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Mental Health Parity: An Overview

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Summary

Mental health parity laws aim to eliminate disparities in insurance coverage of mental illness and other physical illnesses. A partial federal mental health parity law, which requires parity only for annual and lifetime limits in coverage, has been in existence since 1996. Efforts to expand mental health parity, to include provisions like treatment limitations and out-of-network coverage, passed in the 110th Congress, after failing to pass in the 107th, 108th, and 109th Congresses. On October 24, 2008, President George Bush signed into law P.L.110-343, which provided for this expanded mental health parity in addition to providing a rescue package for the U.S. financial system. The mental health parity provisions of this law seem to be widely supported by advocates for individuals with mental illnesses as well as insurers. In the 110th Congress, legislators from the House and Senate struggled to reach compromise language on mental health parity, and in the last days before its passage, they struggled to develop appropriate offsets to pay for the $3.4 billion that mental health parity is estimated to cost over the next 10 years. Despite the passage on this act, some issues persist, which may lead to continued disparity in coverage of mental illnesses and persistent barriers to access mental health care.

This report provides an overview of mental health parity legislation. It includes background on economic issues surrounding mental health parity, summarizes past federal and state parity legislation, details the movement of mental health parity legislation in the 110th Congress until its passage, and describes the provisions of this law. Finally, it analyzes the practical implications of the expanded federal mental health parity law and considers issues that may still persist.

Background

Health insurance coverage for mental illnesses is often less generous than that for other physical illnesses. This disparity can include non-coverage of mental illnesses, or higher copayments and lower treatment limits for mental illnesses. Mental health parity laws aim to eliminate these disparities through two approaches. One type of parity law involves requiring the insurer to cover certain or all mental illnesses. Another type involves parity in the provisions of coverage (e.g., coinsurance, treatment limits). The

federal mental health parity law, which has been in existence since 1996, addresses the issue of disparity in treatment limits. The expanded federal mental health parity law also addresses the issue of disparity in copayment requirements. So far, no federal mental health parity bill has required full parity, which is defined as requiring insurance companies to provide mental health coverage and provide this coverage on par with that for physical health. While federal parity legislation requires parity for mental health coverage only when an insurer has chosen to provide mental health benefits (also called *minimum mandated parity*), some states have taken different approaches. Some states require *full parity* in which an insurer providing medical and surgical benefits must also provide comparable mental health benefits. Some other states require insurers to provide mental health benefits but at a minimum level (also called *mandated offering parity*).

Private health insurers providing less coverage for mental illnesses than for other medical conditions, in part reflects insurers' beliefs that mental disorders are difficult to diagnose, and that mental health care is expensive and often ineffective. However, these concerns have been addressed by researchers in the past decade. A 1999 Surgeon General's report on mental health concluded that effective treatments exist for most mental disorders.[1] Several studies have found that when mental health parity is implemented in the context of managed care, there is little or no increase in costs to the insurer.[2] Possibly as a consequence of these findings, America's Health Insurance Plans (AHIP), which represents the major insurance companies, supports the federal mental health parity law, which requires parity coverage of mental illnesses, if the insurer chooses to provide mental health coverage. For a detailed analysis of economic issues surrounding mental health parity, see CRS Report RL31657, *Mental Health Parity: Federal and State Action and Economic Impact.*

Past Federal Mental Health Parity Legislation

Mental health parity legislation was first introduced in 1992, and the Mental Health Parity Act (MHPA) of 1996 was the first federal mental health parity law.[3] MHPA requires partial parity by mandating that annual and lifetime dollar limits on coverage for mental health treatment under group health plans offering mental health coverage be no less than those for physical illnesses. It also provides an exemption for employers with 50 or fewer employees. MHPA, as well as parity legislation introduced later, amend the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC).[4]

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[1] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, available at [http://www.surgeongeneral.gov/library/mentalhealth/home.html].

[2] See, for example, Howard H. Goldman et. al., "Behavioral Health Insurance Parity for Federal Employees," *New England Journal of Medicine*, Vol. 354, No. 13, March 30, 2006, pp. 1378-1386.

[3] P.L. 104-204.

[4] ERISA regulates employee benefit plans, including employer-sponsored group health plans; the PHSA applies to insurance companies and managed care organizations, and to non-federal government health plans; and the IRC covers group health plans (using a slightly broader definition than ERISA).

