BACKGROUND PAPER 99-1

MENTAL HEALTH PARITY OF INSURANCE COVERAGE

Juliann K. Jenson, Senior Research Analyst
Research Division
Nevada Legislative Counsel Bureau
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>II.</td>
<td>Federal Mental Health Parity Act of 1996</td>
<td>1</td>
</tr>
<tr>
<td>III.</td>
<td>Studies on the Costs of Providing Mental Health Benefits</td>
<td>2</td>
</tr>
<tr>
<td>IV.</td>
<td>Arguments in Favor of and Against Mental Health Parity</td>
<td>4</td>
</tr>
<tr>
<td>V.</td>
<td>State Mental Health Illness Parity Laws</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>A. Parity in Vermont</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>B. Attempts at Parity in California</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>C. Parity in Nevada</td>
<td>8</td>
</tr>
<tr>
<td>VI.</td>
<td>Conclusion</td>
<td>8</td>
</tr>
<tr>
<td>VII.</td>
<td>Selected References</td>
<td>11</td>
</tr>
<tr>
<td>VIII.</td>
<td>Appendices</td>
<td>13</td>
</tr>
<tr>
<td>Appendix A</td>
<td>“Mental Health Parity Act of 1996”</td>
<td>13</td>
</tr>
<tr>
<td>Appendix B</td>
<td>“The Domenici-Wellstone Mental Illness Parity Provision; What the New Law WILL Do and NOT Do,” American Psychiatric Association</td>
<td>23</td>
</tr>
<tr>
<td>Appendix D</td>
<td>“How Expensive is Unlimited Mental Health Care Coverage Under Managed Care?,” by Roland Sturm, Rand Corporation, July 1997</td>
<td>33</td>
</tr>
</tbody>
</table>
Appendix E
“Parity in Coverage of Mental Health Services in an Era of Managed Care," An Interim Report to Congress by the National Advisory Mental Health Council, April 1997 .......................... 39

Appendix F
“State Mental Illness Parity Laws," National Alliance for the Mentally Ill, October 1998 ......................................................... 45

Appendix G
“No. 25. An Act Relating to Health Insurance for Mental Health And Substance Abuse Disorders” ............................................. 53

Appendix H
“California Assembly Bill 1100 — Enrolled,” February 27, 1997 ........................ 59
I. INTRODUCTION

In 1996, the United States Congress enacted a number of important measures affecting health and health care insurance coverage, including one of particular interest that addressed medical benefits and the mentally ill. More specifically, the Mental Health Parity Act of 1996 requires employers to increase dollar limits for mental health coverage to the equivalent of the limits for medical care.

Although the new mental health parity law is viewed as a victory for the mentally ill and mental health advocates, it is widely considered to be narrow in scope. In addition to other limitations, the new law does not impose any conditions on deductibles, copayments, or limits on days or visits. Therefore, the bill does not provide parity, in the true definition of the word, and does not completely eliminate discriminatory coverage. Rather, this law is viewed more as a historic first step toward equalizing health insurance plan coverage for treatment of mental illnesses and other medical conditions.

Because of the limitations of the federal provision, a growing number of states have decided to explore this issue more comprehensively and now require at least some level of insurance coverage for mental illnesses. Similarly, the Nevada Legislature will be examining the possibility of implementing a mental health parity act of its own during the 70th Legislative Session. The measure to be under consideration is designed to cover any condition or disorder involving mental illness, and alcohol or substance abuse (Bill Draft Request No. - 682). Further, the proposed legislation requires that annual and lifetime limits, as well as deductibles and out-of-pocket expense limits for treatment of mental illnesses, be equal to limits for other physical illnesses.

In preparation for the legislative debate on mental health parity, this paper provides an overview of the topic, including a review of the federal Mental Health Parity Act of 1996, a summary of cost studies, arguments in favor of and against parity, and an analysis of parity laws in other states.

II. FEDERAL MENTAL HEALTH PARITY ACT OF 1996

The Mental Health Parity Act, effective January 1, 1998, requires that any group health plan that: (1) is maintained by an employer who employs 51 employers or more; and (2) offers a mental health benefit, must provide for an equal or greater mental health benefit than that allowed for medical or surgical services. This law does not apply to substance abuse treatment, nor does it affect service limits, such as outpatient visits, or cost sharing, such as deductibles.

Therefore, this measure applies to larger employers that, as of January 1, 1998, have provided some level of mental health coverage in their insurance plans. The bill does not mandate mental health coverage. If an employer, however, can show that their costs have risen by more than 1 percent, as a direct result from compliance, they can become exempt from the provisions.
Additionally, existing strong state parity laws are not preempted by the federal law (i.e., a state law requiring more comprehensive coverage would not be weakened by the federal law, nor does it preclude a state from enacting stronger parity laws). The law also applies only to both fully insured, state-regulated health plans, and self-insured plans that are exempt from state laws under the Employee Retirement Income Security Act (ERISA), which are regulated by the Federal Department of Labor.

Attached, as Appendix A, is the text of the Mental Health Parity Act of 1996.

Additionally, Appendix B contains a summary document entitled “The Domenici-Wellstone Mental Illness Parity Provision; What the New Law WILL Do and NOT Do,” prepared by the American Psychiatric Association.

Other Federal Activity Regarding Mental Health Benefits

In 1997, Senator Paul Wellstone (D-Minnesota) and Representative Jim Ramstad (R-Minnesota), backed by a coalition of drug and alcohol treatment groups, introduced legislation that would require health plans to provide the same level of coverage for substance abuse treatment as for medical illnesses. No action has been taken on this bill.

On March 26, 1998, Representative Marge Roukema (R-New Jersey) and several colleagues of both parties introduced a bill that would require insurance companies to offer the same coverage for mental health and substance abuse as they do for medical illnesses. This measure is under consideration.

III. STUDIES ON THE COSTS OF PROVIDING MENTAL HEALTH BENEFITS

The cost of paying for health insurance parity for mental illness has been the topic of much debate on both the national and state level. Opponents of mental health parity claim that implementing it will be too costly for businesses, while advocates report that parity will result in minimal financial impact.

To quell this controversy, the following recent studies have attempted to assess the costs of providing mental health benefits.

- “The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits,” Substance Abuse and Mental Health Service Administration (SAMHSA), United States Department of Health and Human Services (March 1998): This study investigated, among other areas of interest, which states have enacted their own parity laws (going beyond the federal mandate); how premiums have been affected in states where parity
exists; how employers have responded to parity laws; and how health insurance premiums will be affected. Major findings are as follows:

- Costs of premiums are not increasing rapidly;
- Most employers are not trying to evade the new law by becoming self-insured, nor do they tend to shift increased costs to employees; and
- Although previous estimates of cost increases due to parity ranged from 3.2 percent to 11.4 percent, this study found that full parity for mental health and substance abuse would increase premiums by an average of 3.6 percent.

