

Legislative Information Packet

Additional Resources

(Optional Distribution to Members of Congress)

**Memorial Day Recess
May 25-June 1, 2002**



**UPDATE ON MENTAL HEALTH PARITY
(S. 543, H.R. 162, H.R. 4066)
APRIL 30, 2002**

ISSUE:

President Bush expressed his support for the broad concept of mental health parity on April 29, 2002; however, the President has not voiced support for any of the existing Bills on the subject. Please be assured that NASW is continuing to monitor this rapidly changing issue and will continue to post information as soon as it becomes available.

The Mental Health Parity Act of 1996 (MHPA) expired on September 30, 2001. Although Congress passed a temporary extension until December 31, 2002, the issue must be revisited before the end of the 107th Congress.

NASW supports the enactment of full mental health parity and continues its advocacy to that end.

CURRENT STATUS:

On March 20, 2002, Representative Marge Roukema introduced the Mental Health Equitable Treatment Act, H.R. 4066. Although more limited in scope than her previous parity bill, H.R. 162, it is almost identical to S. 543, as amended.

REMEDY:

NASW strongly advocates for the expansion of mental health parity as embodied by either S. 543, or H.R. 4066.

S. 543 and H.R. 4066 aim to finish the work that Congress began with the Mental Health Parity Act of 1996 (the 1996 Act). In fact, 32 states have followed suit and enacted their own mental health parity statutes. However, it is important to note that the vanguard 1996 Act did not induce fundamental changes in employer behavior concerning mental health parity.

The General Accounting Office reported in May 2001 that 86 percent of employers surveyed reported that they had complied with the requirements of the 1996 Act. Nevertheless, the vast majority of those employers substituted new restrictions on mental health benefits, thereby evading the spirit of the law. Given the loopholes and limited scope of the 1996 Act, employers continue to limit mental health benefits more severely than those for medical and surgical coverage, most often by restricting the number of covered outpatient visits and hospital days, and by imposing higher co-payments and deductibles for mental health care.

BACKGROUND:

The 1996 Act took effect on January 1, 1998, and expired on September 30, 2001. The primary champions of the parity movement were Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN) and Representative Marge Roukema (R-NJ).

The basic premise of the 1996 Act was that parity should exist between mental health benefits and those for medical and surgical care with regard to the level of benefits provided. It is important to note that the 1996 Act did not require employers to offer mental health care benefits if they chose not to, but if such benefits were provided, they had to have been equal to those offered for medical and surgical care.

For organizations having more than 50 employees with group health plans that offer mental health benefits, the plans could not have had different annual or lifetime limits for mental health care from those for medical and surgical care. Although mental disorders were covered by the scope of the 1996 Act, neither substance abuse nor chemical dependency treatments were covered.

Specifically, both aggregate lifetime limits and annual limits for mental health benefits had to have been identical to those for medical and surgical benefits, if and only if a covered employer offered mental health benefits. The 1996 Act applied to not only fully insured state-regulated health plans, but also self-insured plans that are exempt from state law under the federal Employee Retirement Income Security Act and thereby regulated by the U.S. Department of Labor. In addition, state mental health parity laws were not preempted by the 1996 Act, ensuring that stronger state statutes were not weakened.

Loopholes did exist, however. Employers who could demonstrate at least a 1 percent or more increase in costs as a result of the implementation of mental health parity were permitted to exempt themselves from the tenets of the 1996 Act. Co-payments, deductibles, out-of-pocket payments, managed care, and caps on the number of inpatient days and outpatient visits were beyond the scope of the legislation, as were organizations with fewer than 50 employees.

Although the 1996 Act did not eliminate all barriers and disparate treatment facing mental health consumers, it represented an important first step.

The 1996 Act had an expiration date—common among federal legislation—of September 30, 2001. To address that issue as well as eliminate the loopholes contained in the 1996 Act, Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN) introduced the Mental Health Equitable Treatment Act of 2001, S. 543. Representative Marge Roukema (R-NJ) introduced similar legislation, the Mental Health and Substance Abuse Parity Amendments of 2001, H.R. 162.

Both S. 543 and H.R. 162 would expand on the 1996 Act by providing full parity for all categories of mental health conditions listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). H.R. 162 is broader than S. 543, as it would include coverage for substance abuse disorders. Health insurance plans would be forbidden from applying different deductibles, co-payments, out-of-network charges, inpatient day and outpatient visit limits for mental health care from those for medical and surgical health care, if mental health benefits are offered. Like the 1996 Act, neither S. 543 nor H.R. 162 would mandate that plans offer mental health benefits if they currently do not.

