The Current and Future State of Mental Health Insurance Parity Legislation

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Health insurance plans typically provide less coverage for mental health and chemical dependency treatment than for general medical services. In 1996 the federal government responded to these inequities by passing the Mental Health Parity Act, requiring equal annual lifetime dollar limits for mental health benefits. However, provisions within the law are easily circumvented, rendering it relatively ineffective as implemented. The Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003 measures (S. 486 & H.R. 953) currently in Congress would expand the language and effectiveness of the Mental Health Parity Act. This paper reviews the limitations of both the 1996 federal law and existing state laws, and explains why federal action to expand the Mental Health Parity Act is so critical to people with mental illnesses.

The percentage of health care funds devoted to behavioral health care has significantly dropped since the advent of managed care in the mid 1980s. A study done in 1998 by the U.S. Department of Health and Human Services (U.S. DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA) found that among private insurers the percentage of health spending attributed to behavioral health declined from 6.6% in 1987, to 5.6% in 1997 (U.S. DHHS, SAMHSA, 1998). Mental health providers and advocates have expressed concerns that service delivery changes are motivated by cost saving measures and compromise the quality of and access to services (Mechanic, 1999). Studies agree that managed care plans help control costs but evidence regarding the quality of behavioral health care is mixed (Office of the Legislative Auditor State of Minnesota, 2001; Mechanic, 1999; Zuvekas, Regier, Rae, Rupp, & Narrow, 2002; Frank, Goldman, & McGuire, 2001).

In the late 1990s people with psychiatric disabilities, mental health advocates, and health care providers expressed concern that health plans were establishing unequal benefit structures for mental and physical health services. States and the federal government initiated legislation to mandate that mental health and chemical dependency services be covered in the same manner as general medical care; this concept is known as insur-

ance "parity." The federal government implemented the Mental Health Parity Act in 1996, which mandated that mental health benefits could not have annual, or lifetime dollar ceilings lower or more restrictive than those for medical and surgical benefits (Otten, 1998). Numerous states have enacted their own forms of mental health parity laws, yet the effectiveness of these laws are limited in scope and application (Otten, 1998). The following includes analysis of the implications of both the federal and state parity legislation. It is intended to provide mental health practitioners with a more thorough understanding of the complexity and variety of parity laws in order to advocate for effective parity legislation on the state and federal level in the future.

Section I: Background of "Parity" Legislation

Mental health parity legislation was spurred in part by the growing inequity in insurance benefits between mental health and general medical care. Health plans offered by employers generally provide more coverage for general medical services and less coverage for behavioral health care or mental health and chemical dependency services (U.S. DHHS, SAMHSA, 1998). Medical plans typically do not place limits on outpatient or inpatient visits, while employer sponsored mental health plans in 1996 imposed several limits, often including visit or hospital limits, in addition to annual or lifetime dollar limits (Sturm & Pacula, 1999). These unequal structures led to action on a federal level.

In 1996 the federal government passed the Mental Health Parity Act (MHPA) of 1996 which prohibits insurers from imposing annual or lifetime dollar limits on mental health coverage that are more restrictive than those imposed on medical and surgical coverage. While the law was instrumental, it has many loopholes that have limited persons with mental illnesses from realizing equal access to quality mental health coverage. Richard Frank, medical professor at Harvard University, argues that policies aimed at mandating certain benefit design structures leave managed care open to other ways of limiting effective mental health coverage (Sturm & Pacula, 1999). In 2000, the U.S. General Accounting Office (GAO) confirmed this statement with a study investigating how the MHPA had been implemented.

The GAO (2000) found that 86% of employers offering insurance were compliant with the federal MHPA regulations. However, the study also found that 87% of plans that comply contain at least one other benefit design feature that is more restrictive for mental health benefits than for medical and surgical benefits (U.S. GAO, 2000). Common mental health benefit restrictions utilized by health plans include higher co-payments, deductibles, or visit limitations that are not applied to medical benefits. One national study found the percentage of health plans imposing day limits on inpatient psychiatric care increased from 38% in 1988 to 62% in 1998. Between 1988 and 1998 plans imposing outpatient day limits also increased from 26% to 57% (OLA, 2001). These findings demonstrate that insurers restructured their benefits rather than expanding them as the law intended.

