrays of strong opinions about parity have emerged. The parity debate tends to be centered on consumer protection versus cost. While there are strong proponents of full parity for mental health and substance abuse treatment, there are equally strong groups opposing parity for various reasons.

Generally speaking, parity means equality. The term parity for mental health and chemical dependency means that insurance benefits for any group of mental health diagnoses are the same as insurance benefits for medical/surgical diagnoses including cost sharing, service limits, and lifetime or annual spending limits. This essentially means one would receive equal coverage for mental health and physical health.

Types of Illnesses Covered

Some state insurance laws provide coverage for all mental illnesses in the International Classification of Disease Manual (ICD) and the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM). Other state laws limit coverage to a specific list of biologically based or serious mental illnesses, known as SMIs. The list of SMIs usually includes, but is not limited to, schizophrenia, schizoaffective disorder, delusional disorder, bipolar disorder, bipolar affective disorders, major depression, and obsessive-compulsive disorders.

In addition to mental illnesses, a majority of states have laws requiring some form of coverage for chemical dependency disorders. In fact, eight states have laws requiring full parity for chemical dependency benefits with other surgical and medical benefits (Connecticut, Delaware, Minnesota, North Carolina, South Carolina, Vermont, Virginia, and West Virginia).

State Legislative Activity

Prior to 1997, seven states had enacted parity legislation (Maine, Maryland, New Hampshire, North Carolina, Rhode Island, and Texas). Although these states chose differing approaches to their parity laws, each addressed providing benefits for mental health care treatments equaling those provided for physical care. The passage of federal parity legislation in 1996 led to a flurry of activity in state legislatures in 1997. Five additional states signed parity laws that year. To date, 34 states have mental health parity laws. Other states have minimum mandated benefit and mandated offering laws related to mental health and chemical dependency.

Mental Health Parity In Nevada

In 1999, the Nevada Legislature passed Senate Bill 557 (Chapter 576, *Statutes of Nevada 1999*). This bill requires certain mental health benefits for the treatment of severe mental illness as defined by the DSM. Although the law is not full parity, it provides for at least 40 days of hospitalization as an inpatient and 40 visits for outpatient treatment per policy year, excluding visits for management of medications. The coverage is not required to provide benefits for psychosocial rehabilitation or care received as a custodial inpatient.

In addition, the law prohibits any deductibles or copayments from exceeding 150 percent of the out-of-pocket expenses required to be paid for medical and surgical benefits provided pursuant to the policy. Further, an insurer may obtain an exemption from the law's requirements under certain conditions. First, the premiums at the end of the policy year must increase by more than 2 percent as a result of the mandated coverage. Second, the insurer must submit certain actuarial information to the Commissioner of Insurance. This law would have expired on May 1, 2004, if, on January 1, 2003, the Commissioner of Insurance had issued a determination that the cumulative average increase in premiums for policies of insurance, contracts for hospital or medical service, and evidence of coverage delivered or issued for delivery that was directly attributable to coverage for the treatment of conditions relating to severe mental illness required to be provided by S.B. 557 was greater than 6 percent. The Commissioner did not issue such a determination. At a later meeting of the Nevada Mental Health Plan Implementation Commission, the Commissioner of Insurance will present data collected in conjunction with this law.

Federal Activity

In 1996, President Clinton signed a parity amendment into law as part of the VA-HUD appropriations bill. The law, otherwise known as the Mental Health Parity Act of 1996**,** prohibits group health plans that offer mental health benefits from imposing more restrictive annual or lifetime limits on spending for mental illness than on coverage of other physical illnesses. The mandate applies only if mental health benefits are offered. In general, the law is viewed as being very limited, because it does not apply to cost sharing, include benefits for chemical dependency treatment, or apply to small employers (2 to 50 employees). Moreover, if a health plan experiences increased costs of at least 1 percent as a result of the new law, these health plans also can be exempt. In May 2000, the General Accounting Office released its report, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited* (GAO/HEHS-00-95), which assesses the effects of the act.

On March 15, 2001**,** in an effort to expand the 1996 federal parity law, U.S. Senators Pete Domenici (R-New Mexico) and Paul Wellstone (D-Minnesota), among others, introduced Congressional Senate Bill 543 titled, "The Mental Health Equitable Treatment Act of 2001." The bill required that, in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provided both medical and surgical benefits and mental health benefits, the plan or coverage would not be allowed to impose any treatment limitations or financial requirements on the coverage of benefits for mental illnesses unless comparable treatment limitations or financial requirements were imposed on medical and surgical benefits. Although it provided coverage for all mental conditions listed in the DSM, the bill did not

include benefits with respect to the treatment of substance abuse or chemical dependency. Like the 1996 law, the bill was a mandate for plans that already provided mental health benefits.

