The Mental Health Care Parity Debate Continues

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Proponents of mental health care parity have reintroduced the legislation that died in the U.S. House of Representatives last year. While the idea of parity has broad bipartisan support, the debate continues over how much it will cost, who will foot the bill, and how it should best be administered. In a time of war and tight budgets, will the bill get the attention it deserves?

Proponents of mental health care parity--the requirement that insurers provide the same levels of benefits for psychiatric illnesses as they do for medical and surgical conditions--returned to the legislative fray early this year with the reintroduction of legislation that died last fall in the U.S. House of Representatives without a vote. The bill has been renamed the Wellstone Act, in honor of the late Sen. Paul Wellstone (D-Minn.), a popular political figure and proponent for mental health care who was killed in a plane crash. The legislation has broad bipartisan support. "We have a majority of House members who have signed up as co-sponsors," Rep. Patrick J. Kennedy (D-R.I.), one of four members of Congress who introduced the bill, told Psychiatric Times. Joining Kennedy were Rep. Jim Ramstad (R-Minn.), Sen. Pete Domenici (R-N.M.) and Sen. Edward J. Kennedy (D-Mass.). Last year, the sponsors of the bill said that the same legislation won 67 votes in the U.S. Senate but was blocked by the House leadership, who prevented it from coming to the floor. "Our challenge this year is to break through to the leadership," Rep. Kennedy said. "We have to make sure that they follow the lead of President Bush, who spoke about this in Albuquerque, New Mexico, and Sen. [Bill] Frist [R-Tenn.], who understands so well the connection of mind and body." Kennedy added, "Government is one of the worst practitioners with a lack of mental health parity when it comes to Medicare, which only pays 50% for mental illness but covers everything else at 80%. And, of course, as members of Congress, we've got full parity. There is a disconnect there." (Please see p28 of the print edition for more information on the 50% copayment--Ed.)

The bill expands on the Mental Health Parity Act of 1996. It would prohibit a covered group health plan from imposing treatment limitations or financial requirements on the coverage of mental health care benefits unless there are comparable limitations on medical and surgical benefits. In addition, it requires full parity for all mental health conditions listed in DSM-IV. However, it excludes substance abuse treatments from the requirement for parity. "Substance abuse is a hopeless cause on the federal level," Erika deFur Malik, program director for health care reform at the National Mental Health Association (NMHA), told PT. "The stigma around substance abuse is so strong, and people are so afraid of risking their political careers, that they won't touch it for fear of being seen supporting a law-breaker." "I'd like to see substance abuse included," Rep. Kennedy said, "but in order to not give the opposition any excuse for not passing parity, we've decided to go with the bill that's passed already in the full Senate and has bipartisan co-sponsorship on both sides. It's better to stay on safe ground so the pressure is maximized. It will be like a wall tumbling down. If we get this victory under our belts, the blow that this is going to make to stigma is so profound that the battle for parity in substance abuse will soon follow."

But the challenge appears to be greater this year, as a host of other issues, including war, terrorism and prescription coverage for Medicare recipients, vie for the attention of lawmakers. "This is a bill that has won support on both sides of the aisles," Ralph Ibson, vice president for government affairs at NMHA, told PT. "In the right circumstances, it should not be difficult to pass. Unfortunately, this year it competes for attention with many other things. The advocates are hopeful that the president would at some point engage the Congress with letters and renew a call that they deliver a bill to him."

In addition, the bill's sponsors can expect stiff opposition from the insurance industry, which succeeded in scuttling last year's measure. "We have a great number of organizations that have endorsed parity," Ibson said. "There is a group of eight of us that have been working together for some time as a coalition for parity, and that includes a number of provider organizations, such as the American Psychiatric Association, the American Medical Association, the American Psychological Association, the American Osteopathic Association, the American Hospital Association, the American Medical Directors Association, the American Hospital Insurance Association, and myself as the representative of NMHA."
Association and even the Managed Behavioral Healthcare Organization. But the rest of the insurance industry certainly has not embraced this legislation. Far from it."

"We will do what we can to defeat it," Larry Akey, director of communications for the Health Insurance Association of America, told PT. "We believe that the best place for benefit design decisions to be taken is between employers, employees and their health plan, not in the emotionally charged atmosphere of Congress or the state legislatures."

Health Insurance Association of America President Donald Young issued a statement that called the parity measure "a misguided effort to provide additional treatment resources for a wide variety of ill-defined and difficult-to-diagnose mental disorders" that will "drive up the cost of health insurance for everyone, and will cause hundreds of thousands of Americans to lose their health coverage altogether."

Mohit Ghose, a spokesperson for the American Association of Health Plans, is concerned about the cost of a legislated mandate. "We believe in this environment of rising health care costs, any type of benefit mandate bill will put a tremendous amount of pressure not only on employers but on employees," he told PT.

"We believe that people need access to the right care in the right setting at the right time, including mental health services," Ghose said. "We also believe it is imperative that we permit employers a level of flexibility in designing their benefits that allows us to bring more people into the system rather than losing their benefits. This bill is almost like giving the employer a disincentive, taking away the flexibility to design a plan that meets his employees' needs, telling him that you provide this or you provide nothing. And that's the danger."