Small businesses with fewer than 50 employees would be exempted, and the 1 percent compliance cost increase opt-out would be eliminated.

The Senate Health, Education, Labor and Pensions Committee, chaired by Senator Edward Kennedy (D-MA), took an aggressive stance with S. 543 and held hearings. The Committee ultimately "marked up" the legislation and reported it out of committee unanimously on August 3, 2001, making S. 543 eligible for debate by the full Senate. The House did not act at all on H.R. 162; the Republican chairs of the three committees of jurisdiction (Ways and Means, Energy and Commerce, and Education and the Workforce) stonewalled and did not schedule hearings during 2001.

A critical mass of support for mental health parity exists. In the House, H.R. 162 garnered 202 cosponsors; in the Senate, S. 543 gathered 66 cosponsors. However, when the “sunset” date for the MHPA arrived September 30, 2001, the Act was allowed to expire.

To rectify that problem, on October 30, 2001, Senators Domenici and Wellstone offered an amendment to the Labor-HHS Fiscal Year 2003 Appropriations bill, which was S. 543 in its entirety. The Senate unanimously approved the Domenici-Wellstone Amendment, thereby forcing the House to address the issue in a conference committee.

On December 18, 2001, conferees on the Labor-HHS-Education Appropriations bill voted to remove the Domenici/Wellstone mental health parity amendment. None of the 10 House Republican conferees voted for Rep. Patrick Kennedy’s (D-RI) motion to accept the amendment, whereas all seven House Democrats voted for it. Rep. Ralph Regula (R-OH), conference chairman, cited opposition from authorizing committee chairs as the reason for their “no” votes. Senate conferees, who strongly supported the provision, did not need to vote.

The Labor-HHS conferees did approve a motion by Rep. Randy “Duke” Cunningham (R-CA) to include in the bill a simple one-year extension of the Mental Health Parity Act of 1996, extending the life of the Act until December 31, 2002.

Acknowledging the timeliness of the issue, the House Committee on Education and the Workforce Subcommittee on Employer–Employee Relations held its first hearing on parity since 1995 on March 13, 2002, entitled "Assessing Mental Health Parity: Implications for Patients and Employers." Parity proponents Representatives Marge Roukema (R-NJ) and Patrick Kennedy (D-RI) testified before the Subcommittee, as did other industry and nonprofit entities.

A week later, Representatives Roukema and Kennedy introduced H.R. 4066, the House companion to the well-supported Senate bill, S. 543, the Mental Health Equitable Treatment Act of 2002. Although H.R. 4066 is more limited in scope than Representative Roukema's prior parity bill, H.R. 162, it provides a uniform platform from which Congressional debate can be launched. H.R. 4066 is generally identical to the amended version of S. 543, which was unanimously approved by the Senate as the Domenici-Wellstone Amendment.

Visit the NASW Web site, www.socialworkers.org, and click on the Advocacy button on the left side of the page to let your Senators and Representatives know how you feel. Should you need further information, please contact Francesca Fierro O'Reilly, NASW Senior Government Relations Associate, via telephone at 202-336-8336 or via e-mail at fforeilly@naswdc.org.

REAUTHORIZATION OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT

WELFARE REFORM'S DISPARATE EFFECTS BASED ON RACE AND ETHNICITY

OVERVIEW

Virtually any policy change can result in unintended effects on different populations and the policy changes in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) are no exception. To date, few comprehensive studies have focused on the effects of PRWORA implementation on racial and ethnic minorities. However, there is enough evidence to warrant further study and to take new steps to ensure that all participants receive fair and equitable treatment.

Disparate effects do not necessarily imply intentional discrimination. Nonetheless, examples of differential treatment are widespread. They range from private-sector employment practices to state-level policy choices to the exercise of frontline workers' discretion.

Do You Know . . .