An Executive Summary of the SAMHSA study can be found in Appendix C.

“How Expensive is Unlimited Mental Health Care Coverage under Managed Care?” Rand Corporation Study (November 12, 1997): This study found that equalizing annual limits will increase costs by only about $1 per employee per year under managed care. Further, the study revealed that even more comprehensive changes in state laws (i.e., removing limits on inpatient days and outpatient visits) will increase costs by less than $7 per enrollee per year.

Additionally, the study determined that the main beneficiaries of parity will be families with children. Children, especially, were reported to be more likely than adult users to exceed their annual benefit limits and go uninsured for the remainder of the year.

Appendix D is the abstract of the Rand study.

“Parity in Coverage of Mental Health Services in an Era of Managed Care, ” An Interim Report To Congress by the National Advisory of Mental Health Council (April 29, 1997): The Senate Appropriations Committee has assigned the National Advisory of Mental Health Council the task of preparing reports on the cost of insurance coverage that offers parity for mental and physical health services in the context of managed care. Most recently, this Council documented insurance trends and associated out-of-pocket costs for obtaining mental health services by patients and families. Several case studies of managed care in states with parity legislation were also examined. This study found:

- The introduction of parity in combination with managed care results in very modest cost increases. In fact, lower costs and lower premiums were reported within the first year of parity.
Maryland reported a 0.2 percent decrease after implementation of full parity at the state level; Rhode Island reported a less than 1 percent increase of total plan costs under state parity; and Texas experienced a 47.9 percent decrease in costs for state employees enrolled in its managed care plan under parity.

An Executive Summary of the Council’s report is provided in Appendix E.

Full copies of the above-referenced studies can be found in the Research Library of the Legislative Counsel Bureau.

IV. ARGUMENTS IN FAVOR OF AND AGAINST MENTAL HEALTH PARITY

The idea of equal treatment in health insurance coverage for mental illness has spurred controversy between advocates for the mentally ill, insurance companies, health care providers and private employers. The more common arguments, both in favor of and against, are as follows:

Supporting Arguments

• Mental illness is biologically-based and should not be treated differently than other physical diseases. Because of this, treating brain disorders differently than physical ones results in insurance discrimination.

• Taxpayers bear the burden of the costs for brain disorders. For example, inequities in private insurance cause people with brain disorders to rely heavily on public programs like Medicaid. Further, of the total $26.6 billion spent for treating brain disorders in the United States in 1990, 57 percent was paid for by taxpayer money.¹

• More comprehensive insurance coverage will provide better access to treatment, including pharmaceuticals. Moreover:

  1. Brain disorders can be treated quickly and simply with pharmaceuticals, and treatments of various disorders have high success rates.

  2. Pharmaceutical treatment regiments have reduced patient expenses.

3. Outpatient treatment and rehabilitation programs for people with schizophrenia, bipolar disorder, and other brain disorders can reduce psychiatric rehospitalization rates, improve quality of life, prevent homelessness, and increase the likelihood of gainful employment.

4. Following treatment for brain disorders, work outcomes improve consistently and significantly. Outcomes continue to improve with increased duration of treatment.

- Cost-benefit studies have revealed that parity will not significantly increase insurance costs.
- Mental health parity is the “morally right” way to respond to individuals with a mental illness. Those suffering from mental illness deserve assistance in securing a productive and self-rewarding life.

**Opposing Arguments**

- Mental health parity is an unfunded mandate that will add costs to the corporate bottom line and to workers’ premiums.
- Treating mental illness is open-ended: Individuals may spend weeks or months in the hospital with no cure in sight, or in sessions of weekly therapy with a mental health expert.
- Some employers have economic limitations and will not be able to provide mental health insurance, at any level, with parity laws. Therefore, the possibility will exist that previously insured individuals will lose mental health coverage all together as a result of expensive parity requirements. In short, parity laws will be undermined and less coverage will be provided.
- Once coverage is applied to those with clearly defined mental problems, it will gradually expand to the so-called “worried well,” medicalizing everyday problems.
- Parity may cause employers to negotiate with insurance carriers to drop coverage of some physical ailments or to raise overall deductibles or copayments for all doctors’ visits in order to cover mental health treatment and keep premiums to a minimum.
- Although mental health treatment is now more pharmaceutical than analytical, the medical community still does not have a firm grip on treatment outcomes for mental illnesses.
- There is a wide potential for hospital and physician fraud.
V. STATE MENTAL HEALTH ILLNESS PARITY LAWS

Although all states are required to comply with the provisions of the Mental Health Parity Act of 1996, a total of 19 states currently have mental health parity laws that either: (1) were enacted before the effective date of the federal law; or (2) are stronger than the federal provisions. These states include: Arizona, Arkansas, Colorado, Connecticut, Delaware, Georgia, Indiana, Maine, Maryland, Minnesota, Missouri, New Hampshire, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, and Vermont.²

While each state parity law provides for some level of equality in mental health insurance coverage, the laws differ in their scope and application. More specifically, the various state parity provisions differ significantly in: (1) what is covered; (2) specificity of parity; (3) minimum benefit requirements; (4) approved providers; (5) use of managed care; and (6) exemptions/populations covered.³

To better illustrate the differences in state parity laws, many states only provide coverage for identified severe mental illnesses that are thought to be biologically based. For example, Colorado's coverage applies only to schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, and obsessive-compulsive disorder. Substance abuse treatment is also discretionary, and many states, such as Arizona and Indiana, have opted not to include it in mental health care packages. Further, some states (North Carolina, for example) limit mental health parity to certain populations, such as state employees.

Additionally, the term "coverage" is clearly defined by Maine and Maryland, including specific language regarding the application of mental health benefits, while other states prefer to leave the term open to interpretation. Vermont addresses the role of managed care and outlines approved providers, but many other states do not. In sum, the inclusion or exclusion of the above-referenced differences dictate to what extent parity is provided and to whom.

For a more detailed analysis, Appendix F provides a state-by-state breakdown of mental illness parity laws, including the year enacted, type of bill, and effective date.

² "State Mental Illness Parity Laws" National Alliance for the Mentally Ill's Campaign to End Discrimination, Science and Treatment Fact Book, May 1998.

A. Parity in Vermont

Vermont’s mental health parity law is important because it is considered to be the most comprehensive of the state parity measures. It is widely viewed as model legislation, and many states seek to emulate its provisions. Likewise, the bill draft request in Nevada regarding mental health parity is to be based on Vermont.

Although Vermont’s law is thought to be optimal by those in the mental health field, most states do not have the political climate to pass such a comprehensive measure. As a result, narrower versions of the Vermont law can be found in many of the states that have enacted parity legislation.

Regarding its content, Vermont law covers any condition or disorder involving mental illness and alcohol, or substance abuse. Additionally, it requires that annual and lifetime limits, and deductibles and out-of-pocket expense limits for treatment of mental illnesses, be equal to limits for other physical illnesses.