As expected, most of the opposition to mental health parity focuses on the costs of providing additional benefits--costs that will be born by employers in nearly all cases. Both sides are quick to trot out figures supporting their contentions about the probable effects of increasing the benefit level.

In 1996, the Congressional Budget Office (CBO) projected that parity could result in an increase of up to 5.3% in a fee-for-service plan and 4% in all plans. Two years later, the Substance Abuse and Mental Health Services Administration lowered the estimate for all plans to 3.6%. In June 2000, the National Advisory Mental Health Council told Congress that a study by the Hay Group, a health care consultant, found the cost to be 1.4% for fee-for-service and all other plans.

In materials released at their press conference, the sponsors of the parity bill said, "CBO has estimated that this legislation will increase health care costs by less than 1%. ... The CBO estimate may, in fact, overstate the cost increase, because it does not take into account productivity gains, lower absenteeism, and lower health care costs that research shows result from better mental health care."

However, the American Association of Health Plans cites other studies. "The California Public Employees' Retirement System has reported that mental health parity legislation will cause premiums for its two PPO options to increase by 3.3% and 2.7%, respectively, in 2003," according to a handout from the association.

Akey added, "We now have close to 2,000 mandated health benefits on the books at the state and federal level. Every time a new mandate is passed, we hear the same arguments. But health insurance premiums are already soaring. Upwards of 25% of the health insurance premium is a direct result of mandated benefits. And most of them probably resulted in a decrease of well-being for those Americans who lost coverage because it became unaffordable."

But Ghose cited other problems with the legislation as well: "The bill would require parity for all conditions included in the Diagnostic and Statistical Manual of Mental Disorders. The DSM-IV, and whatever future versions, were never written to be codified into a payment mechanism. This bill codifies a diagnostic tool into a payment mechanism. There are conditions listed in DSM-IV that would be difficult to provide evidence-based care for. What is the evidence-based approach for jet lag? Is it five sessions? Is it 25 sessions? Is it 40 sessions? Nobody is saying that there shouldn't be coverage for illnesses where there is a biological basis. In those cases, we believe there should be adequate coverage."

Rep. Kennedy disagreed, however. "In Minnesota, when they put parity through--with substance abuse included--they saw their premiums go down," he said. "Most businesses who've had the experience will tell you that it is not a benefit that's abused. It's only used when people need it.

"When compared with other chronic diseases, mental illness fares the best with treatment. We've been trying to get the leadership to just agree to hearings, but these are arguments that they're not willing to hear. They know they can't disagree with them, so they prefer to feign ignorance rather than take the moral position,"
Supporters of parity said arguments over conditions like jet lag amount to a red herring. They said the law only requires parity for treatments that are deemed "medically necessary."

Individual states have been attempting to deal with the issue of discriminatory benefits and mental health parity since the 1970s, but most states did not start enacting parity laws until the 1990s. "It's been a priority issue across the country for six or seven years for all of the state mental health associations," Malik said.

According to her, "Thirty-three states have some type of parity law. The best is Vermont," which mandates full parity for both group and individual policies and requires that co-pays and deductibles must be equal for mental illness and medical or surgical conditions. Vermont also includes substance abuse among the conditions for which parity is required.

"Twenty-five states have significant limitations on those laws. Many states have not moved to next level, broad-based parity," Malik said. "We believe strongly that it's got to be broad-based, covering all of the diagnoses under the latest version of DSM or the International Classification of Diseases. Some states, like California, for example, only list certain types of disease. That causes confusion and creates another level of discrimination. People who don't fit into those categories get the short end of the stick. Eating disorders, posttraumatic stress disorder and children's disorders are usually excluded because they don't fit neatly into those categories."

Twenty-one states also include coverage for substance abuse, alcoholism or drug addiction, according to the National Conference of State Legislatures (NCSL). But an official of the NCSL indicated that future progress might be restricted on the state level. "We are well aware of a strong trend away from statutory mandates in general, not just mental health," said Richard Cauchi, health care program manager at NCSL. "States are increasingly shying away from enacting statutory mandates.

"Twenty states have mandate review commissions. They say the legislature can't just pass a bill without bringing it to a special group that will evaluate it in terms of its costs, the risks of people losing coverage, and so forth. Mental health parity is one more thing on the list."

According to Malik, many states are looking at making improvements in their parity laws, including New York, Michigan, Indiana, Ohio, Wisconsin and Iowa. But with virtually all states facing budget shortfalls this year, local mental health associations are forced to devote most of their energies to staving off cuts in services.

Passage of a comprehensive parity law on the national level would help resolve one issue that individual state laws cannot: Many health plans are governed by a federal law, the Employee Retirement Income Security Act, which supercedes state regulation. But the Wellstone Act would amend the law to require that those health plans also offer parity benefits.

Kennedy believes the only way to overcome roadblocks in the House is for President Bush to reaffirm his commitment to parity. "What we need the most is for people to write the White House and get their friends and activists in the health care field to use their political clout to contact the White House," he said. "President Bush spoke in favor of parity last year. We have the majority of members of the House behind this bill. We can get this done with a presidential commitment. The House will do this if the president says it's a priority of his. We know the Senate's already there."

View Figure.