Many states followed the federal trend to implement parity for mental health insurance benefits by passing state parity legislation. However, the Employee Retirement Income Security Act (ERISA) of 1974 statute preempts the scope of state parity action by exempting self-insured plans from state regulation. Therefore true insurance parity in the private sector is unlikely unless the MHPA of 1996 is amended to restrict insurance companies from using unequal cost sharing mechanisms currently allowed by the law. The following discussion is intended to further explain the history of mental health parity legislation and inform mental health practitioners about the current measures in Congress that would expand parity at the federal level.

Section II: The Federal Mental Health Parity Act of 1996

Senators Domenici (R-NM) and Wellstone (D-MN) initiated many proposals for mental health in the 1990s. In August of 1996, Senators Domenici and Wellstone introduced the Mental Health Parity Act (MHPA) of 1996, a freestanding piece of legislation and a compromise of a previous mental health parity bill they authored. The bill was referred to the Labor and Human Resources Committee of the Senate but did not make it out of Committee.

In September of 1996, Wellstone and Domenici drafted a parity amendment attached to the unrelated Veterans Administration Housing and Urban Development (VA-HUD) appropriations bill. This amendment restricted insurers from placing lifetime and annual caps on mental health benefits. During a House-Senate conference committee, provisions were added to decrease the potential costs to employers. These cost saving provisions exempt small employers and those employers who experienced a cost increase of more than 1% after implementation (Gitterman, Sturm, Pacula, & Scheffler, 2001). The House and Senate passed the amendment, later known as the Mental Health Parity Act, with the committee provisions. On September 26, 1996, President Clinton signed the compromised parity amendment attached to the VA-HUD, which prohibit-

ed insurance companies and large self-insured employees from placing annual or lifetime dollar limits on mental health coverage. The Mental Health Parity Act (MHPA) of 1996 (P.L. No. 104-204) was implemented on January 1, 1998 and had a sunset date of September 30, 2001. The MHPA, despite the best efforts of Senators Wellstone and Domenici, was enacted with limitations in the populations it covered and the actual duration of the Act. Despite the law, insurance companies still had the ability to use different deductibles and co-payments, not prohibited by the law (University of South Florida, 1997).

Summary of Mental Health Parity Act

The MHPA was a major first step for equitable mental health coverage and provided a blueprint for more comprehensive state laws. The MHPA states that when "a group health plan, or health insurance coverage offered in connection with a group health plan, provides both medical and surgical benefits as well as mental health benefits, it may not impose an aggregate lifetime dollar limit or annual dollar limit on mental health benefits if it does not also impose such a limit on substantially all of the medical and surgical benefits" (National Institute of Health, National Institute of Mental Health (NIH, NIMH), 2000, p. 6). The MHPA applies to fully insured plans in which the insurance company retains the financial risk and self-insured plans in which the employer retains the financial risk.

Implementation of Mental Health Parity Act

The MHPA amended the Public Health Service Act (PHSA) and the Employee Retirement Income Security Act (ERISA) of 1974 to provide parity in dollar limits on certain mental health benefits when limits are implemented for medical and surgical benefits. The MHPA provisions apply to insurers that offer health insurance coverage in connection with certain state and local government and group health plans (NIH, NIMH, 2000). The ERISA statutes exempt private employers who are self-insured from state health insurance laws (NAMI, n.d.). Such self-insured plans are regulated by the U.S. Department of Labor. Many large companies in the United States are self-insured; therefore many Americans with health care coverage through large, private employers are in plans that are not subject to state parity requirements (Sturm & Pacula, 1999). For this reason the federal MHPA was significant in its application to self-insured plans.

Limitations of the Mental Health Parity Act

The removal of annual and lifetime dollar limits was intended to be a major expansion in mental health coverage, but the compromises and provisions that were necessary for parity legislation to pass minimized its effect. First, the law does not require insurance companies to provide mental health coverage if they previously did not. The law only states that dollar limits on mental health must be equal to dollar limits on medical or surgical benefits if coverage is offered. Second, the law does not designate the number of inpatient hospital day or outpatient visits that must be covered by health plans, nor does it impose restrictions on deductibles and co-payments. Therefore the MHPA allows insurance companies to impose different benefit limits or co-payments for mental health than those for general medical services. Implementation has shown that mid-sized to large-sized companies eliminated inpatient and outpatient mental health dollar limits in exchange for visit or day stay limits (NIH, NIMH, 2000). Additionally, the 2000 study by the GAO found that plans complying with equal limits imposed new limits on coverage for inpatient drugs and outpatient mental health care not addressed by the law (U.S. GAO, 2000). The GAO (2000) found that many employers may have implemented newly restrictive mental health benefit design features since 1996 to offset more generous dollar limits they adopted as a result of the federal law.