When compared to the more narrow federal provisions, Vermont:

- Mandates mental health insurance to be offered in health insurance plans;
- Provides coverage for treatment of substance abuse or chemical dependency;
- Does not allow for cost-shifting mechanisms and requires that service charges such as copayments, deductibles, out-of-pocket payment limits be equal to limits for other physical illnesses;
- Places restrictions on managed care;
- Provides coverage in connection with Medicare or Medicaid; and
- Applies to all businesses, regardless of the number of employees.

A copy of the Vermont law is attached as Appendix G.

B. Attempts at Parity in California

California Assembly Bill 1100, introduced in February 1997, would have required health insurers to provide the same level of treatment for certain severe mental illnesses as they do for other physical ailments. The measure was reported to have received support from both political parties, major newspaper editorial boards, and thousands of residents across the state who wrote the Governor in favor of the measure.
The bill was approved by both the Senate and Assembly; however, California Governor Pete Wilson vetoed the bill in September 1998. In his veto message, the Governor said his office suggested “several options” to improve the measure. Further, the Governor’s Office reported that the bill’s authors “instead engaged in a shortsighted ‘all or nothing’ strategy that would impose on California employers coverage beyond what other states require and, in the case of many small employers, unaffordable cost increases.”

Representatives from the National Alliance for the Mentally Ill (NAMI) report that mental health parity will be reintroduced to the California Legislature in 1999. With the newly-elected Governor, mental health advocates are hopeful that the measure will be enacted.

C. Parity in Nevada

To comply with federal mental health parity requirements, the 1997 Nevada Legislature enacted Assembly Bill 521 (Chapter 586, Statutes of Nevada 1997). This bill incorporates federally mandated provisions, described earlier, regarding mental health parity for group health plans. This bill does not go beyond the federal requirements and is codified in Nevada Revised Statutes 689B.600.

As referenced earlier, a bill draft request has been submitted regarding mental health parity for consideration by the 1999 Nevada Legislature (Bill Draft Request No. - 682). This measure is more far-reaching than what is currently in the statutes and is to be based on the Vermont law. The local chapter of NAMI, other interested parties, and community groups have made public statements supporting this measure.

VI. CONCLUSION

With the passage of the federal Mental Health Parity Act of 1996, the concept of mental health parity has become more widespread. Further, because this federal law is generally recognized as well-intentioned but weak, a flurry of legislative activity on a statewide level has been generated on the topic. In short, states are seeking to enact stronger, more comprehensive mental health parity than provided for in federal law.

Research suggests that health insurance premiums would not significantly increase if private insurance plans provide mental health benefits equal to those for medical and surgical care. Despite these findings, there appears to be some resistance in providing mental health benefits by the health care industry. This resistance may be attributed to increased costs, no matter how minimal, and the possibility of “widening the net” for many other types of illnesses and diseases. Additionally, there may be some unwillingness to equate mental illness with other physical diseases of the body.
In contrast, mental health advocates claim that society as a whole will reap the rewards of mental health parity. For example, the work force will be more productive, homelessness will ebb, and dollars will be saved in treatment costs. Further, advocates contend that many mental illnesses can be successfully treated with pharmaceuticals, which assists at keeping insurance costs at a minimum.

In conclusion, an increasing number of states across the nation, including Nevada, will be debating the merits of implementing some level of mental health parity. This topic will most likely be revisited on a federal level as well. Decision and policy makers, mental health advocates, the health care industry, and businesses will need to search for a balance between the needs of the mentally ill and feasible and viable mental health treatment coverage.
VII. SELECTED REFERENCES


California Assembly Bill 1100, February 27, 1997.


“Parity in Coverage of Mental Health Services in an Era of Managed Care,” An Interim Report to the Congress by the National Advisory Mental Health Council, April 1997.


Regier, Darrel A., M.D., M.P.H., “Mental Health Parity Under Managed Care: Results to Date and Implications,” Behavioral Healthcare Tomorrow, August 1998.

Science and Treatment Fact Book, National Alliance for the Mentally Ill’s Campaign to End Discrimination, 1998.


Vermont Statutes Annotated (8 V.S.A. § 4089).
APPENDIX A

“Mental Health Parity Act of 1996”
Public Law 104-204 (110 Stat. 2874)
Mental Health Parity Act of 1996

Federal Parity Amendment PL 104-204 as finally enacted PUBLIC LAW 104-204
104th Congress -- 2nd Session
H.R. 3666
104 P.L. 204, *; 110 Stat. 2874,*;
1996 Enacted H.R. 3666, *; 104 Enacted H.R. 3666, *

DATE: SEPT. 26, 1996 -- PUBLIC LAW 104-204
SYNOPSIS: An Act

Making appropriations for the Departments of Veterans Affairs and Housing and Urban Development, and for sundry independent agencies, boards, commissions, corporations, and offices for the fiscal year ending September 30, 1997, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the Departments of Veterans Affairs and Housing and Urban Development, and for sundry independent agencies, boards, commissions, corporations, and offices for the fiscal year ending September 30, 1997, and for other purposes, namely:

[The Mental Health Parity Amendment came at the end of the bill, after the following: Title1 - Department Of Veterans Affairs - Veterans Benefits Administration, compensation and pensions, (including transfers of funds); Title II - Department Of Housing And Urban Development - Housing Programs, Development of Additional New Subsidized Housing; Title III -- Independent Agencies - American Battle Monuments Commission, Salaries And Expenses; Title IV -- General Provisions; Title V -- supplemental Department Of Veterans Affairs -- Veterans Benefits Administration, Compensation And Pensions; Title VI -- Newborns' And Mothers' Health Protection Act Of 1996

TITLE VII--PARLTY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS

{701) Sec. 701. Short Title.-- This title may be cited as the "Mental Health Parity Act of 1996".

{702) Sec. 702. Amendments to the Employee Retirement Income Security Act of 1974.--(a) In General.--Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by section 603(a)) is amended by adding at the end the following new section:

712 " Sec. 712. PARLTY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.

"(a) In General.--

"(1) Aggregate lifetime limits.-- In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both
medical and surgical benefits and mental health benefits--

"(A) No lifetime limit.--If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

"(B) Lifetime limit.--If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable lifetime limit'), the plan or coverage shall either--

"(i ) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

"(ii ) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

"(C) Rule in case of different limits.--In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

"(2) Annual limits.-- In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits--

"(A) No annual limit.--If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

"(B) Annual limit.--If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable annual limit'), the plan or coverage shall either--

"(i ) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

"(ii ) not include any annual limit on mental health benefits that is less than the applicable annual limit.

"(C) Rule in case of different limits.--In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

"(b) Construction.--Nothing in this section shall be construed--
"(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or

"(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).