- *A study of job interviews found that 55 percent of African-American applicants were interviewed for 5 minutes or less, while all white applicants received interviews of 10 minutes or longer. Black applicants also were more likely than white applicants to be subjected to pre-employment tests.*
- *Former white recipients earn significantly higher wages during the first three months after exiting welfare than former recipients of color. From 1997 to 1999 the median hourly wage for white leavers was \$7.31, for African-American leavers, \$6.88, and for Hispanic leavers, \$6.71.*
- *States in which African Americans make up a higher proportion of welfare recipients are statistically more likely to adopt full-family sanctions, family cap policies, and time limits shorter than the federal government requires.*
 - *Among white families, the percentage exiting welfare due to increased income has been higher than the percentage exiting because of sanctions. For black families, the pattern is reversed. One 1999 Florida Study found that black recipients were three times more likely to be sanctioned than white recipients.*
 - *Out of the current welfare caseload, researchers estimate that approximately 41 percent will exhaust their eligibility under time limits. Approximately two-thirds of these families will be families of color.*

In 1999, the Office of Civil Rights (OCR) in the U.S. Department of Health and Human Services found welfare offices that failed to provide translators for Spanish-speaking immigrants were guilty of discriminating on the basis of national origin. OCR subsequently sent a memo reminding state agencies of PRWORA's non-discrimination policy.

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- *A study in two rural counties in Virginia found that caseworker discretion had a significant impact on what assistance recipients were offered. Forty-seven percent of white recipients but no African-American recipients received discretionary transportation assistance beyond the gas vouchers available to all recipients and 41 percent of white recipients but no African-American recipients were referred to discretionary educational programs.*
 - *Transportation--White recipient: "I own my own car but it needed a brake job. I contacted [my caseworker] ... She told me she would try to come up with some money to get it fixed." African-American recipient--"She [my caseworker] told me to use gas vouchers to take a cab or ride with a friend until I saved the money to fix the car."*
 - *Education--White recipient: "They encouraged me to get my GED. I hope to graduate in the spring. My worker kept telling me 'You're smarter than you think.' She really convinced me that I could do it." African-American recipient--"the [caseworkers] say: 'Go get a job.' I told them that I only had two parts left on my GED and I wanted to finish, and they said, 'That's not what the program is about.'"*
- *In Illinois, about half of white recipients were referred to educational programs as compared to only 19 percent of African American recipients.*
- *Another study found that 12 percent of white recipients received help with expenses in the first three months after leaving welfare compared to 9 percent of Hispanic leavers and 7 percent of African-American leavers.*
- *There also is evidence that low-income Hispanic parents are less likely to receive the Earned Income Tax Credit (EITC) than their non-Hispanic counterparts, in part due to lack of awareness and language barriers. Low-income Hispanic children and adults also are less likely to have health insurance coverage than low-income white or African-American families.*

NASW RECOMMENDATIONS

- Fund additional research on welfare reform's disparate impact on racial and ethnic minorities, especially in the areas of education and training, work supports and transitional benefits, health care, barriers to employment, and sanctions.
- Require standardized data collection and dissemination of administrative data by race and ethnicity at the federal, state and local levels.
- Ensure that states have clear policies on nondiscrimination and applicable grievance procedures.
- Improve education and training of frontline workers and supervisors, including on cultural sensitivity and nondiscrimination.
- Support better enforcement of federal and state civil rights laws.
- Improve outreach to employers.

March 2002

REAUTHORIZATION OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996

WELFARE REFORM

The 1996 welfare law, Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (P.L. 104-193), is due to be reauthorized or extended by September 30, 2002. NASW believes significant improvements can and should be made to the law, which includes the Temporary Assistance for Needy Families (TANF) block grant. **As the leading professional social work organization, NASW wants to ensure that the social work perspective is taken into account during this debate.**

NASW believes that the most promising strategies to improve public welfare lie beyond the TANF program. However, we are ready to advocate for systematic changes in the program that will improve the quality of life for Americans who are mandated to be a part of this program to receive monetary assistance.

Since the passage of PRWORA in 1996, welfare caseloads throughout the country have decreased tremendously. However, the dilemma of poverty still exists overwhelming in the same communities. On November 30, 2001, NASW submitted recommendations on the reauthorization to the U.S. Department of Health and Human Services and with your help will portray a strong voice in the debate on welfare authorization on Capitol Hill. In those comments NASW identified many problems associated with the current legislation. Currently, NASW is focusing its efforts on three legislative priorities:

1. **Shifting the focus of the law from reducing caseloads to reducing poverty.**

FACT

Since 1993 welfare caseloads have fallen by more than 50 percent, but in 2000, nearly 40 percent of former welfare recipients continued to live below the federal poverty line.

2. **Improving assistance to recipients with significant or multiple barriers to self-sufficiency. The barriers for people and families receiving TANF include mental health disorders, substance abuse, domestic violence, and racial and ethnic discrimination.**

FACTS

Nationally, between 70 percent and 90 percent of working-age adults with serious mental illness are unemployed.

