New Law Moves Insurance Plans Closer to Total Mental Health Parity

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The Mental Health Parity Act of 1996 was enacted to change the long-held practice of providing more limited insurance coverage for mental health services than is provided for medical and surgical services; new data suggests employer-provided health insurance plans have made some changes designed to move closer to mental health parity.

A mental disorder has been defined as any illness that has significant psychological or behavioral manifestations and is associated with either a painful or distressing symptom or impairment in one or more important areas of functioning. In the United States, about 15 percent of adults seek mental health or addictive disorder care each year. It is estimated that two-thirds of the population with diagnosable mental disorders do not seek treatment--either due to a lack of health insurance coverage, the restrictions placed on mental health coverage by many insurance plans, or the stigma surrounding mental disorders.[1]

For a variety of reasons, including the high cost of care, the potential subjective nature of mental illnesses, and the historic social stigma associated with such illnesses, most health insurance plans place more restrictive limits on mental health benefits than are applied to other illnesses.[2] A major source of the social stigma lies in the 19th-century separation of the mental health treatment system in the United States from the mainstream health treatment system. In colonial times in the United States, people with mental illnesses often were described as "lunatics" and were largely cared for by their families, most of which were scattered among small rural communities. There was no serious effort made to treat mental illness until the widespread urbanization that occurred in the early 19th century showed that it was a societal problem. Then, social policy assumed the form of isolated asylums where persons with mental illness were administered the governing treatments of the era.[3]

Mental health care was rarely covered under health insurance plans prior to World War II. After that time, the availability of hospital psychiatric facilities prompted insurers to expand benefits to include inpatient mental health care. Subsequently, many States have legislated mandates that require insurers to include coverage for mental health care benefits. Gradually, coverage has become more widespread, and currently most employer-provided health care plans include at least some coverage for both inpatient and outpatient mental health services.[4]

In 1996, $69 billion was spent in direct costs for the diagnosis and treatment of mental illnesses. Approximately 53 percent of the funding for mental health treatment came from public sources (Medicaid, Medicare, and others). Of the 47 percent of funding from private sources, 27 percent came from private insurance, with most of the remainder coming from individual out-of-pocket expenses.[5]

Mental illness cost the U.S. economy an estimated $79 billion in 1990. Most of the indirect costs ($63 billion) reflect the loss of productivity in usual activities due to illness. Indirect costs also include almost $12 billion in lost productivity due to premature death, and almost $4 billion in productivity losses for incarcerated individuals and for the time of individuals providing family care.[6] According to a report by the American Psychological Association, mental disorders are the health condition that most limits the ability to work. They are the third most limiting health condition in terms of performing major daily activities, exceeded only by cancer and stroke. A three-year study of a large corporation showed that 60 percent of employee absences were due to psychological problems.[7]

The Mental Health Parity Act Of 1996

Traditionally, there have been more restrictions placed on health insurance coverage for mental disorders than on coverage for other illnesses.[8] Efforts have been undertaken to enact legislation requiring that insurance coverage for mental health services be comparable to coverage for medical and surgical services. On September 26, 1996, President Clinton signed the

Mental Health Parity Act of 1996.[9] Mental health parity refers to the effort to treat the financing of mental health care benefits provided through a health insurance plan on the same basis as the financing of general health services.

Key provisions of the Mental Health Parity Act, which went into effect on January 1, 1998, include the following:

- It equates lifetime and annual dollar limits for mental health benefits with lifetime and annual dollar limits for medical and surgical benefits.
- It does not preempt existing State parity laws.
- It applies only to employers offering mental health benefits.
- It does not prohibit a group health plan from utilizing other forms of cost containment.
- It applies to fully insured State-regulated health plans and self-insured plans.
- It exempts small businesses (those with 50 employees or less).
- It exempts employers that predict expenditures will increase by 1 percent or more as a result of compliance.