"(c) Exemptions.--

"(1) Small employer exemption.----

"(A) In general.--This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

"(B) Small employer.--For purposes of subparagraph (A), the term 'small employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

"(C) Application of certain rules in determination of employer size.-- For purposes of this paragraph--

"(i ) Application of aggregation rule for employers.--Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

"(ii ) Employers not in existence in preceding year.--In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

"(iii ) Predecessors.--Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

"(2) Increased cost exemption.-- This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.

"(d) Separate Application to Each Option Offered.-- In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

"(e) Definitions.--For purposes of this section--
(1) Aggregate lifetime limit.-- The term 'aggregate lifetime limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(2) Annual limit.-- The term 'annual limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

(3) Medical or surgical benefits.-- The term 'medical or surgical benefits' means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health benefits.

(4) Mental health benefits.-- The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.

(f) Sunset.--This section shall not apply to benefits for services furnished on or after September 30, 2001.

(b) Clerical Amendment. --The table of contents in section 1 of such Act, as amended by section 603 of this Act, is amended by inserting after the item relating to section 711 the following new item: "Sec. 712. Parity in the application of certain limits to mental health benefits."

(c) Effective Date.--The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

2705 "Sec. 2705. PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.

(a) In General.--

(1) Aggregate lifetime limits.-- In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits--

(A) No lifetime limit.--If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

(B) Lifetime limit.--If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable lifetime limit'), the plan or coverage shall either--
“(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

“(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

“(C) Rule in case of different limits.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

“(2) Annual limits.— In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits—

“(A) No annual limit.— If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

“(B) Annual limit.—If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable annual limit'), the plan or coverage shall either—

“(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

“(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

“(C) Rule in case of different limits.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

“(b) Construction.—Nothing in this section shall be construed—

“(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or

“(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) (in regard to parity in the
imposition of aggregate lifetime limits and annual limits for mental health benefits).

"(c) Exemptions.--

"(1) Small employer exemption.-- This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

"(2) Increased cost exemption.-- This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.

"(d) Separate Application to Each Option Offered.--In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

"(e) Definitions.--For purposes of this section--

"(1) Aggregate lifetime limit.-- The term 'aggregate lifetime limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

"(2) Annual limit.-- The term 'annual limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

"(3) Medical or surgical benefits.-- The term 'medical or surgical benefits' means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health benefits.

"(4) Mental health benefits.-- The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.

"(f) Sunset.--This section shall not apply to benefits for services furnished on or after September 30, 2001.".

(b) Effective Date.-- The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

This Act may be cited as the "Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1997".

There were eight versions of this bill considered during the Congressional
session in 1996. The dates were June 19, 27, and 28; July 2 and 12; September 9 (2 versions considered that day), and September 26.

DEBATE: 142 Congressional Record, 104th Congress, 2nd Session - 1996
Apr. 18, Senate consideration and adoption of Domenici/Wellstone Amendment No. 3681 to S. 1028, p. S3588.
Aug. 1, Senate consideration of H.R. 3666, p. S9416.
Sept. 4, Senate consideration of H.R. 3666, p. S9821.
Sept. 5, Senate consideration and passage of H.R. 3666 with amendments, p. S9875.
APPENDIX B

"The Domenici-Wellstone Mental Illness Parity Provision:
What the New Law WILL Do and NOT Do"
American Psychiatric Association
The Domenici-Wellstone Mental Illness Parity Provision

What the New Law WILL Do and NOT Do

Background
The Domenici-Wellstone mental illness parity amendment was adopted overwhelmingly by the Senate and House as part of the FY ’97 VA-HUD appropriations bill (H.R. 3666) and signed into law by President Clinton on September 26th. While the mental illness parity provision does not completely eliminate discriminatory coverage -- visit limits, copayment or deductibles -- for the treatment of mental illnesses, the provision nonetheless represents an historic first step toward equalizing health insurance plan coverage for treatment of mental illnesses and other medical conditions. It provides basic lifetime and annual expenditure financial protection for some of our most vulnerable citizens -- those individuals with chronic or economically catastrophic mental illnesses.

What the New Law Will Do

The Domenici-Wellstone mental illness parity provision will require equal group health plan lifetime and annual payment limits for mental and physical illnesses if the plan provides any mental health benefit. Currently, private insurers typically place lifetime payment limits of $1 million for cancer, heart disease and/or diabetes, however lifetime plan payment limits on a mental illness are typically set at $50,000 or less. Additionally, health plans impose annual coverage caps of $10,000 or less on treatment of mental illness, yet such caps are typically NOT imposed on other medical conditions. These limits push persons who have exhausted their private health coverage to forgo treatment, pay entirely out-of-pocket or rely on public mental health programs. The new law prohibits these two types of health plan discrimination for coverage of treatment of mental illnesses.

The new law applies to group health plans sold to businesses with 51 or more employees. Small businesses -- with 50 or fewer employees as with the small business exemption in the
Kassebaum-Kennedy health reform measure that was signed into law this summer -- are exempted from the mental illness parity requirement.

The new law applies to self insured plans. Large businesses which self insure under ERISA will be required to comply with the Domenici-Wellstone mental illness parity provision. This law marks the first successful Congressional mandate of a benefit against the barricade protection of the ERISA preemption. At the same time the conference report protects State-required "more favorable" mental health benefits.

The new mental illness parity requirement on lifetime and annual plan payment limits will be required as of January 1, 1998. Three Federal agencies -- the Departments of Health and Human Services, Labor and Treasury -- will develop the regulatory framework for implementation.

What the New Law DOES NOT DO

The Domenici-Wellstone mental illness parity law DOES NOT REQUIRE employers or health plans to cover or maintain coverage for treatment of mental illness.

Benefits for treatment of substance abuse or chemical dependency are EXCLUDED from the mental illness parity requirement.

The Domenici-Wellstone mental illness parity law DOES NOT REQUIRE parity with respect to day or visit limits, beneficiary cost sharing, or managed care measures.

The mental illness lifetime and annual plan payment parity law DOES NOT APPLY to the individual health insurance market.

If compliance with the mental illness parity law results in an increased cost of at least 1 percent, health plans would be exempt.
APPENDIX C

“The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits”
United States Department of Health and Human Services, March 1998
The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits

Merrile Sing
Steven Hill
Suzanne Smolkin
Nancy Heiser

U.S. Department of Health and Human Services
Public Health Service
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

Additional Copies

For additional copies of this document or associated background reports, please write or call the Knowledge Exchange Network, 11426-28 Rockville Pike, Suite 405, Rockville, MD 20852, 1-800-789-2647.