A third limitation is that the MHPA includes two explicit exemptions for small employers (employers who employ at least 2 but not more than 50 employees), and for group plans if the provisions result in an increase in cost under the plan or coverage of at least 1% (NIH, NIMH, 2000). In addition, the law does not provide a definition of mental illnesses; rather it is defined by the health plan. The law does not apply to public insurance programs such as Medicare or Medicaid and does not cover chemical dependency treatment (NAMI, n.d.).

Regardless of the rhetorical requirement of parity, the provisions allow insurance companies to utilize unequal cost-sharing mechanisms such as raising co-insurance, co-payments, and deductibles for mental health services as well as modifying the definition of medical necessity. Despite these limitations the MHPA demonstrates government recognition of the inequities in behavioral health benefits and legitimates persons with mental health needs' and mental health advocates' goal of parity for behavioral health insurance benefits. The principal beneficiaries of the MHPA are people with the most severe and persistent mental illnesses and children and adolescents that typically have long inpatient stays, as these groups are the most likely to exceed annual or lifetime benefits (Otten, 1998).

The passage of the 1996 federal Mental Health Parity Act gave impetus to state parity legislation. In general, the provi-

sions of state parity laws are more comprehensive than those of the MHPA but are limited by federal ERISA statutes by only applying to fully insured plans. States vary widely in their statutory definitions of mental illnesses and parity. The following section will discuss the implications of state parity statute variations in comparison to the federal Mental Health Parity law.

Section III: State Mental Health Parity Laws

Prior to 1996 a mere five states had passed parity legislation. The MHPA of 1996 stimulated parity legislation as parity bills increased in number and 29 states passed legislation (NIH, NIMH, 2000). There are currently 34 states with laws requiring some form of parity and 23 requiring complete mental health parity (National Institute of Health Policy NIHP, 2002). The following section will provide an overview of eight of the earliest states to implement parity laws in order to examine the variation in state parity regulations.

Between 1991 and 1996, before the federal MHPA was implemented, Maine, Maryland, Minnesota, New Hampshire, and Rhode Island passed mental health parity mandates. In addition, during the same time period, three states implemented parity for state employees (Massachusetts, North Carolina, and Texas). Some states (Massachusetts & Texas) implemented parity level benefits as a pilot for state employees before expanding the law's coverage to state regulated health care plans (NIH, NIMH, 2000). As previously stated, the variation and scope among state parity laws is immense, as some state laws mirror the federal legislation while others are more demanding. After 1996, 14 states enacted statutes to match the federal Mental Health Parity Act. Of these 14, 7 states matched the federal statute in 1997 or 1998 and then opted to implement a stronger state parity statute more recently (Hennessy & Goldman, 2001).

In 2000 the National Institute of Health (NIH) and National Institute of Mental Health (NIMH) (2000) published a report examining state and federal mental health parity laws. In their report, the institutes classify the variations in state law along six dimensions: type of mental health mandate, definition of mental illnesses, coverage for substance abuse, terms and conditions, small employer, and cost increase exemptions. These six dimensions are important in parity discussion because they delineate how comprehensive a state's law is. The following chart includes a comparison of these six dimensions among eight of the earliest states to implement mental health insurance parity laws as well as the federal MHPA (NIH, NIMH, 2000).

Mental Health Benefit Mandate

It is important to understand that a state implementing a mental health parity law does not necessarily mean that it is an effective law. How a state enacts a parity statute is fundamental to the scope of the parity law. As the chart indicates, there are three variations of mandate benefits: mandated benefit, mandated offering, and mandated if offered. The mandated if offered benefit design is the least stringent of state mandates and is utilized by the federal MHPA.

Definition of Mental Illnesses

A major distinction among the strength of state parity laws is the definition of mental illnesses mandated by a state to determine parity eligibility. As the chart explains, state statutes have utilized various classifications to define mental illnesses for parity eligibility. In general, many states utilize the biologically based definition of mental illnesses, as it is more widely accepted by insurance companies and politicians (Otten, 1998).