Since its enactment, MHPA, which originally sunset in 2001, has received annual extensions and is now extended through the end of 2008. Expanded parity legislation that failed to pass in the 107th, 108th and 109th Congresses passed in the 110th Congress. For more information on the history of this legislation, see CRS Report RL33820, *The Mental Health Parity Act: A Legislative History*.

State Mental Health Parity Legislation

Forty-nine states have passed some version of mental health parity legislation in order to address aspects of parity coverage beyond the federally mandated parity in treatment limits.[5] Just over half of them have passed laws requiring full parity for mental health coverage. Of the remainder, 15 states have laws requiring mandated offering, and 7 states require minimum mandated coverage.

State laws vary on key aspects of parity, including the extent of coverage for the treatment of mental illnesses and substance abuse, financial limitations, and populations covered. State mental health parity laws do not apply to employee-sponsored health insurance plans and self-insured plans, which would be covered only by federal parity laws as described in footnote 4.

Mental Health Parity Legislation in the 110th Congress

In the 110th Congress, the Senate and House passed different versions of expanded mental health parity legislation (S. 558 and H.R. 1424). Aside from some differences in extent of parity requirements in the two bills, they expanded the requirements for mental health parity beyond MHPA, which only requires parity in annual and lifetime dollar limits on coverage. The bills required parity for mental health coverage in a number of additional matters, including copayments, deductibles, annual treatment limits (e.g., number of covered visits to a provider in a calendar year), and in- and out-of-network coverage. These bills had always been strongly supported by advocates for the mentally ill and had broad, bipartisan support in Congress. Although employers and health insurance groups opposed the legislation in the past because of concern that it would drive up costs, the provisions in S. 558 appeared to have their support. S. 558 is very similar to the final version of expanded parity legislation contained in P.L.110-343.

Senate and House Action. On February 12, 2007, Senators Pete Domenici and Edward Kennedy introduced the Mental Health Parity Act of 2007 (S. 558) to amend and expand the MHPA by requiring employer-sponsored group health plans to impose the same treatment limitations and financial requirements on their mental health coverage as they do on their medical and surgical coverage. The bill was referred to the Senate Health, Education, Labor, and Pensions Committee, where it was marked up on February 14, 2007.[6] The Senate passed S. 558, with an amendment, by unanimous consent on September 18, 2007.

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[5] At the current time, Wyoming is the only state that has not passed any mental health parity legislation at the state level.

[6] S.Rept. 110-53.

On March 7, 2007, Representatives Patrick Kennedy and Jim Ramstad introduced the Paul Wellstone Mental Health and Addiction Equity Act (H.R. 1424). On July 18, 2007, the House Education and Labor Committee approved H.R. 1424, with an amendment. The measure, as amended, was approved by the House Ways and Means Committee on September 26, 2007, and by the House Energy and Commerce Committee on October 16, 2007.[7] The House passed H.R. 1424 by a vote of 268-148 on March 5, 2008.

In June 2008, Senate and House negotiators reached agreement on bill language that was a compromise between S. 558 and H.R. 1424. A number of subsequent efforts to pass this compromise language were unsuccessful, primarily due to disagreement on the offsets to be developed to pay for the estimated $3.4 billion that mental health parity will cost over 10 years. Some of the proposed offsets used tax measures and restrictions on the financing of physician-owned hospitals and deferred the break on worldwide income tax for two years.

Cost. The Congressional Budget Office (CBO) scored the House-passed and Senate-passed mental health parity bills and estimated that, if enacted, parity legislation would increase health insurance premiums by 0.4%.[8] CBO also estimated that, if enacted, these bills would cost the federal government approximately $3.4 billion over 10 years in lost tax revenues because of higher insurance premiums, which then would result in more of an employee's compensation being received in the form of nontaxable employer-paid premiums, and less in the form of taxable wages.

Final Passage. On September 23, 2008, the House introduced and passed the compromised mental health parity bill as H.R. 6983.[9] The Senate did not take any action on this bill. On September 29, 2008, the Senate passed the compromised mental health parity bill by including it in H.R. 6049.[10] The House did not take any action on this bill. Finally, key negotiators in the Senate used H.R. 1424, the original mental health parity legislation passed in the House in the 110th Congress, as the vehicle to pass the compromised mental health parity legislation within the Emergency Economic Stabilization Act of 2008. While this bill did not include a specific offset for mental health parity, the entire bill was offset by taxing individuals on a current basis if such individuals receive deferred compensation from a tax indifferent party.