Originating Office

Office of Managed Care
Center for Mental Health Services, SAMHSA
5600 Fishers Lane, 15C-17
Rockville, MD 20857
March 1998

Contents

Acknowledgements
Executive Summary
Introduction
Chapter 1: State Parity Laws
   Federal Parity Legislation
   State Parity Mandates
Chapter 2: Case Studies
   Study Methods
   Study Findings
Chapter 3: Actuarial Assumptions
   Previous Actuarial Studies of Parity
   Actuarial Study for This Report
Chapter 4: Cost Estimates
   Options for Providing Parity in MH/SA Insurance Benefits
   Method for Estimating Costs
   Estimated Premium Increases for Families
   Estimated Premium Increases for Child Health Plans
   Interpreting the Estimates
Conclusion
References

29
Appendix A: Glossary
Appendix B: Calculating the Premium Increase
Appendix C: Policy Advisory Panel Members
Appendix D: Expert Panel Members

TABLES

1.1 Characteristics of Mental Health and Substance Abuse Parity Legislation by State
1.2 Serious/Biologically Based Mental Illnesses Specified in Parity Legislation
3.1 Actuarial Cost Studies Estimating the Effects of Expanded MH/SA Insurance Benefits
4.1 Partial and Full Parity Benefit Options for A Fee-for-Service Plan
4.2 Full Parity Benefit Options
4.3 Average Premium Increases Aggregated Across Plan Types
4.4 Percentage Increases in Total Premiums by Diagnosis and Plan Type
4.5 Increases in Children's MH/SA Expenditures and Premiums for Full Parity by Plan Type
EXECUTIVE SUMMARY

Background

Health plans offered by employers typically provide less coverage for mental health and substance abuse (MH/SA) treatment than for general medical and surgical services. States and the federal government have begun to require that mental health and/or substance abuse treatment be covered in the same way as other medical care. This concept is known as "parity."

In 1996, Congress passed and President signed the Mental Health Parity Act. Effective January 1, 1998, this law requires that health plans provide the same annual and lifetime limits for mental health benefits as they do for other health care benefits. The act does not affect service limits, such as limits on outpatient visits, or cost sharing, such as deductibles. Nor does it apply to substance abuse benefits.

States have mandated parity, as well. By September 1997, 12 states had passed laws that, to various degrees, require parity in mental health and/or substance abuse benefits. Others have enacted legislation conforming to the federal mandate.

Opinion differs as to the costs and effects of parity mandates. This study was designed to address these issues by:

- summarizing the characteristics of state parity laws,
- conducting detailed case studies of five states with such laws,
- analyzing previous actuarial estimates of the costs of parity, and
- providing updated estimates of premium increases due to full and partial parity.

Following are the key findings of the study. Please see the full text for the specific context of each finding.

Key Findings

- **Most State parity laws are limited in scope or application.** Few address substance abuse treatment, and many are limited to treatment for serious mental illnesses. Many exempt small employers or only apply to plans for government employees.

- **State parity laws have had a small effect on premiums.** Cost increases have been lowest in systems with tightly managed care and generous baseline benefits.

- **Employers have not attempted to avoid parity laws by becoming self-insured, and they do not tend to pass on the costs of parity to employees.** The low costs of adopting parity allows employers to keep employee health care contributions at the same level they were before parity.
- Costs have not shifted from the public to the private sector. Most people who receive publicly funded services are not privately insured.

- Previous actuarial predictions of premium increases due to MH/SA parity ranged from 3.2 percent to 11.4 percent, primarily due to differences in their assumptions. Some of these assumptions may have limited support. For instance, some estimates have assumed a cost shift from the public to the private sector as a result of a parity mandate. This study did not find support for this assumption, however.

- Based on an updated actuarial model, full parity for mental health and substance abuse services is estimated to increase premiums by 3.6 percent, on average. Mental health care accounts for most of this increase. Increases for mandates limited to parity in cost sharing or service limits will be lower (see table below).

- Premium increases vary by type of plan. Fee-for-service and preferred provider organizations would have a 5 percent premium increase. In contrast, health maintenance organizations that tightly manage care would have only a 0.6 percent premium increase.

- Projected premium increases do not reflect potential market responses. For example, employers might contract with more managed care firms to manage MH/SA benefits under a parity mandate. This employer response would result in lower premium increases.

- Premium increases are greater for plans that are limited to children. Under the Balanced Budget Act of 1997, states will receive block grant funds to fund health insurance for uninsured, low-income children. Including parity in these plans will likely increase premiums more than that for an equivalent plan for adults and families. However, these differences are minimal for services provided within health maintenance organizations.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Parity in Cost Sharing</th>
<th>Parity in Service Limits</th>
<th>Full Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH/SA</td>
<td>0.4%</td>
<td>1.2%</td>
<td>3.6%</td>
</tr>
<tr>
<td>MH only</td>
<td>0.3%</td>
<td>1.1%</td>
<td>3.4%</td>
</tr>
<tr>
<td>SA only</td>
<td>0.1%</td>
<td>0.03%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>
APPENDIX D

"How Expensive is Unlimited Mental Health Care Coverage Under Managed Care"
by Roland Sturm, Rand Corporation, July 1997
How Expensive is Unlimited Mental Health Care Coverage Under Managed Care?

Roland Sturm
RAND

January 1997
revised July 1997

Working Paper No. 107

FUNDED BY THE NATIONAL INSTITUTE OF MENTAL HEALTH
JAMA, in press
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How Expensive is Unlimited Mental Health Care Coverage Under Managed Care?

Roland Sturm, RAND
(second revision)
JAMA, in press

Abstract: Objective. Study costs, access, and intensity of mental health care under managed carve-out plans with generous coverage; compare to assumptions used in policy debates; simulate the consequences of removing coverage limits for mental health care as required by the Mental Health Parity Act. Design. Claims data from 1995/1996 for 24 managed care carve-out plans; all plans offered unlimited mental health coverage with minimal copayments. Outcome Measures. Probability of care, intensity of care, total costs; broken down by service type and type of enrollee. Results. Assumptions used in last year’s policy debate overstate actual managed care costs by a factor of 4-8. In the plans studied, costs are lower due to reduced hospitalization rates, a relative shift to outpatient care, and reduced payments per service. However, access to mental health specialty care increased (7.0 percent of enrollees) compared to the preceding fee-for-service plans (6.5 percent) or free care in the RAND Health Insurance Experiment (5.0 percent). Removing an annual limit of $25,000 for mental health care, which is the average among plans currently imposing limits, will increase insurance payments only by about $1 per enrollee per year. Children are the main beneficiaries of expanded benefits. Conclusion. Concerns about costs have stifled many health reform proposals. However, policy decisions were often based on incorrect assumptions and outdated data that lead to dramatic overestimates. For mental health care, the cost consequences of improved coverage under managed care, which by now accounts for most private insurance, are relatively minor.