Chemical Dependency Coverage

Many states have gone further than the scope of the federal MHPA by including chemical dependency services for persons with alcohol or drug related disorders as listed in the DSM-IV in their mandates. As of May 2000, 11 of the 34 states with parity statutes include coverage for chemical dependency (NIH, NIMH, 2000). Inclusion of chemical dependency services is key as experts contend mental illnesses and substance abuse are intertwined in a substantial proportion of instances and good medicine and sound economics would demand they be treated together (Otten, 1998). Currently, numerous states are expanding their original definitions of mental illnesses or adding provisions for chemical dependency treatment. As of March 2002, 88 bills related to coverage for the treatment of mental illnesses or chemical dependency had been introduced in 28 states (NIHP, 2002).

Set Terms and Conditions

Some states with insurance parity laws do not actually require insurers to utilize the same rates, terms, and conditions for mental illness as for physical illness, as the word parity insinuates. For example, in Maryland the law mandates coverage for a minimum of 60 partial inpatient days with the same terms and conditions as those for a physical illness. Yet, differential rates are set for outpatient visits for mental health services than those for physical health. For outpatient mental health services, the insurer is only required to pay for 80% for the first 5 visits, 65% for the next 25 visits, and 50% for any other visits (American Psychiatric Association, 2000).

Exemptions

Like the Federal MHPA, in order to reduce business or economic opposition

CHART 1—VARIATION IN STATE MENTAL HEALTH PARITY STATUTES (AS OF MAY 2000)

State	Year Enacted	MH Benefit Mandate[A]	Broad Definition Mental Illness[B]	Covers Substance Abuse[C]	Set Terms and Conditions[D]	Covers Individual and Group Plans[E]	Small Employer Exempt[F]	Cost Exempt[G]
Federal MHPA	96	M(if off)	X				X	X
Maine	95	MB MO[i]			X	X (MO only)	X	
Maryland	94	MB	X	X		X		
Mass. (A)	93	MB	X	X		SE only[1]		
Mass. (B)	2000	MB		X[ii]	X[iii]	X	X[iv]	
Minnesota	95	MB M (if off)[v]	X	X	X			
New Hampshire	94	MB			X			
North Carolina	91	MB	X	X	X	SE only[1]		
Rhode Island	94	MB	X	X	X[vi]	X	X	X
Texas (A)	91	MB			X	SE only[1]		
Texas (B)	97	MB					X	

Source: Adapted from the National Institute of Health, National Institute of Mental Health, 2000.

to parity, some states include exemptions for small businesses and those employers who experience a certain percentage of cost increase after implementing parity. With many large companies being exempt under ERISA statutes and many small businesses exempt by state mandate, state parity laws generally affect a small number of people.

Effectiveness of State Parity Legislation

Parity laws were designed to improve access to behavioral health services, although studies suggest that parity laws have not been significantly effective in promoting access under managed care (OLA, 2001). A study by Sturm and Pacula (1999) found that states with parity laws have lower rates of utilization for mental health services than other states, and found no measurable effect on utilization in states that enacted parity laws. The study concludes that parity laws are likely to make a difference only in states where previous coverage of mental health services was poor and where the laws are more comprehensive. The relationship between parity laws and managed care is significant as managed care controls service use by reviewing the medical necessity of services rather than relying on the contractual limitations that are eliminated by many state parity laws (OLA, 2001). Therefore, the removal of contractual limits on behavioral health care has not resulted in major changes as most health care coverage is provided through managed care plans (OLA, 2001).

The 2000 GAO study concluded that employees and employers in states without more comprehensive (in comparison to the MHPA) parity laws have seen only minor changes in their mental health benefits. The report asserts that changes in mental health benefits have resulted in little or no increase in access to mental health services, and costs associated with the MHPA have been small for most health plans (U.S. GAO, 2000). However, this study did not include states that have more comprehensive parity laws, such as Maryland, Minnesota, and Rhode Island.