Data from four studies revealed that 15 percent to 32 percent of the women on welfare are current victims of domestic violence and that an additional 60 percent were abused in the past.

3. **Enhancing the capacity of the welfare system infrastructure, particularly the welfare workforce. A critical component of that infrastructure includes the skills and abilities of the welfare workforce and the effectiveness of coordination among programs and agencies.**

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FACT

In a study done by the Northwest Federation of Community Organizations, 77 percent of welfare recipients learned of income support programs from other resources rather than welfare offices.

NASW believes that as a nation, we should concentrate on creating economic opportunity, strengthening families, and maximizing the ability of everyone—not just those on welfare—to contribute to society. We should develop universal systems of support for meeting basic needs, including health care, food, housing, child care, and education; create job opportunities that pay a living wage and provide a full range of benefits; and ensure economic security through adequate income support for individuals and families unable to support themselves.

While working toward those universal systems of support, NASW believes significant improvements can and should be made to PRWORA.

March 2002

REAUTHORIZATION OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT

USING WORK SUPPORT PROGRAMS TO INCREASE SELF-SUFFICIENCY

OVERVIEW

The reauthorization of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (P.L. 104-193) made clear that “work first” was the primary goal of welfare reform. Therefore, as caseloads decreased, states begin to invest some of their Temporary Assistance for Needy Families (TANF) funds in “work support” programs that would help families keep jobs and stay off the rolls. Work supports are part of an overall strategy to “make work pay.” Important work supports include child support payments, food stamps, Medicaid, childcare, and the Earned Income Tax Credit (EITC). However, many welfare leavers who qualify for these services are not receiving them because of misinformation, cumbersome application processes, unlawful practices, or administrative errors. Another concern is that as the country lingers in recession after the longest period of economic prosperity seen by the United States, states may be forced to redirect funds for work support programs back into cash assistance.

DO YOU KNOW....

- ***Only 23 percent of applicants learned of a support program from their local welfare office or state welfare agency, even though about one-half were enrolled in an income support program.***
- ***Seventy percent of women who have left welfare and are employed receive no childcare subsidies.***
- ***One-third of women who have left welfare report severe difficulties in affording food.***
- ***One-third of women who leave welfare are without health insurance within the first six months of leaving.***

FOOD STAMPS

Although many families who leave welfare still fall below the poverty line, the number of families receiving food stamps has decreased since 1996. The decline in program participation is much greater than expected from changes in the law and the strong economy.

- Food Stamp participation declined 20 percent between 1996 and 1998.
- A study by the General Accounting Office found that the share of poor children receiving food stamps fell from 94 percent in 1994 to 84 percent in 1997.
- Sixty-five percent of former welfare families who left the food stamp program still had incomes below food stamp eligibility standards according to a study done by the Urban Institute in 1999.

MEDICAID

Continued access to Medicaid, the State Child Health Insurance Program (SCHIP), or other medical coverage is a key component of family self-sufficiency and is particularly important to families addressing on-going barriers to work, such as poor physical or mental health, disability, substance abuse, or domestic violence.

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- Medicaid enrollment for non-disabled and non-elderly people declined by 7.4 percent between 1995 and 1997; the majority of those who left Medicaid were children.
- Twenty-three percent of children in families below 200 percent of the poverty level were uninsured in 1999.
- Only 29 percent of women who were denied Medicaid were told about SCHIP.

CHILD CARE

Families making under \$14,000 dollars a year use twenty-five percent of their income for childcare. Increased expenditures for childcare have resulted in more families and children receiving assistance. However, many families are still not receiving the assistance for which they are eligible.

- Only one in eight families who are eligible for federal childcare subsidies actually receives them, largely because of limited funding and long waiting lists.
- Fifty percent of applicants leaving TANF because of employment were not told about childcare benefits.
- Less than one-third of families who have left welfare for work are receiving childcare assistance.

CHILD SUPPORT

Child support is a significant income source for low-income families that receive it—decreasing the number of poor children by half a million. However, 70 percent of poor children eligible for child support do not receive it. Thirty percent of non-resident fathers earn less than \$14,000 a year. So even if child support enforcement procedures were perfect, one-third to one-half of female-headed households would remain poor and financially insecure.

- Child support is the second largest component of family income after earnings for poor single-headed families, amounting to 25 percent of the family's budget.
- Less than 20 percent of child support caseloads involve families currently receiving TANF.
- Most families on TANF who are granted child support receive as little as \$50 a month. The states take the bulk of the support for repayment of welfare benefits.