Comparison of Bills. The original mental health parity bills passed in the Senate and the House in the 110th Congress were largely similar to each other as well as the final compromise legislation, with a few key differences. Like the MHPA, these bills apply only to group plans that choose to offer mental health coverage. The bills include parity

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[7] H.Rept.110-374.

[8] Congressional Budget Office (CBO), Cost Estimate, H.R. 1424 Paul Wellstone Mental Health and Addiction Equity Act of 2007, September 2007, available at [http://www.cbo.gov/ftpdocs/86xx/doc8608/hr1424.pdf]. Congressional Budget Office (CBO), Cost Estimate, S. 558 Mental Health Parity Act of 2007, March 2007, available at [http://www.cbo.gov/ftpdocs/78xx/doc7894/s558.pdf].

[9] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

[10] Energy Improvement and Extension Act of 2008.

for substance abuse treatment services. The bills also exempt small employers, defined as having 50 or fewer employees, and employees who demonstrate a specific cost increase as a result of compliance with the requirements of parity legislation. They require the Government Accountability Office (GAO), within two years, to evaluate the impact of the new federal parity standards on access to insurance coverage and on insurance costs.

The key elements of the final law are as follows:

- Applies mental health parity provisions to all group health plans for employers larger than 50 employees.

- Adds on to the 1996 parity law standard for annual and lifetime dollar limits. Expands definition of mental health to include substance use disorders.

- Allows insurance companies to determine which mental illnesses they cover. This was a point of difference between the House and Senate bills, where the House bill required coverage for all mental illnesses.

- Defers to HIPAA preemption standard, thus forming the floor and not preempting more restrictive state mental health parity laws.

- Requires a plan to provide parity out-of-network mental health and substance abuse benefits if it provides out-of-network medical and surgical benefits. This was a point of difference between the House and Senate bills, where the Senate bill did not require out-of-network mental health or substance abuse benefits but requires parity if a plan chooses to provide these benefits.

- Includes a reference that recognizes that this Act would not affect the terms and conditions of the managed care plan.

- Requires plan administrator to make information about medical necessity requirements and any denial available to any current or potential participant, beneficiary, or contracted provider.

- Allows health plans that experience a cost increase of at least 1% (2% in the first year of this Act) as a result of complying with this Act to be exempt from parity requirements for one year.

- Goes into effect at the start of a plan year, one year after enactment of P.L.110-343.

- Requires GAO to conduct a study analyzing specific rates, pattens and trends in coverage, any exclusion of specific mental health or substance use diagnoses by health plans, and the impact of this Act on coverage and costs.

Issues for Congress

This section discusses several policy issues that are not addressed by the federal mental health parity law. These factors may lead to continued disparity in coverage of mental illnesses and persistent barriers to access mental health care. Some experts believe that the current downturn in the economy could increase the need for mental health services, thus straining the behavioral health care delivery system.

Federal mental health parity law does not require a health plan to provide coverage for mental health. It requires parity coverage for any mental illnesses that an insurer chooses to cover. Some analysts believe this could lead insurance companies to drop coverage for mental health, rather than provide on par coverage. In addition, mental health parity laws do not address the issue of mental health care need of the uninsured.

The Act allows insurers to provide parity coverage within the context of managed care. Some advocates for people with mental illnesses believe this will cause more aggressive management of mental health benefits because insurers can no longer impose differential treatment and financial limits.

It is not easy to come up with exact equivalence to determine parity in treatment options for mental health and physical health. For example, Cognitive Behavior Therapy (CBT) is one treatment option that has been shown to be effective for treating some mental illnesses, but CBT is not comparable to treatment for any physical illnesses.

The federal parity laws do not address quality of care issues such as training for providers of behavioral health care as well as basic mental health training for primary care providers. Due to this lack of training of providers, some analysts believe this law could lead to an increase in quantity of mental health care provided, without a corresponding improvement in health outcomes.

Finally, this law does not address workforce issues and shortage of mental health providers, especially in rural areas. When this shortage is combined with an anticipated increase in demand for care as a result of the current economic crises, it is believed that individuals who need mental health care may still not receive it.[11]

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[11] For more information on federal programs addressing mental health workforce issues, see CRS Report RL32546, *Title VII Health Professions Education and Training: Issues in Reauthorization*.