TRENDS IN AMERICA

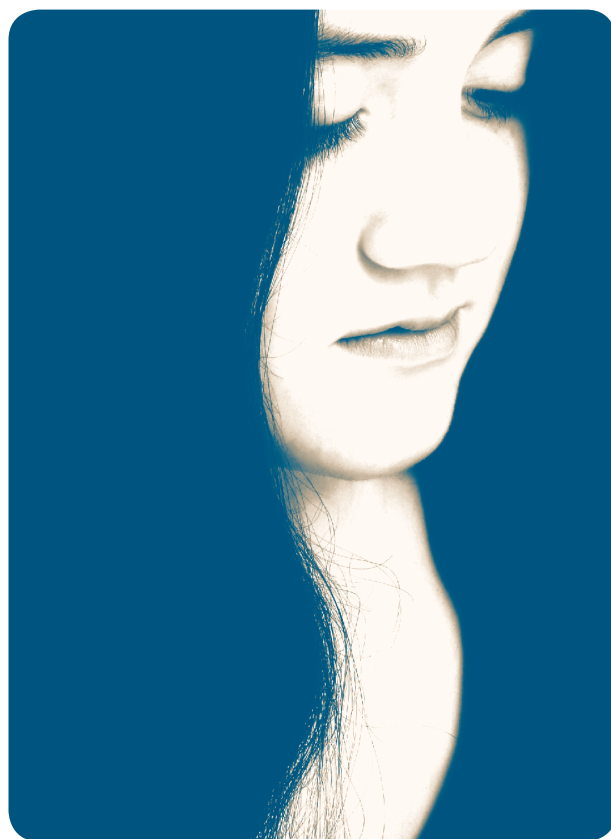
MENTAL HEALTH PARITY

In 2008, a New Jersey family won a landmark lawsuit against the Aetna Insurance Company because the company denied payment of claims for their 16-year-old daughter who required inpatient treatment for an eating disorder. The insurance company denied coverage for the daughter even though she required months of inpatient care. This would not have happened had she been receiving treatment for leukemia or another physical illness. Tragically, in a similar situation years earlier, a Minnesota teen died from an eating disorder after her health insurance carrier, Blue Cross Blue Shield of Minnesota, refused to cover necessary mental health care. This family subsequently won a lawsuit against the Minnesota-based insurance company.

While America was focused on a rescue plan for the financial markets, a law that affects how employers must provide mental health care was quietly passed in the last days of the Bush administration. The Mental Health Parity and Addiction Equity Act was buried within the Emergency Economic Stabilization Act signed by then President Bush Oct. 3, 2008. Although it received little attention outside the mental health community, the law will have a significant impact on an estimated 113 million people in the United States who are enrolled in group health insurance plans, including 82 million who are enrolled in self-insured plans subject to the federal Employment Retirement Income Security Act, commonly called ERISA.[1]

The act seeks to make mental health and substance abuse benefits more comparable to physical health benefits provided under group health plans. For many years, insurance companies set higher co-payments, deductibles and limits on mental health and substance abuse treatment than for treatment of physical illnesses such as cancer, heart disease or diabetes. This inequity between physical and mental health benefits left many people without proper treatment; which resulted from and contributed to the continuation of the stigma surrounding mental health disorders.

The act does not require health plans to *offer* mental health or substance abuse benefits. Rather, the new federal parity law requires group health plans covering 50 or more employees, whether they are regulated under ERISA or under state law, to provide mental health or substance abuse benefits comparable to physical health benefits. Most large employers offer mental health and substance abuse benefits; however differential co-payments, deductibles and limits on treatment often act as significant barriers to needed treatment and care.



Many states had already addressed mental health parity and passed various insurance reform laws. The new federal law does not pre-empt state laws that provide for stronger protections and there is no requirement for states to enact it for it to take effect. The federal law will apply to plans beginning in the first plan coverage year that is one year after the enactment date. For most plans, this will be Jan. 1, 2010.