Comprehensive State Parity Laws

Minnesota is considered to have one of the more comprehensive state insurance parity laws, as it includes chemical dependency services and uses a broad definition of mental illnesses for parity eligibility criteria. A study done by the Minnesota State Auditor concluded that after the parity law was implemented in that state there were no major changes in utilization or costs to insurers or purchasers (OLA, 2001). A study by the Substance Abuse and Mental Health Services Administration found premium increases due to compliance with the parity regulations in Minnesota were 1–2%, which is considered minimal (U.S. DHHS, SAMHSA, 1998). The Health Economics department within the Minnesota Department of Health contributes to the conclusion that the law has been relatively ineffective by finding that utilization of mental health services by Health Maintenance

Chart I: Definitions/Variation in State Mental Health Parity Statutes/Regulation

[A] **Mental Health Benefit Mandate:** There are three types of mental health benefit mandates:

MB: "mandatory inclusion" mandates—minimum coverage standard—require insurance policies to include certain provisions. A statute that includes a "mandated inclusion" provision typically states that a plan shall provide benefits for diagnosis and mental health treatment under the same terms and conditions as provided for covered benefits for the treatment of other physical illnesses;

MO: "mandated benefit offerings" require sellers to offer certain mental health coverage, with the decision of whether to purchase coverage left to the buyers. A statute that includes a "mandated benefit offering" provision typically states that insurers must make available coverage for the treatment of mental illness, and the coverage must be at least as extensive and provide at least the same degree of coverage as that provided for any other physical illness;

M (if off): "mandated if offered" does not require employer/insurer to offer mental health coverage. However, if employer offers coverage, then the coverage must comply with parity provisions. A statute that includes a "mandated, if offered" provision typically states that in the case of a group health plan that provides mental health benefits, those benefits must be provided on par with benefits for other physical illnesses and insurers shall not establish any rate, term or condition that places a greater financial burden on an insured for treatment of mental illness than for treatment of other physical illnesses.

[B] **Definition of Mental Illness:** "Broad-based mental illness coverage" is defined as encompassing all disorders listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and/or the International Classification of Diseases Manual. Some states allow health plans to define the scope of the mental health benefit. Several states narrow the scope of the statute by requiring coverage for "serious mental illness," most commonly defined as including schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, schizoaffective disorder, and delusional disorder.

[C] **Covers Substance Abuse (X):** indicates the statute covers drug and alcohol disorders as listed in the American Psychiatric Association's Diagnostic and Statistical Manual or as defined in the statute.

[D] **Set Terms and Conditions (X):** indicates that the statute requires rates, terms, and conditions to be the same for mental illness coverage as for the coverage for all other physical illnesses. Those states that *do not* have an "X" permit a disparity in the terms and conditions required for mental health coverage compared to other physical health conditions. For example, the parity statute may set a cap on the number of inpatient and/or outpatient days required by insurers for mental health coverage, without setting the same cap on coverage for other physical illnesses.

[E] **Individual and Group Plans (X):** specifies the statute apply to all policies, including individual and group. "SE only1" implies that the law applies to state employees only.

[F] **Small employer exemption (X):** indicates the statute allows small employers an exclusion from compliance. The statutes most commonly define small employers as those with either 25 or fewer employees or those with 50 or fewer employees.

[G] **Cost exemption (X):** indicates that the statute allows employers that experience a premium increase at or above a specified percentage are excluded from the parity requirements.

[i] **Maine**: The statute mandates coverage for group plans and requires a mandated offering for individual policies.

[ii] **Massachusetts:** Existing limitation ($500/year for outpatient and 30 days for inpatient treatment) for alcoholism or chemical dependency shall not apply when treatment is rendered in conjunction with treatment for mental disorders.

[iii] **Massachusetts:** The statute requires equal terms and conditions for biologically based mental illnesses as defined in the statute, however, does not require parity for other mental disorders.

[iv] **Massachusetts:** The statute exempts businesses with 1 to 50 employees and non-group health plans from compliance until 1 year after effective date of the statute.

[v] **Minnesota:** The statute mandates coverage for HMOs and a "mandated, if offered" requirement for individual and group plans.

[vi] **Rhode Island:** The statute includes one limitation that may not result in setting equal terms and conditions: "[i]npatient coverage in cases where continuous hospitalization is medically necessary shall be limited to ninety (90) consecutive days."