What is not covered by the Mental Health Parity Act:

- It provides no mandate for health insurance plans to offer mental health benefits.
- It provides no coverage for treatment for substance abuse or chemical dependency.
- It contains no regulations on how health insurance providers should handle service charges like co-payments and deductibles.
- It does not stipulate the number of inpatient hospital days or outpatient visits that must be covered by a particular plan.
- It does not apply to Medicare or Medicaid.

Before 1998, only five State legislatures had enacted mental health parity laws: Maryland (1994), New Hampshire (1994), Rhode Island (1994), Maine (1995), and Minnesota (1995). These statutes differed substantially in their respective provisions. For example, among the five States, Maryland, Rhode Island, and Minnesota covered substance abuse, and only Rhode Island and Maine offered an exemption for small employers.[10] When the Mental Health Parity Act was enacted, it required all States to eliminate certain limits placed on mental health coverage. Since then, 28 States have passed laws prohibiting discrimination in insurance and managed care coverage of mental illness. Some of these State laws are even more strict on mental health discrimination than the Federal law.

Implementation Of The Mental Health Parity Act

The effect of the Mental Health Parity Act on mental health coverage can be examined by comparing mental health benefits provided by employer-sponsored plans before and after January 1, 1998. BLS data show the percent of workers with mental health care benefits in their health insurance plans and the percent whose plans impose certain restrictions. Table 1 provides a summary of these data for 1997 and 2000.[11]

Although there was little difference from 1997 to 2000 in the extent to which plans in establishments employing 100 or more workers imposed separate limits on mental health care benefits, there were changes in the specific limitations. There was a significant decrease, for example, in the percent of establishments imposing dollar limits on care received: For inpatient care, the percent of covered workers who had a dollar limit imposed on services received dropped from 41 percent in 1997 to 10 percent in 2000. Outpatient care saw an even greater drop in the percent of those with a limit placed on dollars, from 55 percent in 1997 to 15 percent in 2000.

The Mental Health Parity Act does not prohibit a health insurance plan from utilizing other limits on the extent of coverage. Thus, there was an increase in restrictions on the number of inpatient and outpatient days of care available under the health plan. The percent of covered workers whose plan imposed a limit on the number of days covered for hospital room and board increased from 61 percent in 1997 to 72 percent in 2000. Similarly, the percent subject to a limit on the number of days covered for outpatient visits increased from 53 percent in 1997 to 71 percent in 2000. There was virtually no change in the percentage of employees with health plans imposing a coinsurance rate for mental health inpatient care.[12] Those subject to a coinsurance rate for outpatient care, on the other hand, decreased to 19 percent in 2000 from 36 percent in 1997.

Data from the 2000 survey show little difference between the extent to which limits are placed on mental health care benefits between establishments with fewer than 50 workers and those with 50 or more workers. Table 2 shows the percent of covered workers with selected plan limits.[13]

Further Legislation To Improve Access To Quality Mental Health Care

The Mental Health Parity Act included a sunset provision, meaning the legislation would expire at a certain date unless renewed by Congress. Currently, the law is set to expire on December 31, 2003, after having been extended once thus far. Legislation to renew and expand the act was introduced in Congress. On March 20, 2002, the Mental Health Equitable Treatment Act of 2002 (HR 4066) was introduced in the U.S. House of Representatives. This was a revision of an earlier bill introduced in 2001 in the Senate.

The Mental Health Equitable Treatment Act would require health insurance plans to use the same treatment limitations (frequency of treatment, number of visits, or days of coverage) and financial requirements (deductibles, coinsurance, co-payments, and other cost sharing) for mental health benefits as are used for medical and surgical benefits. For example, health insurance providers would no longer be able to limit the number of days of hospital room and board for patients being treated for schizophrenia, unless the provider placed equal limits on hospital days for a patient being treated for a medical condition such as cancer. There was a provision requiring the U.S. General Accounting Office to conduct a study that evaluates the effect of implementing the amendments of the Act on health insurance coverage, including cost, access, and other issues. This is an expansion of the Mental Health Parity Act, which did not dictate rules for deductibles, coinsurance, or co-payments. The Mental Health Equitable Treatment Act was not passed by the 107th Congress, which concluded in late 2002. A similar bill was introduced this year, the Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003.