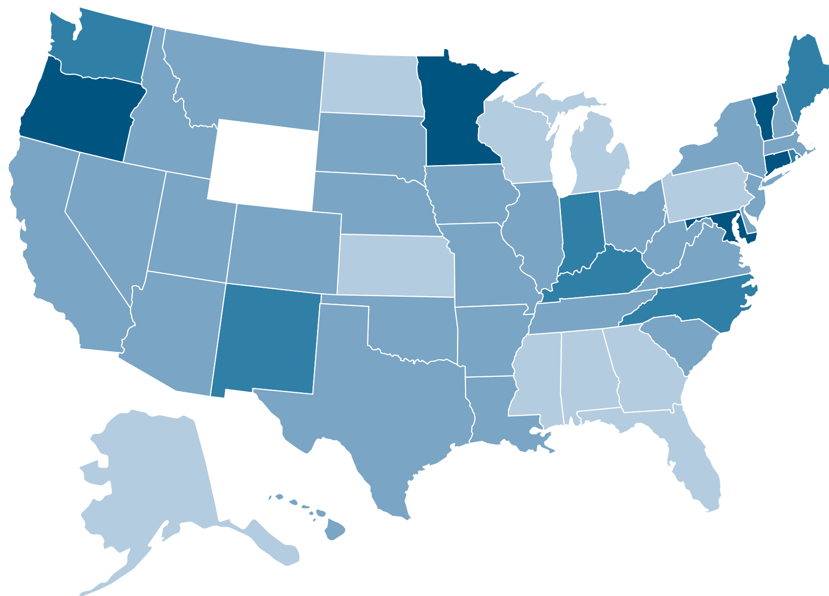
The new federal law mandates that financial requirements and treatment limitations applied to mental health and substance use benefits be no more restrictive than those applied to physical health benefits. Gone are the days, for instance, when mental health hospitalization can be limited to 30 days per calendar year if physical health hospitalizations are unlimited. Further, the federal parity legislation requires a plan that makes physical health benefits available through out-of-network providers also authorize equal coverage for mental health or substance abuse benefits by out-of-network providers. The law also provides that a health plan can be exempted from the federal parity law if it can prove that providing parity increases its total health plan costs by more than 2 percent in the first year and 1 percent thereafter. Many experts do not expect increases of that magnitude.

Mental Illness is Costly for Individuals, Families and Society

Recent research found only severe heart disease is associated with more disability and interruption of daily functioning than depression.[2] The National Institute of Mental Health reports that mental health disorders cost the United States more than $150 billion each year; that includes the costs of treatment, social services and disability payments, lost productivity and premature death. The indirect cost of mental illness is an estimated $79 billion—$63 billion of that is due to lost productivity.[3] A 2006 Bureau of Justice study found that more than half of all prison and jail inmates had a mental health problem.[4] According to a Government Accountability Office report, inadequate health care coverage is a leading cause of custody relinquishment for youth. Thousands of youth are placed each year in child welfare or juvenile justice systems due to unmet intensive mental health needs.[5]

In a given year, just one-third of adults and half of children who have a mental illness receive mental health care for their condition.[6] This serious gap in care persists at the same time research has established that most mental disorders are as treatable and manageable as general medical conditions. With proper treatment, persons with mental illness have at least a 75 percent rate of recovery, surpassing the recovery rates for other medical problems, such as coronary disease which has only a 50 percent success rate.[2] The connection between parity and services is clear: The more comprehensive a state's mental health parity requirement, the greater the number of people in the state who receive mental health services.[7]

Mental Health Parity Laws



- Strong Parity Laws
- Good Parity Laws
- Limited Parity Laws
- Mental Health Mandates, Not Parity
- No Parity or Mandate Laws

Source: Mental Health America, *http://www.mentalhealthamerica.net*.
Note: Idaho's parity law applies to state employees only.

States Led the Way in Enacting Parity Legislation

When it comes to health care, states have often taken the lead and mental health parity is no exception. Concern about access to mental health treatment has led every state but one to enact legislation to address mental health coverage in some manner. While some of these laws provide for strong parity protections, many do not. Some limit coverage to only the most severe mental health diagnoses, while other states cover all mental health and substance abuse disorders. In those states with stronger protections than the new federal law that takes effect in 2010, provisions such as mandated benefits or parity for smaller group sizes or for the individual market will remain.

The approaches taken by states to address mental health coverage can be classified into three general categories (See state examples of each below):

- *Parity mandate.* Requires coverage for mental health conditions to be equal to insurance provided for physical health conditions. The new federal parity law mirrors this category of state statute.
- *Mandated benefits.* Requires some level of coverage be provided for specific behavioral health conditions.
- *Mandated offering.* Requires an option of coverage for mental health conditions be provided to the insured (often as a "rider"), but does not require employers to purchase these plans. Further, this category of state law does not require equal benefits, copayments and limits.