Organization enrollees have increased a little more than 1% since the MHP law was implemented in that state in 1995 (Minnesota Department of Health, 2002). Many persons with mental health needs, mental health practitioners, and advocates in the state voice frustration with the lack of growth in access to and spending for behavioral health services they expected after the law's implementation (OLA, 2001).

It appears that even more comprehensive state parity laws will not facilitate broad changes in employer-sponsored mental health coverage, mainly because of the ERISA statutes. State mandates affect state regulated health plans but do not apply to self-insured plans, which account for 29.7% of all firms offering insurance coverage (Agency for Healthcare Research and Quality, 2000). Therefore, full parity in mental health benefits is unlikely unless the 1996 MHPA is amended to prohibit insurance companies from imposing limitations on visits or days covered, scope of treatment, or the use of differential deductibles, co-payments, co-insurance, or other cost sharing measures (Gitterman, Sturm, & Scheffler, 2001).

Section IV: Current Status of Federal Mental Health Parity Efforts

In 1999 President Clinton stated, "We must make it clear once and for all: mental illness is no different from physical illness—and our nation's health plans should provide both with the same quality coverage" (NIH, NIMH, 2000, p. 6). Clinton took action on this statement by directing the Office of Personnel Management to implement a full parity level benefit for the 8.7 million beneficiaries of the Federal Employees Health Benefit Program (FEHBP) by 2001 (NIH, NIMH, 2000). The FEHBP requires full parity in benefit coverage of mental health, substance abuse, medical and surgical treatment costs for services on an "in-network" basis. The FEHBP parity is more stringent than the MHPA as it does not allow private insurance plans to impose higher cost sharing requirements or set limits on outpatient mental health visits or hospital stays (Feldman, Bachman, & Bayer, 2002). The FEHBP is a full parity model by which the federal government can analyze the utilization and cost implications of full parity.

Senators Domenici and Wellstone introduced expanded parity legislation in March of 2001, in anticipation of the sunset of the MHPA of 1996. The new legislation included full parity, applied to companies with 25 or fewer employees, and eliminated the September 30, 2001 sunset date (NAMI, n.d.). In October of 2001, Congress failed to pass this new mental health parity legislation and the existing law was extended until December of 2002 (Zuvekas, Regier, Rae, Rupp, & Narrow, 2002). Congress again failed to pass new mental health parity legislation in December of 2002, therefore an enforcement provision extended the MHPA until the end of 2003 (A. Sperling, personal communication, November 4, 2002). There are two bills currently under consideration in Congress, which would extend the strength of the MHPA.

Current Mental Health Parity Bills Before Congress

In April 2002 President Bush announced that he plans to improve access to quality, effective mental health care by working to pass federal mental health legislation to eliminate disparities in coverage of mental health services this year (White House, 2002). He did not give support to a specific bill in his speech but it was a hopeful sign for people with mental health needs, advocacy groups, and mental health providers. During the 107th Congressional session, there were two bills introduced for legislation, which were never passed secondary to debates surrounding the cost implications. The two bills were the Mental Health Equitable Treatment Act (MHETA) of 2002 (H.R. 4066), co-sponsored by Representatives Marge Roukema (R-NJ) and Patrick Kennedy (D-RI). The Senate version was the Mental Health Equitable Treatment Act (MHETA) of 2001 (S. 543), co-sponsored by Pete Domenici (R-NM) and Paul Wellstone (D-MN). There are currently two versions of the mental health parity bill introduced in the 108th Congress that are indistinguishable from H.R. 4066 and S. 543.

The House version is the Senator Paul Wellstone Mental Health Equitable Treatment Act (MHETA) of 2003 (H.R. 953), sponsored by Representative Patrick Kennedy (D-RI). The Senate version is the Senator Paul Wellstone Mental Health Equitable Treatment Act (MHETA) of 2003 (S. 486), sponsored by Pete Domenici (R-NM). In general, H.R. 953 and S. 486 are identical bills, as they would both implement full parity for cost and access related benefits for mental illnesses. Both bills include expanded language of the original MHPA to include "all categories of mental conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV-TR)" but would be subject to the medical necessity criteria of a health plan (H.R. 953; S. 486). The bills would impose a private sector mandate on group health plans and group health insurance issuers by prohibiting them from imposing treatment limitations or financial requirements for mental health benefits that differ from those placed on medical or surgical benefits (Congressional Budget Office, 2001). The current MHPA allows treatment lim-

itations and unequal use of cost sharing mechanisms.