In 2001, there was a separate initiative to provide equal health coverage for the treatment of substance abuse and chemical dependency, which is not covered by the Mental Health Protection Act. The bill was known as Fairness in Treatment: The Drug and Alcohol Addiction Recovery Act of 2001 (HR 5595). Arguing in support of the bill, its sponsor cited a study by Brandeis University's Schneider Institute for Health Policy, which estimated that untreated addiction costs America $400 billion per year. This estimate includes costs for alcohol addiction treatment and prevention costs, as well as costs associated with related illnesses, reduced job productivity or lost earnings, and other costs to society such as crime and social welfare programs.[14]

Similar to provisions for mental illnesses, health insurance plans often place more restrictions on coverage for substance abuse treatment services than for medical and surgical services. For example, data from the benefits portion of the 2000 National Compensation Survey indicate that among workers in private industry covered by a health maintenance organization (HMO), 59 percent could receive hospital room and board services without any restrictions on the amount of coverage or without any required patient payment. In contrast, 24 percent of those covered by an HMO could receive inpatient alcohol detoxification treatment without any restrictions or required payments.[15] The types of limits placed on substance abuse treatment are similar to those placed on mental health care treatment, such as a maximum number of days, a maximum dollar benefit, or a required patient payment.

The Drug and Alcohol Addiction Recovery Act called for the same provisions introduced in the Mental Health Equitable Treatment Act of 2002 to apply to substance abuse treatment benefits. The sponsor of the bill addressed the issue of unequal coverage for substance abuse treatment: "This legislation does not mandate that health insurers offer substance addiction treatment benefits. What it does is prohibit discrimination by health plans who offer substance addiction treatment from placing unfair and life-threatening limitations on caps, access, or financial requirements for addiction treatment that are different from other medical and surgical services."[16] This legislation also was not passed by the 107th Congress.

Mental health care issues continue to receive national attention. In a 2002 speech, the President said, "[Americans with mental illness] deserve a health care system that treats their illness with the same urgency as a physical illness." He established a new commission to identify the needs of patients, the barriers to care, and community-based care models that

have been successful in coordinating and providing mental health services.[17] It will then make recommendations on ways to improve coordination and quality of services of the public and private mental health system with existing resources.

BLS Will Continue To Track Benefit Provisions

As part of the National Compensation Survey, detailed provisions of health and retirement plans will continue to be tracked, and the effect of policy changes such as the Mental Health Parity Act will be revealed through statistics on employer benefit practices. BLS expects to publish annual estimates of benefit plan provisions, and may in the future be able to indicate how such provisions vary by occupation, industry, union status, and location. Data series are being developed that will link employer insurance costs with plan provisions to provide an indication of the effect changes in plan design have on employer costs.

Appendix A. Types Of Limits On Health Care Benefits

Day limit. The number of days in the hospital or in outpatient care covered by the plan. This includes hospital room and board, individual therapy visits, and group help sessions. For example, a health insurance plan may place a 30-day annual limit on hospital treatment for a mental illness.

Dollar limit. An annual or lifetime ceiling on payments paid by the plan. For example, some plans impose lifetime limits on hospital expenses for mental health care while imposing no such limits for physical illnesses. Such differences were prohibited by the Mental Health Protection Act.

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

Co-payment. A required dollar amount paid by the patient per medical session. For example, a patient might be required to pay $20 each time he visits a therapist.

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Notes

1 U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* , 1999.

2 For background information on the limitation of benefits covering mental illness, see Jerry S. Rosenbloom, ed., *The Handbook of Employee Benefits, 1996*, pp. 115-16, 155-56.

3 *Mental Health: A Report of the Surgeon General*, 1999.

4 For more information, see Allan P. Blostin, "Mental health benefits financed by employers," *Monthly Labor Review*, July 1987, pp. 23-27.

5 *Mental Health: A Report of the Surgeon General*, 1999.