RECOMMENDATIONS ON WORK SUPPORTS

- Create a new federal incentive program to reward states who improve access to benefits and services through
 - systematic training of front-line workers about eligibility and available benefits
 - better administrative procedures, including simplified applications
 - evening and weekend office hours
 - improved outreach.
- Sanction states that continue to violate either the spirit or the letter of the law by providing inadequate, incomplete, or false information on available benefits and services.
- Require states to pass on a substantial share of all child support payments to the families—including monthly payments and arrearages—whether they are receiving

TANF benefits or have left the rolls. In addition, a significant portion of child support payments received by a family should be disregarded in determining eligibility for other benefits.

- Require child support payments to be determined as a percentage of the non-custodial parent's income. Evidence suggests that percentage-based child support orders lead to substantially higher, not lower payments.
- Require states to revise guidelines so that obligations imposed on poor and near poor non-custodial parents can be no higher in percentage terms than those imposed on middle- and high- income non-custodial parents.
- Create a child support program that guarantees a minimum benefit for all families legally entitled to private child support. Such payments must be exempt from current TANF time limits and work participation requirements.

March 2002

Coalition for Fairness in Mental Illness Coverage

EMPLOYERS SHOULD SUPPORT MENTAL HEALTH PARITY

Mental health and physical health are inextricably linked. Mental illnesses can affect a person's productivity and health as much, if not more than, a physical illness. An employee with an untreated or undertreated mental illness may add to employer costs via: absenteeism, turnover and retraining expenses, poor morale and lower productivity, injury and compensation costs, conflict among employees, and increased medical costs. Investing in mental health parity provides a return of productivity and economic gain.

UNTREATED/UNDERTREATED MENTAL ILLNESS COSTS EMPLOYERS

The 1999 Surgeon General's report on mental illness estimates the direct business costs of lack of parity coverage of mental illness treatment of at least \$70 billion per year, mostly in the form of lost productivity (absenteeism and "presenteeism") and increased use of sick leave. Other studies have shown that employees with inadequate mental health coverage resort to increased use of general health care services.

- An MIT Sloan School of Management report showed in 1995 that **clinical depression costs American businesses \$28.8 billion a year in lost productivity and worker absenteeism.**
- Depressed workers have **between 1.5 and 3.2 more short-term work disability days in a given thirty-day period than other workers.** The average salary equivalent **disability costs of these days range between \$182 and \$395 per depressed worker** (Health Affairs; Volume 18, Number 5; 1999).
- Of the 11 million individuals who suffer from depression in any given year, approximately 7.8 million are found in the workplace (American Journal of Psychiatry; 1996; 145:1351-1357). **The annual cost per employee is \$4,200** (Journal of the American Medical Association; 1997; 277:333-340).

TREATMENT OF MENTAL ILLNESS SAVES EMPLOYERS

- When workers with depression were treated with prescription medicines **medical costs declined by \$882 per employee per year and absenteeism dropped by 9 days** (Health Economics).
- A 1998 study by the UNUM Life Insurance Company and Johns Hopkins University found that **employer plans with good access to outpatient mental health services have lower psychiatric disability claims costs than plans with more restrictive arrangements** (Salkever, 1998; also Frank, 1999).
- "A four-year study of program effectiveness at McDonnell Douglas yielded a **four-to-one return on investment** after considering medical claims, absenteeism and turnover" (Wall Street Journal; June 11, 1999).
- "The important message from large employers like Delta is that in the last decade we have introduced and implemented generous mental health and substance abuse benefits for our employees and their families, not in response to legislative mandate, but because **it improves our corporate 'bottom line'**" (Delta Air Lines testimony May 18, 2000).
- "When the Kennecott Copper Corporation provided mental health counseling for employees, its **hospital, medical, and surgical costs decreased 48.9 percent**" (GWCMHPC, Inc., 2000).

Coalition for Fairness in Mental Illness Coverage

The Human Face of Mental Health Parity

Alison: "I require mental health treatment on a regular basis, since I am a survivor of thirteen years of sexual abuse. The abuse began when I was three years old, lasted throughout most of my childhood, and took many forms....You might call [my abuser] many things. I called him 'Daddy'. Even now, at the age of 38, I struggle to come to terms with what happened to me...I struggle to pay for the treatment I need, with my health insurance only covering a bare minimum of sessions each year."