Mailing Address:
RAND
1700 Main Street
Santa Monica, CA 90401
(310) 393-0411 ext. 6164
Fax: (310) 451-7004
E-mail: Roland_Sturm@rand.org
APPENDIX E

"Parity in Coverage of Mental Health Services in an Era of Managed Care"
An Interim Report to Congress by the National Advisory Mental Health Council, April 1997
Parity in Coverage of Mental Health Services in an Era of Managed Care

An Interim Report to Congress by the National Advisory Mental Health Council

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health
National Institute of Mental Health
EXECUTIVE SUMMARY

In its report accompanying the 1997 appropriations bill (Senate Report No 104-368), the Senate Appropriations Committee requested that the National Advisory Mental Health Council (NAMHC) report on what is known about the costs of providing equitable coverage for people with mental illness—particularly those illnesses that are “severe and clearly identifiable, diagnosable, and treatable.” The NAMHC was also asked to report on current efforts by the National Institute of Mental Health (NIMH) to investigate managed care arrangements relevant to mental health (p.107). The following is submitted as a preliminary response to that request.

Current information concerning how parity and/or managed care affect mental health utilization and costs is both inconsistent and inconclusive, and national data are not yet available. Prior estimation efforts within the past 5 years, made in response to congressional interest and requests by both public and private sponsors, were hampered by many factors. Among those factors were reliance on outmoded economic and actuarial models using data from the pre-managed care era, and lack of empirical information on current practice patterns.

To overcome many of these limitations, a special NAMHC workgroup is developing a new comparative empirical database that can inform economic assumptions and models for estimating national effects of parity and managed care on the costs of mental health services. The database builds on cost and utilization data from several States that have implemented parity, and on updated empirically based models that use the experience of managed care in the context of generous (parity) mental health benefits. Although the workgroup's study is far from complete, the major results to date are these:

- Very recent findings, based upon empirical studies and economic simulations across diverse populations, managed care approaches, and parity structures suggest that the introduction of parity in combination with managed care results in lowered costs and lower premiums (or, at most, very modest cost increases) within the first year of parity implementation.

- These findings do not support earlier concern about potentially high financial costs caused by parity. Prior estimates were based on fee-for-service (FFS) models that are no longer valid for a market dominated by managed care and...
likely to become even more so.

- The parity experience of States studied to date suggests that introducing parity nationwide would induce insurance companies to introduce managed behavioral health care approaches wherever they are not already in place.

- The national introduction of parity (as defined in the Domenici-Wellstone parity amendment to H.R. 3666) in private health insurance will not have uniform effects across States; the effects on mental health service costs and access will depend in large measure on the extent of managed care and parity already in place in those States.

- Results of a recent carefully designed study of a large managed behavioral health care plan with generous mental health and substance abuse benefits suggest that benefit design alone—and therefore parity legislation—cannot necessarily assure access to mental health and substance abuse services in the presence of managed care.

- Important research and policy issues related to those under study concern how managed care, whether parity-driven or not, affects access to mental health care and the quality and outcome of that care for all Americans who require it. These issues, as well as the expansion and refinement of findings to date, will be addressed in the NAMHC workgroup's final report.
APPENDIX F

“State Mental Illness Parity Laws”
National Alliance for the Mentally Ill, October 1998
Overview of Parity in the States

Officially designated "The Decade of the Brain," the 1990s have brought unprecedented federal and state legislative activity on behalf of people with serious brain disorders. After the Mental Health Parity Act of 1996 was signed into law, the momentum shifted to the states. A firestorm of legislative activity is creating a patchwork quilt of various parity laws around the country.

In 1998:
- 4 states passed parity legislation (Delaware, Georgia, South Dakota, Tennessee)
- 13 states have parity legislation pending
- A total of 19 states now have some degree of mental health parity, with fairness bills pending in many other state legislatures

In 1997:
- 34 states introduced parity legislation
- 9 states passed mental illness parity legislation (Arizona, Arkansas, Colorado, Connecticut, Indiana, Missouri, South Carolina, Texas, Vermont)

Between 1991 - 1996:
- 6 states effected mental illness parity measures (Maine, Maryland, Minnesota, New Hampshire, North Carolina {state employees only}, Rhode Island, Texas {state employees only})