Among these approaches, mandated offering laws are the weakest in terms of requiring equality in mental health cov-

erage while parity laws are the strongest. A state seeking to ensure the availability of a high level of mental health benefits is more likely to enact a parity mandate. Within these three approaches are a multitude of differences in the types of insurance plans and policies to which the statutes apply, the mental illnesses that fall under the law and rules regarding copayments and deductibles. Depending on the mandates of a particular state law, either the federal law will prevail and provide more coverage or the state law will remain in force with more protections than the new federal law.

Alabama, **Michigan** and **Vermont** provide clear examples of these three approaches.

Alabama is considered a mandatory offering state because it requires group health plans to offer coverage for mental illness on the same basis as for physical illness. The law adopted in 2000 provides equitable health insurance coverage for mental illnesses as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), an internationally recognized manual of diseases commonly used by health care professionals. Under the law, group health plans must offer to provide coverage for the treatment and diagnosis of mental illnesses equal to the coverage provided for medical illnesses.

http://www.legislature.state.al.us/searchableinstruments/Enrolled%20Acts/2000%20Regular%20Session/HB677-enr.pdf

Michigan is a mandated benefit state. The 2000 state law applies only to health maintenance organizations that are required to provide minimum benefits for inpatient and outpatient mental health and substance abuse services.

http://www.legislature.mi.gov/(S(xyxgmh45fr0ogo2kb44cxibc))/documents/1999-2000/billintroduced/Senate/pdf/2000-SIB-1209.pdf

Vermont has the strongest and most comprehensive parity law among the states. It requires equity in health insurance coverage for both mental health and substance abuse services. The law defines mental health conditions broadly, covers substance abuse, and requires equal terms and conditions with physical health care for service limits and cost-sharing. The Vermont law covers the entire commercially insured population, with no exemptions for small businesses or individual policies. The sole exception is self-insured groups because of federal ERISA laws.

http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=08&Chapter=107&Section=04089b

Several states have what could be called a tiered parity system in which parity exists for some specified mental illnesses, while coverage for other conditions is not required or permits limitations such as higher deductibles. An example of a tiered system is **Montana**. In 1999, the state legislature passed a parity law that requires equal coverage by individual and group health insurance plans for severe mental illnesses. The law defines severe mental illness to include such ailments as schizophrenia, major depression, autism and obsessive-compulsive disorder. In addition, the state has mandated less-than-parity coverage for mental illness including alcoholism and drug addiction since 1981.

Impact of Federal Act on State Laws

Advocates for the federal law wanted to preserve previous progressive actions by state legislatures to remove barriers to mental health and substance abuse care. The federal law leaves in place all state mandates to offer mental health benefits or cover treatment for mental illness, including state parity laws that require offering mental health benefits or covering specific mental illnesses. In essence, the new federal law is a floor from which states may provide for greater protection.

Some state laws provide coverage for the full range of recognized mental health illnesses. Other state laws limit coverage to a specific list of biologically based or serious mental illnesses, such as schizophrenia and bipolar disorders. State laws that either define or mandate coverage of specific mental illnesses or services will continue to apply to state-regulated plans. For example, if a state law requires

By the Numbers: Mental Health & Substance Abuse

26.2%—Estimated percentage of Americans age 18 and older who suffer from a diagnosable mental disorder in a given year

6%—The number of those who suffer from a serious mental illness

20.9%—Approximate percentage of American adults who have a mood disorder such as major depressive disorder or bipolar disorder

32,439—The number of people who died by suicide in the United States in 2004

1.1%—Percentage of the population age 18 and older in a given year who have schizophrenia

40 million—Approximate number of American adults who have an anxiety disorder such as panic disorder, obsessive-compulsive disorder or phobias

41.6 million—Number of visits to office-based physicians for mental disorders in 2006

4.3 million—Number of hospital emergency department visits for mental disorders in 2006

7.3 million—Number of hospital outpatient department visits for mental disorders in 2006

19.9 million—The number of Americans age 12 or older in 2007 who were current (past month) illicit drug users, such as using marijuana, cocaine, heroin or hallucinogens