Kate: "Health insurance discrimination is putting everything that I have worked hard for my whole life in jeopardy. Five years ago I experienced an episode of severe depression....I needed to be hospitalized because I was extremely suicidal. After five weeks in the hospital I was discharged against the vehement protests of my psychologist because the hospital was concerned that I had exceeded my \$2500 per year inpatient insurance cap and that I was at the limit of what I could afford to pay out of pocket. That night I tried to kill myself and I am only here today because a friend was concerned when she could not reach me. To add insult to injury, I was left with \$70,000 in uncovered bills."



Kevin's mother: "This is Kevin's story. I am forced to tell it for him....We were warned to watch out for increased symptoms [of bipolar disorder] in Kevin's 'early thirties'. Thus we were aware that Kevin was at risk but we never knew just how much. We never knew that as many as 30% of manic depressives carry out a successful suicide or that it is estimated that 50-60% make an attempt, that indeed it is a fatal disease. We did not know that each new crisis episode is deeper and longer than the one before. And we did not know ...[we would face efforts at cost-cutting] by limiting the amount (either by the amount of dollar coverage or by the limit of days of treatment allowed) of coverage for mental related illnesses. So when the day came we once again realized that Kevin (then 29) was slipping into another crisis we began to fight for his sanity, not even thinking that it would mean his very life....Kevin was rapidly



getting worse and in November 1997 we found him with a loaded gun and found it necessary to have him committed to the stress unit. Up until he started his slide into depression, Kevin was working steadily. He had health care insurance that had served him well through a serious motorcycle accident and several knee surgeries. But now, when he needed it the most, he was "allowed" seven days of inpatient care and another three weeks of an out-patient program...He began to make progress in this program and we were all hopeful that he could soon return to work. On Friday of his fourth week he was told that he had reached his insurance limit and not to come back on Monday. He was assigned to a psychiatrist to monitor his medication monthly. Kevin tried to live with this but began to backslide immediately... Approximately two weeks later we got a call in the middle of the night. He was in crisis and, not knowing where to turn we drove him to the hospital emergency room. All ER personnel and the attending physician in the stress unit agreed that he should be hospitalized, but he was denied admittance...The next day we drove him back for the promised [day] treatment. He was allowed to remain one day....We at this time found a psychologist to work with him but...the bills began to mount. It just wasn't enough and the stress of financial bankruptcy only added to Kevin's mental burden and lack of self worth. He never recovered...At the end of July he again became unstable and continued the downward slide until August when he made the decision that would free him forever."

April 5, 2001

Coalition for Fairness in Mental Illness Coverage

Americans Want the Benefit 9 Million Federal Employees Have: Mental Health Parity!

Effective January 1, 2001, 9 million federal employees (including Members of Congress) and their dependents have access to mental health and substance abuse benefits equivalent in coverage to those provided for other health problems. This “parity” policy is one of most comprehensive in the country, and stands in stark contrast to widespread practices. Too often, individuals lack the kind of protection this Federal Employee Health Benefit (FEHB) Program offers, and instead have lower levels of coverage for treating mental and substance abuse disorders than for other conditions. As a result, people can easily exhaust their benefits or incur staggering out-of-pocket costs.

Parity under the FEHB Program brings a vast improvement in benefits coverage for mental health and substance abuse care. Rather than more limited coverage and higher costs, the health plan choices offered to beneficiaries must set the same limitations and cost-sharing (such as deductibles, coinsurance, and copays) for mental health and substance abuse care as for any other care. This policy, implemented by the Office of Personnel Management (OPM), not only sets a major precedent, but OPM’s explanation of the Federal government’s employee-benefits parity policy is itself highly instructive:

Cost of parity: It has been argued that the cost of parity is prohibitive and will result in fewer people having insurance coverage. OPM’s response: this argument “appears to be a myth”. OPM says,

“A growing body of research and actual industry experiences indicate that parity can be implemented without substantially increasing premiums, as long as it is coupled with efforts to manage the benefit. These studies have been highlighted in several recent reports to Congressional committees...For the FEHB Program the... average increase for fee-for-service plans is 1.64%, for HMOs it’s .3%, with an aggregate Program increase of 1.3%. Per biweekly pay period, those with a self-only enrollment will pay \$0.46 for parity. Family enrollees will pay \$1.02.”