6 *Ibid*.

7 American Psychological Association, "The Costs of Failing to Provide Appropriate Mental Health Care," on the Internet at www.apa.org/practice/failing.html, visited January 3, 2003.

8 For detailed information on limits imposed on mental health care benefits, see Blostin, "Mental health benefits financed by employers,"pp. 23-27.

9 *The Mental Health Parity Act of 1996*, PL-104-204.

10 *State Parity Legislation: Current Status (1991-2000)*, National Institute of Mental Health, on the Internet at http://www.nimh.nih.gov/parity/status.cfm, visited January 3, 2003.

11 Data for 1997 are from the BLS Employee Benefits Survey (EBS), and those for 2000 are from the National Compensation Survey (NCS), which replaced the EBS. For more information on the change to the NCS, see *Employee Benefits in Private Industry, 1999*, USDL 01-473

(U.S. Department of Labor), December 19, 2001, especially the Technical Note. The 1997 EBS was limited to private industry establishments employing 100 or more workers; the 2000 NCS included all private industry establishments, regardless of their level of employment. Data from both surveys are restricted to full-time employees. To facilitate comparisons with the 1997 EBS data, the 2000 NCS data were tabulated by employment size; data from the 2000 NCS for establishments with 100 or more workers were compared with data from the 1997 EBS. Because the Mental Health Parity Act applies only to establishments employing 50 or more workers, Table 2 shows comparisons of establishments above and below that threshold. More complete survey results, as well as survey methodology and definitions of terms, may be found at the BLS National Compensation Survey, Benefits, website at http://www.bls.gov/ncs/ebs/home.htm (visited January 3, 2003).

12 Coinsurance is the amount (usually expressed in percent terms) of a health benefit's cost not paid by the individual's plan. See the appendix A for a more complete definition of coinsurance.

13 Because of the small sample of establishments with fewer than 50 employees, readers should use these figures with caution; they are presented here to compare with data for larger establishments.

14 Floor Statement of Senator Paul D. Wellstone, March 22, 2001. The text of *Fairness in Treatment: The Drug and Alcohol Addiction Recovery Act of 2001*, can be found on the Internet at http://www.senate.gov/~wellstone/daara01.htm, visited January 3, 2003. See also information on substance abuse treatment benefits prepared by Brandeis University's Schneider Institute for Health Policy on the Internet at http://sihp.brandeis.edu/, visited January 3, 2003.

15 Data are from the 2000 survey of employee benefits in private industry. For survey results, see http://www.bls.gov/ncs/ebs/home.htm, visited January 3, 2003.

16 Wellstone, March 22, 2001.

17 *President Says U.S. Must Make Commitment to Mental Health Care*, Office of the Press Secretary, The White House, April 29, 2002, on the Internet at http://www.whitehouse.gov/news/releases/2002/04/20020429-1.html, visited January 3, 2003.

Table 1. Percent of full-time employees covered by employer-provided health insurance plans by restriction on mental health care benefits, 1997 and 2000 (1)

	Percent	
	1997	2000
Total with mental health care benefits	100	100
Inpatient care (hospital room and board):		
Subject to separate limits (2)	86	82
Days	61	72
Dollars	41	10
Coinsurance	13	12
Co-payment	7	3
Outpatient care:		
Subject to separate limits (2)	96	90
Days	53	71
Dollars	55	15
Coinsurance	36	19
Co-payment	30	29

Footnotes:
(1) Data are limited to private industry establishments with 100 or more workers.
(2) Employees in plans that did not impose separate limits for mental health benefits generally imposed the same deductible and coinsurance for all services, including mental and nonmental illnesses.

NOTE: Sums of individual items may not equal totals because some workers were subject to more than one limit.

Table 2. Percent of workers in plans placing limits on mental health care benefits, by establishment size, 2000

Limitations	Establishments with fewer than 50 workers	Establishments with 50 or more workers
Impatient day limit	80	73
Impatient dollar limit	8	10
Outpatient day limit	72	73
Outpatient dollar limit	16	15