State-By-State Breakdown of Mental Illness Parity Laws

<table>
<thead>
<tr>
<th>State</th>
<th>Year Enacted</th>
<th>Type of Bill</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas</td>
<td>1997</td>
<td>Provides for equal coverage of mental illness and developmental disorders; excludes state employees, companies with less than 50 employees, and companies that anticipate a cost increase of more than 1.5 percent.</td>
<td>August 1, 1997</td>
</tr>
<tr>
<td>State</td>
<td>Year</td>
<td>Law Description</td>
<td>Effective Date</td>
</tr>
<tr>
<td>----------</td>
<td>------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Colorado</td>
<td>1997</td>
<td>Provides for coverage of schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder that is no less extensive than the coverage provided for other physical illnesses.</td>
<td>January 1, 1998</td>
</tr>
<tr>
<td>Delaware</td>
<td>1998</td>
<td>Requires health insurers to provide coverage for biologically based mental illnesses, including schizophrenia, schizoaffective disorder, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, anorexia and bulimia, under the same terms and conditions of coverage offered for physical illnesses.</td>
<td>January 1, 1999</td>
</tr>
<tr>
<td>Georgia</td>
<td>1998</td>
<td>Requires smaller employers (2-50 employees) that choose to provide mental health benefits provide equal lifetime and annual caps for mental health benefits as is offered for other physical illnesses, and provide the same dollar limits, deductibles, coinsurance factors; requires larger employers (51+ employees) that choose to provide mental health benefits must provide equal lifetime and annual caps for mental health benefits as is provided for other physical illnesses, and provide the same dollar limits, deductibles, coinsurance factors; employer groups of 51+ employees who choose to provide mental health benefits cannot impose separate outpatient and visit limits on the treatment of mental illnesses; mental illnesses covers all brain disorders listed in the</td>
<td>April 6, 1998</td>
</tr>
<tr>
<td>State</td>
<td>Year</td>
<td>Legislation</td>
<td>Date</td>
</tr>
<tr>
<td>------------</td>
<td>------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Indiana</td>
<td>1997</td>
<td>Mirrors federal law; no substance abuse; also includes full parity in coverage for mental health for all state employees.</td>
<td>July 1, 1997</td>
</tr>
<tr>
<td>Maine</td>
<td>1995</td>
<td>Provides for coverage of schizophrenia, bipolar disorder, pervasive development disorder, or autism, paranoia, panic disorder, obsessive-compulsive disorder, and major depressive disorder in group contracts that is no less extensive than medical treatment for physical illnesses; no substance abuse; excludes groups of 20 or fewer employees.</td>
<td>July 1, 1996</td>
</tr>
<tr>
<td>Maine</td>
<td>1993</td>
<td>Raised minimum benefits to $100,000 lifetime, 60 days annual inpatient, $2,000 outpatient. Other terms same as 1995 measure (see above).</td>
<td>January 1, 1994</td>
</tr>
<tr>
<td>Maryland</td>
<td>1994</td>
<td>Insurers and HMOs are prohibited from discriminating against any person with mental illness, emotional disorder, or drug abuse or alcohol abuse by failing to provide treatment or diagnosis equal to physical illnesses.</td>
<td>August 1, 1994</td>
</tr>
<tr>
<td>Minnesota</td>
<td>1995</td>
<td>Requires cost of inpatient and outpatient mental health and chemical dependency services to be not greater or more restrictive than those for outpatient and inpatient medical services.</td>
<td>August 1, 1995</td>
</tr>
<tr>
<td>Missouri</td>
<td>1997</td>
<td>Covers all disorders in DSM-IV in managed care plans only (roughly 40% of population) equal to physical illnesses; part of larger managed-care regulatory measure.</td>
<td>September 1, 1997</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1994</td>
<td>Provides for coverage of schizophrenia,</td>
<td>January 1, 1995</td>
</tr>
<tr>
<td>State</td>
<td>Year</td>
<td>Description</td>
<td>Date</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>North Carolina (state employees only)</td>
<td>1991</td>
<td>Requires non-discriminatory coverage in state government employee health contracts.</td>
<td>January 1, 1992</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>1994</td>
<td>Provides for coverage of &quot;serious mental illness&quot; that current medical science affirms is caused by a biological disorder of the brain and substantially limits life activities.</td>
<td>January 1, 1995</td>
</tr>
<tr>
<td>South Carolina</td>
<td>1997</td>
<td>Mirrors federal law.</td>
<td>March 31, 1997 (sunset 9/30/2001)</td>
</tr>
<tr>
<td>South Dakota</td>
<td>1998</td>
<td>Provides coverage for the treatment and diagnosis of biologically based mental illnesses, including schizophrenia, schizoaffective disorder, bipolar affective disorder, major depression, obsessive-compulsive disorder, and other anxiety disorders, with the same dollar limits, deductibles, coinsurance factors and restrictions as for other covered illnesses.</td>
<td>July 1, 1998</td>
</tr>
<tr>
<td>Tennessee</td>
<td>1998</td>
<td>Provides mandated mental health coverage, but does not cover alcohol or substance abuse treatment; annual and lifetime limits and out-of-pocket expense limits must be the same as for other medical and surgical benefits; covers at least 20 inpatient</td>
<td>January 1, 2000</td>
</tr>
<tr>
<td>State</td>
<td>Year</td>
<td>Description</td>
<td>Effective Date</td>
</tr>
<tr>
<td>------------</td>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Texas</td>
<td>1997</td>
<td>Covers schizophrenia, paranoia and other psychotic disorders, bipolar disorder, major depressive disorder, schizoaffective disorder, pervasive developmental disorder, obsessive-compulsive disorder, and depression in childhood and adolescence; exempts businesses with fewer than 50 employees; 60 outpatient visits and 45 inpatient days annually.</td>
<td>January 1, 1998</td>
</tr>
<tr>
<td>Texas (public employees only)</td>
<td>1991</td>
<td>Covers all public state and local employees and all teachers and university system employees. This plan covers schizophrenia, schizoaffective disorder, bipolar disorder and major depression.</td>
<td>September 1, 1991</td>
</tr>
<tr>
<td>Vermont</td>
<td>1997</td>
<td>Coverage for any condition or disorder involving mental illness or alcohol or substance abuse; comprehensive coverage for deductibles and out-of-pocket expenses.</td>
<td>January 1, 1998</td>
</tr>
</tbody>
</table>
APPENDIX G

“No. 25. An Act Relating to Health Insurance for Mental Health and Substance Abuse Disorders”

_Vermont Statutes, Annotated_ (8 V.S.A. § 4089)
NO. 25. AN ACT RELATING TO HEALTH INSURANCE FOR MENTAL HEALTH AND
SUBSTANCE ABUSE DISORDERS.

(H.57)

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 8 V.S.A. § 4089a(g) and (h) are added to read:

(g) Members of the independent panel of mental health care providers shall be compensated as provided in 32 V.S.A. § 1010(b) and (c).

(b) A review agent shall pay a license fee for the year of registration and a renewal fee for each year thereafter of $200.00. In addition, a review agent shall pay any additional expenses incurred by the commissioner to examine and investigate an application or an amendment to an application.

Sec. 2. 8 V.S.A. § 4089b is added to read:

§ 4089b. HEALTH INSURANCE COVERAGE; MENTAL HEALTH AND
SUBSTANCE ABUSE

(a) As used in this section,

(1) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402(7). Health insurance plan includes any health benefit plan offered or administered by the state, or any subdivision or instrumentality of the state.

(2) "Mental health condition" means any condition or disorder involving mental illness or alcohol or substance abuse that falls under any of the diagnostic categories listed in the mental disorders section of the international classification of disease, as periodically revised.

(3) "Rate, term or condition" means any lifetime or annual payment limits, deductibles, copayments, coinsurance and any other cost-sharing requirements, out-of-pocket limits, visit limits and any other financial component of health insurance coverage that affects the insured.

(b) A health insurance plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible or out-of-pocket limits required under a health insurance plan shall be comprehensive for coverage of both mental health and physical health conditions.

(c) A health insurance plan that does not otherwise provide for management of care under the plan, or that does not provide for the same degree of management of care for all health conditions, may provide coverage for treatment of mental health conditions through a managed care organization provided that the managed care organization is in compliance with the rules adopted by the commissioner that assure that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this section. The rules adopted by the commissioner shall assure that timely and appropriate access to care is available; that the quantity, location and specialty distribution of health care providers is adequate and that administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured.

(d) A health insurance plan shall be construed to be in compliance with this section if at least one choice for treatment of mental health conditions provided to the insured within the plan has rates, terms and conditions that place no greater financial burden on the insured than for access to treatment of physical...
conditions. The commissioner may disapprove any plan that the commissioner determines to be inconsistent with the purposes of this section.

(e) To be eligible for coverage under this section the service shall be rendered:

(1) For treatment of mental illness,

(A) by a licensed or certified mental health professional, or (B) in a mental health facility qualified pursuant to rules adopted by the secretary of human services or in an institution, approved by the secretary of human services, that provides a program for the treatment of a mental health condition pursuant to a written plan. A nonprofit hospital or a medical service corporation may require a mental health facility or licensed or certified mental health professional to enter into a contract as a condition of providing benefits.

(2) For treatment of alcohol or substance abuse,

(A) by a substance abuse counselor or other person approved by the secretary of human services based on rules adopted by the secretary that establish standards and criteria for determining eligibility under this subdivision, or 

(B) in an institution, approved by the secretary of human services, that provides a program for the treatment of alcohol or substance dependency pursuant to a written plan.