The rationale for parity (cited by OPM):

“There is a growing consensus on the effectiveness of treatment and the ability of managed health care delivery systems to control costs. Most experts agree that mental health and substance abuse diagnoses have well-established biological bases, diagnoses are reliable, and treatment is effective and available. We believe that this is important because adequate mental health and substance abuse benefits coverage has been shown to improve patient health, provide patients with greater financial protection against unforeseen costs, and to reduce work place absences and employee disabilities. Recent advancements in the treatment and management of mental illness have left no justifiable rationale for disparate treatment of mental illness.”

**If parity can be achieved for Federal employees,
other Americans deserve nothing less!**

April 5, 2001

Coalition for Fairness in Mental Illness Coverage

Findings of the U.S. General Accounting Office: Access to Mental Health Services Remains Limited Despite Compliance

Findings indicate that 86% of employers comply with the federal parity requirements set forth in the Mental Health Parity Act of 1996, which prevents employer-sponsored health plans from imposing lifetime and annual dollar limits on mental health benefits that differ from those imposed on medical/surgical benefits. However, the scope of this Act is narrow. It does not apply to individuals outside of a group plan, plans with 50 or fewer employees, or plans whose claims costs have increased at least 1% due to compliance. Also, additional loopholes remain that enable employers to restrict employee mental health coverage. These restrictions arise out of an unsubstantiated fear of higher costs and the attraction of high-risk individuals.

Despite a high percentage of compliance, employers continue to limit their mental health benefits. More specifically, 87% of those who comply end up restricting other mental health services in their health plans. In other words, the majority of employers who alter their benefits to achieve parity in annual/lifetime dollar limits *restrict another mental health benefit* to counteract feared cost increases due to compliance. Most prevalent are restrictions on the number of hospital days and outpatient visits, as well as higher copayments and deductibles.

Initial concerns that the 1996 Act would increase claims costs by more than 1% seem to be unconfirmed. In fact, GAO findings support past estimates that implementing federal parity for dollar limits would have a *negligible* effect on claims costs (premium increases were estimated at 0.16% and 0.12% by CBO and Coopers & Lybrand, respectively). Of the employers aware of how compliance affects their claims costs, *over 90% report no increases*. Furthermore, less than 1% of responding employers actually dropped coverage of mental health benefits after federal parity was enacted, possibly indicating unsubstantiated concern for increased costs.

Several states have already enacted parity laws that exceed the federal parity requirements. In addition to requiring dollar limit parity, these more comprehensive laws may also require parity in service limits and cost-sharing provisions and mandate the inclusion of mental health benefits in group health plans. Premium cost increases for *full parity* are estimated to be between 2% and 4%, both nationally and for individual states.

Loopholes and limited scope of the Mental Health Parity Act of 1996 continue to impede overall access to mental health services. The Act affects only lifetime/annual dollar limits, placing no restrictions on any other plan benefits. This continues the trend of consistently lower levels of coverage for mental health benefits than for surgical/medical benefits. Furthermore, a significant minority (14%) of employers do not comply with federal parity law. The existing federal parity requirements most often produce only minor changes in mental health benefits.

Source: "Compliance with the Mental Health Parity Act of 1996: Effects/Costs of Implementation," U.S. General Accounting Office, May 2000.

April 5, 2001

Coalition for Fairness in Mental Illness Coverage

PASS MENTAL HEALTH PARITY NOW! END DISCRIMINATORY MENTAL HEALTH COVERAGE

No matter the form, discrimination is wrong. Yet, mentally ill patients seeking treatment are discriminated against by requiring higher copayments, allowing fewer doctor visits or days in the hospital, or higher deductibles than imposed on other medical illnesses. This discrimination results from outdated misconceptions and the stigma surrounding mental illnesses. If left to continue, the financial and human costs of untreated mental illness will far exceed the costs purported by opponents—that covering mental health services will exponentially and unfairly increase premiums for all enrollees. In fact, data have shown that the cost of instituting equal coverage for treatment of mental illnesses is inconsequential.

The Mental Health Parity Act (MHPA) of 1996 will sunset on December 31, 2002. This current federal law prohibits discriminatory annual and lifetime dollar caps for mental health benefits as compared to medical and surgical benefits. The Act has had a minimal cost, but 87% of complying health plans have evaded the spirit of the law by replacing dollar limits with arbitrary limits on inpatient days and outpatient visits or another part of the benefit, found the U.S. General Accounting Office (May 2000).

The Mentally Ill Population

According to the Surgeon's General Report on Mental Health, about 20 percent of the U.S. population are affected by mental disorders during a given year.