17.6 million—The number of Americans age 18 or older who abused alcohol or were alcohol dependent in 2001–2002

3.1 million—The number of youths age 12 to 17 who received treatment or counseling in 2007 for problems with behavior or emotions in a specialty mental health setting (inpatient or outpatient care)

Sources: U.S. Centers for Disease Control and Prevention; Department of Health and Human Services (2007 National Survey on Drug Use and Health: National Findings); National Center for Health Statistics; National Institute of Mental Health.

parity for all diagnoses in the DSM, this state requirement remains in force as does a state law that requires parity for specific diagnoses only, such as those that are biologically based. There is no requirement in the federal parity law for what conditions must be covered.

In addition to mental illness, a majority of states have laws requiring some form of insurance coverage for substance abuse disorders. The federal law extends the parity requirement to any substance abuse disorder covered by a health plan. For example, **Colorado** requires coverage for substance abuse treatment but with treatment limitations and financial requirements that are not equal to those for physical health benefits. Under the new federal law, insurance plans in Colorado will now be required to provide coverage for substance abuse treatment at parity. Nine states — **Connecticut**, **Delaware**, **Kentucky**, **Maryland**, **Minnesota**, **Rhode Island**, **Utah**, **Vermont** and **Virginia**— already include coverage equivalent to the new federal law for substance abuse treatment in their parity statutes.

Some states have differentiated between types of insurance plans when enacting either parity or mandated offering requirements. For example, **Connecticut** and **Vermont** cover group plans of any size and their laws extend to the individual insurance market. The new federal law will not pre-empt these more comprehensive provisions. In contrast, **Mississippi** exempts small employers with fewer than 100 employees, and **Idaho**'s parity law applies only to state employees. These state provisions will be pre-empted since they are less comprehensive than federal law, which applies to all group plans larger than 50 employees.

State parity laws do not apply to federally funded public programs such as Medicaid or Medicare or to self-funded health insurance plans that fall under the auspices of the federal ERISA law, the majority of which do not have mental health provisions. The federal Mental Health and Addiction Equity Act will apply to self-funded plans, as well as to State Children's Health Insurance Program plans and Medicaid managed care health plans. Medicare plans do not fall under the new parity law; however, Congress provided for Medicare coinsurance parity when it enacted the Medicare Improvements for Patients and Providers Act of 2008.

The Cost of Parity

Cost analyses in states that have enacted comprehensive parity legislation suggest mental health parity often leads to savings. In **Minnesota**, Blue Cross Blue Shield's insurance premiums fell by 5 percent to 6 percent after one year under the state's comprehensive parity law.[8] In **North Carolina**, expenses for mental health services have decreased each year since the state enacted parity for state and local employees in 1992.[8]

The National Mental Health Association estimates providing mental health coverage commensurate to physical health coverage for all U.S. children and adults would lead to a net annual savings of $2.2 billion, when savings for general medical services and indirect costs are considered.[8] Cost data from federal employee health insurance showed an increase of less than half a percentage point when health plans for federal workers were required to provide full parity coverage starting in 2001.[9] Studies also show that an increase in what insurance companies pay up front could help them save money over time.[10] Nonetheless, despite these findings, employers and insurers are still concerned about the cost of providing parity.

Conclusion

The Mental Health Parity and Addiction Equity Act of 2008 is a positive step for individuals with mental health and substance abuse needs and is evidence of just how far the nation has come in reducing the stigma associated with mental illness. The new law applies to all insurers, including ERISA plans, and does not pre-empt state laws that provide stronger protections and rights for individuals. The impact of the federal parity statute on state laws will depend on whether a particular provision in state law is more or less stringent than the federal parity statute. For example, a state law that addressed mental health coverage in plans that are not regulated by the federal ERISA law, such as small group plans, will remain in force while state laws that mandate coverage for mental health services but allow for a differential benefit will be overridden. Federal regulations, which will be issued in the coming months, will define exactly how the federal parity requirements will impact existing state laws. Until draft regulations are issued, it is unclear specifically what provisions of various state laws will be overridden. An analysis on a state-by-state basis will be needed to determine whether a state mandate conflicts with the parity law and is thus pre-empted. States may elect to enact new statutes, joining a handful of states that have been leaders in mental health parity, to guarantee mental health benefits to their citizens beyond the floor established in federal law.

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