The MHETA bills are intended to overcome some of the limitations of the 1996 MHPA (P.L. 104-204). Yet there are compromised provisions that even Senator Wellstone admitted “are not a be-all or end-all” (Mental Illness Parity, 2002). Although both versions include all diagnosis within the DSM IV-TR, both bills exclude chemical dependency benefits (H.R. 953; S. 486). If plans offer mental health benefits through a network of providers, the requirement of parity would apply to benefits provided by members of the plan’s network, not to benefits provided to health professionals outside the plan’s network (H.R. 953; S. 486). Neither bill would mandate that group health plans offer benefits, but if they do they must offer them at parity level. The MHETA provisions would apply to both self and fully insured group health plans as well as those within the non-group market. Exemptions exist in both bills for persons purchasing insurance in the individual market and for small employers who employ at least 2, but not more than 50 employees.

President Bush and the insurance industry have expressed concern over potential premium increases of the MHETA bills. According to the Congressional Budget Office (CBO) estimates, S. 543 would have increased premiums by 0.9% (CBO, 2001), although specific costs may vary from business to business, depending on the benefits that are offered. Conflicting statistics regarding the cost increases of parity have caused some skepticism and concerns among Congressional leaders.

An important implication of both Senator Paul Wellstone MHETA bills is that states that have enacted parity laws would be required to meet the federal regulations, thus serving to strengthen less stringent state laws. Also, states with laws that are more comprehensive than the federal law would not be preempted by the federal regulations. Like the original MHPA, the application of the Senator Paul Wellstone MHETA bills would be limited to private health insurance and would not address the concerns of the 17.5% of the U.S. population that do not have health insurance (Frank, Goldman, & McGuire, 2001). In addition the Senator Paul Wellstone MHETA bills do not address Medicare beneficiaries, who have to pay a 50% co-pay for outpatient mental health services as compared to a 20% co-pay Medicare beneficiaries pay for physical health services, and beneficiaries are subject to a 190-day lifetime limit on inpatient hospitalizations for mental illnesses (NAMI, 2001). Although there are limitations to these bills, passage would affect numerous states by further amending the ERISA statutes. Therefore self-insured plans, which nationally account for 29.7% of all firms offering insurance coverage, would be mandated by these regulations (Agency for Healthcare Research and Quality, 2000).

Conclusions

Unfortunately, mental health parity legislation by itself cannot address the numerous concerns and needs of the behavioral health care system in the United States. Parity laws rhetorically and incrementally advance efforts to put insurance coverage for mental illnesses on the same level as coverage for physical illnesses, yet do little for Medicare beneficiaries or persons who lack health insurance coverage entirely.

While some state laws provide coverage that is more comprehensive than the limited MHPA of 1996, less than one-third of those laws extend parity for chemical dependency treatment (NIH, NIMH, 2000). In addition, even the most comprehensive state laws cannot provide coverage protection for the nearly 30% of Americans who are enrolled in self-insured plans exempt from state mandates under ERISA (Agency for Healthcare Research and Quality, 2000). While passage of state parity laws enhanced mental health benefits for some, only strong federal parity provisions will preclude efforts to achieve equal coverage for all persons with mental illnesses and chemical addictions. Expanded federal parity legislation is needed to further amend ERISA statutes, thereby mandating more stringent state parity laws.

While the current bills to expand parity legislation (H.R. 953; S. 486) may be limited, they are another step towards equal and fair insurance coverage for mental illnesses. The nature of the measures encourages further public awareness and recognition of the disparity in insurance coverage for mental health care. While the Mental Health Equitable Treatment Act was not passed during the 107th Congressional session, there is hope that it will pass in the 108th Congressional session. The Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003 has vocal support of President Bush, 54 Senate cosponsors, and 224 House cosponsors, yet it continues to face opposition from employer and insurance groups (NAMI, 2002). With the experience of the 1996 Mental Health Parity Act, policy makers, mental health advocates, and consumers recognize that future policy must address managed care mechanisms that unfairly limit services for persons with mental illnesses. By not recognizing the inequities that exist in mental health insurance benefits congressional leaders and policy makers unintentionally reinforce society’s belief that mental illnesses are somehow less real, less debilitating,

and less worthy of treatment than are physical illnesses.

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