Sec. 3. REPORT

On or before January 15, 1999, the Department of Banking, Insurance, Securities, and Health Care Administration shall report to the general assembly on the following:

(1) An estimate of the impact of this act on health insurance costs.

(2) Actions taken by the department to assure that health insurance plans are in compliance with this act and that quality and access to treatment for mental health conditions provided by the plans are not compromised by providing financial parity for such coverage.

(3) When a health insurance plan offers choices for treatment of mental health and substance abuse conditions as provided by 8 V.S.A. § 4089b(d), an analysis and comparison of those choices in regard to level of access, choice and financial burden.

(4) Identification of any segments of the population of Vermont that may be excluded from access to treatment for mental health and substance abuse conditions at the level provided by this act, including an estimate of the number of Vermonters excluded from such access under health benefit plans offered or administered by employers who receive the majority of their annual revenues from contract, grants or other expenditures by state agencies.

Sec. 4. CONSTRUCTION; TRANSITIONAL PROVISIONS

(a) The provisions of this bill shall not be construed to:

(1) Limit the provision of specialized Medicaid covered services for individuals with mental health or substance disorders.

(2) Supersede the provisions of federal law, federal or state Medicaid policy or the terms and conditions imposed on any Medicaid waiver granted to the state with respect to the provision of services to individuals with mental health or substance abuse disorders.

(3) Affect any annual health insurance plan until its date of renewal or any health insurance plan governed by a collective bargaining agreement or employment contract until the expiration of that contract.
(b) The rules of the secretary of human services adopted under 8 V.S.A. § 4089, relating to eligibility for payment for treatment of mental illness, and adopted under 8 V.S.A. § 4099, relating to eligibility for payment for treatment of alcoholism, shall remain in effect until the effective date of this act and thereafter shall be deemed to be the rules adopted by the secretary under 8 V.S.A. § 4089b(e), to the extent that they are consistent with the provisions of this act and until amended or repealed by the secretary.

Sec. 5. REPEAL

8 V.S.A. § 4089 (mental illness) and §§ 4097-4099b (alcoholism) are repealed in regard to any health insurance plan only after the provisions of this act take effect in accordance with Sec. 6 of this act.

Sec. 6. EFFECTIVE DATE

This act shall take effect on passage and shall apply to any health insurance plan offered or renewed on and after January 1, 1998.

Approved: May 28, 1997
An act to add Section 1374.72 to the Health and Safety Code, and to add Section 10144.5 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL’S DIGEST

AB 1100, Thomson. Health care coverage: mental illness.

Under existing law, a disability insurer or health care service plan may not discriminate based on race, color, religion, national origin, ancestry, or sexual orientation. An insurer is also prohibited from refusing to insure a person or from charging a different premium because of that person’s blindness.

This bill would require certain health care service plan contracts that are, or a disability insurance policy that is, issued, amended, or renewed on or after July 1, 1999, to provide coverage for the diagnosis of and medically necessary treatment of biologically based severe mental illnesses for persons of all ages under the same terms and conditions applied to other medical conditions. The bill would exempt from the provision relating to a health care service plan contract, a contract between the State Department of Health Services and a health care service plan for enrolled Medi-Cal beneficiaries.

The bill would also authorize a health care service plan and disability insurer to provide coverage of all or part of mental health services through a separate specialized health care service plan or mental health plan for purposes of compliance with the requirements of the bill and would prohibit a requirement that the plan or insurer obtain an additional or specialized license for this purpose.

Because a willful violation of the provisions relating to health care service plans is a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.
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The bill would also authorize a health care service plan and disability insurer to provide coverage of all or part of mental health services through a separate specialized health care service plan or mental health plan for purposes of compliance with the requirements of the bill and would prohibit a requirement that the plan or insurer obtain an additional or specialized license for this purpose.

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This bill would provide that no reimbursement is required by this act for a specified reason.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:
Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(e) (1) A plan may provide coverage of all or part of mental health services through a separate specialized health care service plan or mental health plan for purposes of compliance with this section and shall not be required to obtain an additional or specialized license for this purpose.

(2) Each plan shall provide the mental health coverage required by this section in its entire service area and in emergency situations as may be required by applicable statute and regulation. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

(f) Notwithstanding any other provision of this section and any other law, in the provision of benefits required in this section, a health care service plan may utilize case management, network providers, or utilization review techniques, prior authorization, copayments, or other cost sharing.

(g) Nothing in this section shall be interpreted to restrict coverage only to those services provided by physicians and surgeons or to alter the scope of practice of any health care professional.

SEC. 3. Section 10144.5 is added to the Insurance Code, to read:

10144.5. Every policy of disability insurance that covers hospital, medical, or surgical expenses in this state that is issued, amended, or renewed on or after July 1, 1999, shall provide coverage for the diagnosis and medically necessary treatment of the biologically based severe mental illnesses, as specified in subdivision (c), for a person of any age, under the same terms and conditions applied to other medical conditions, as specified in subdivision (b).

(a) These benefits shall include the following:

(1) Outpatient services.

(2) Thirty days of inpatient treatment in each 12-month benefit period.

(3) Thirty partial hospitalization treatment days in each 12-month benefit period.

(4) The ability to trade up to 10 inpatient days for an additional 20 partial days at a two-to-one tradeoff ratio.

(5) Prescription drugs, if the policy or contract includes coverage for prescription drugs.

(b) The terms and conditions applied to the benefits required by this section that are to be applied equally to all benefits under the disability insurance policy shall include, but not be limited to, the following:

(1) Maximum lifetime benefits.

(2) Copayments or coinsurance.

(3) Individual and family deductibles.

(c) For the purposes of this section "biologically based severe mental illnesses" are:

(1) Schizophrenia.

(2) Schizoaffective disorder.

(3) Bipolar disorder (manic-depressive illness).

(4) Major depressive disorders.

(5) Panic disorder.

(6) Obsessive-compulsive disorder.

(d) (1) A disability insurer may provide coverage of all or part of mental health services through a separate specialized health care service plan or mental health plan for purposes of compliance with this section and shall not be required to obtain an additional or specialized license for this purpose.

(2) A disability insurer shall provide the mental health coverage required by this section in its entire in-state service area and in emergency situations as may be required by applicable statute and regulation. For purposes of this section, disability insurers are
not precluded from requiring insureds who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

(e) Notwithstanding any other provision of this section and any other law, in the provision of benefits required in this section, a disability insurer may utilize case management, managed care, or utilization review.

(f) This section shall not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental only, vision only, or long-term care insurance policies.

(g) Nothing in this section shall be interpreted to restrict coverage only to those services provided by physicians and surgeons or to alter the scope of practice of any health care professional.

(h) Any action a disability insurer takes to implement this section, including, but not limited to, contracting with preferred provider organizations, shall not be deemed to be an action that would otherwise require licensure as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIIIB of the California Constitution.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.