On December 18, 2001, a House-Senate conference committee formally rejected the Domenici-Wellstone amendment (S. 543), despite Senate approval of the bill on October 30, 2001, but voted to extend the then-recently expired 1996 Mental Health Parity Act for an additional year. This one-year extension subsequently was enacted into law. House negotiators, however, promised to consider the subject again in 2002. To that end, the House Education Committee and the Workforce Subcommittee on Employer-Employee Relations held a hearing on mental health parity on March 13, 2002, followed by a House Energy and Commerce Committee hearing in July 2002. The committees met to "investigate current and proposed laws to provide mental health care to patients," including S. 543 and a companion bill introduced in the House during 2002, H.R. 4066, the Mental Health Equitable Treatment Act.

In a speech at the University of New Mexico, President Bush lent his support in favor of the federal parity legislation and agreed to reach an agreement in 2002 on a federal mental health parity bill. He cautioned that, in doing so, "It is critical . . . that we do not significantly run up the cost of health care." In his remarks, the President identified unfair treatment limitations placed on mental health in insurance coverage as one of three major barriers to adequate mental health care. Despite the President's support, however, the legislation failed to pass the 107th Congress, which adjourned November 22, 2002, leaving in doubt whether an expanded federal mental health parity law will be a future reality. The Mental Health Parity Act of 1996, however, which was scheduled to expire December 31, 2002, was extended to December 31, 2003.

In late February 2003, a bipartisan group of House and Senate lawmakers reintroduced mental health parity legislation, S. 486 and H.R. 953. Named in honor of Senator Paul Wellstone (D-Minnesota), a sponsor and advocate of the original Senate bill who died in a plane crash, the Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003 provides for equal coverage of mental health benefits by specified health insurers, unless comparable limitations are imposed on medical and surgical benefits. There has been no substantive action on the bills, however, since their introduction.

The newly introduced Senate and House bills are sponsored by Senators Pete Domenici (R-New Mexico) and Edward Kennedy (D-Massachusetts) and representatives Jim Ramstad (R-Minnesota) and Patrick Kennedy (D-Rhode Island). From Nevada, Senator Harry Reid (D) and Representative Shelley Berkley (D) have signed on as cosponsors.

Key Issues of Debate

Opponents of parity argue that including mental health and chemical dependency in insurance plans will drastically increase the already rising costs of health care, pricing many people out of the market. This, they contend, is particularly problematic in the wake of rising health care costs. An annual survey of 3,262 employers released by the Kaiser Family Foundation/Health Research and Educational Trust, for example, found that sharply rising health care costs and the downturn in the economy resulted in a 12.7 percent increase in employer health insurance

costs in 2002—the highest one-year increase since 1990—and that employees were contributing more in premiums and copayments for their health coverage. The report concludes that employers can expect health costs to continue to increase. These numbers, opponents argue, have huge implications for the debate about expanding health insurance coverage (http://www.kff.org/content/2002/20020905a/).

Proponents of parity also point to cost to support their case, but argue that treating mental illness and chemical dependency reduces secondary conditions such as HIV, fetal alcohol syndrome and other physical illnesses--conditions that will increase overall health care costs if left untreated. In addition, mandating coverage can reduce costs to employers by increasing worker productivity, decreasing absences, and reducing overall health care costs. Those who favor parity also argue that excluding these disorders from insurance coverage is discrimination stemming from stigma and an erroneous belief that they do not have a physiological basis.

Even those who agree that coverage for mental illness should be provided disagree about whether parity should encompass all mental illnesses or only a select group of illnesses. Like those who oppose coverage for *any* mental illnesses, those who oppose including *all* mental illnesses, are concerned that it will lead to abuse of the benefit and inflate the benefit's cost, resulting in escalating premiums. Opponents also object to providing coverage for certain disorders—such as jet lag and academic skills disorders—that, they argue, have no basis in medical science. Proponents counter that even if parity does increase costs, no other major illnesses have been dropped from coverage because of cost, thus supporting the argument that exclusion of these illnesses is based in discrimination. In addition, proponents argue that costs will not skyrocket if all illnesses are included, because plans generally require showing clinical necessity.

Another issue in the parity debate is whether to include coverage for chemical dependency. Opponents typically shape the debate to be about lifestyle versus illness. Proponents counter that insurers have provided coverage for many illnesses that were, arguably, the result of lifestyle. Following that logic, they contend, we would have to exclude coverage for many individuals with illnesses such as lung cancer and heart disease. Proponents also point to studies that show that there are long-term savings when money is invested into treatment for chemical dependence. A 1994 study for example, *Evaluating Recovery Services: The California Drug and Alcohol Treatment & Assessment (CALDATA),* showed that every $1 spent on treatment of drug and alcohol use saved state residents $7. The study also found that the level of criminal activity in the population studied decreased by two-thirds from before treatment to after treatment. The longer participants remained in treatment, the study concluded, the greater the reduction in criminal activity.

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