- About 20 percent of children are estimated to have mental disorders with at least mild functional impairment. Over 50 million adults suffer from mental or substance abuse disorders on an annual basis.
- The National Institute of Mental Health has shown that success rates of treatment for disorders such as schizophrenia (60%), depression (70-80%) and panic disorder (70-90%) surpass those of other medical conditions (heart disease, for example, has a treatment success rate of 45-50%).

Parity in Mental Illness Coverage Can Save Money

Providing equal coverage for all illnesses makes good economic sense; when mental illnesses go untreated, costs begin to escalate.

- The 1999 Surgeon General's report on mental illness estimates the direct business costs of lack of parity coverage of mental illness treatment of at least \$70 billion per year, mostly in the form of lost productivity (absenteeism and "presenteeism") and increased use of sick leave. Other studies have show that employees with inadequate mental health coverage resort to increased use of general health care services.
- An MIT Sloan School of Management report showed in 1995 that clinical depression costs American businesses \$28.8 billion a year in lost productivity and worker absenteeism.

January 23, 2002

Coalition for Fairness in Mental Illness Coverage

THE TRUTH ABOUT DSM AND PARITY

The Issue

Parity opponents are waging a campaign of misinformation about what is covered under the Mental Health Equitable Treatment Act (H.R.4066/S. 543). The campaign is focused on the bill's reference to the widely-used and accepted standard diagnostic reference for mental disorders known as the Diagnostic and Statistical Manual of Mental Disorders, or DSM-IV.

H.R. 4066 & S. 543 Do Not Mandate Treatment Coverage of all Conditions in DSM-IV Those who are misrepresenting the DSM are confusing the diagnoses of mental disorders with every health plan's right to determine what treatments are medically necessary according to their own criteria, explicitly protected in the bill.

- The bills require treatment for services for a DSM-listed mental health condition **ONLY** when (1) such **services are included as part of an authorized treatment plan**, (2) that plan is **in accord with standard protocols**, (3) the services **meet the plan or issuer's medical necessity criteria**, and (4) the **services meet such managed care practices** as the plan employs.
- In addition, both S. 543 and H.R. 4066 explicitly and carefully preserve the ability of health plans to use **"concurrent and retrospective utilization review, utilization management practices, preauthorization, and the application of medical necessity and appropriateness criteria applicable to behavioral health and the contracting and use of network providers."**
- Parity opponents claim that if parity is adopted the floodgates will open for treatment of "peripheral" conditions not worthy of insurance coverage, such as "malingering" and "jet lag." **This is clearly false. Health plans would be no more likely to pay for treatment for "malingering" or "jet lag" in a post-parity world than they do today.** Furthermore, they would be no more likely to pay for treatment for such "peripheral" conditions than they do now for freckles, corns, baldness, premature grayness, flatulence or first degree sunburn – all of which are listed in the widely used medical/surgical diagnostic tool known as the International Statistical Classification of Diseases-Tenth Revision (ICD-X).
- Parity opponents also claim that the legislation covers "caffeine addiction" or "caffeine intoxication" and other similar substance abuse disorders. It does not! **The legislation expressly states that ALL substance abuse disorders are NOT covered.**

What is the DSM and Why is it Important to Parity Legislation?

The Diagnostic and Statistical Manual of Mental Disorders is a uniform standard system of classification for the diagnosis of mental disorders and is a diagnostic tool for health professionals, like the ICD-X is for the diagnoses of medical conditions.

- The DSM-IV was developed through an open process involving more than 1,000 national and international researchers and clinicians drawn from a wide range of mental and general health fields.

- DSM-IV is based on a systematic, empirical study of the evidence (consisting of literature reviews, data analyses, and field trials funded by NIMH and other government entities).
- "DSM-IV is a classification of mental disorders that was developed for use in clinical, educational, and research settings. The diagnostic categories, criteria, and textual descriptions are meant to be employed by individuals with appropriate clinical training and experience in diagnosis. It is important that DSM-IV not be applied mechanically by untrained individuals." (DSM-IV-TR)

Who Uses the DSM?

The DSM is widely used in making diagnosis, treatment, and coverage determinations in both the public and the private sectors.

- **The same parity opponents who complain that DSM criteria are too broad currently use DSM criteria every day in determining whether to pay claims for mental health treatment.**
- Thirteen states that have enacted broad-based parity laws to cover all mental illness diagnoses are based upon the DSM. They are: Arkansas, Connecticut, Georgia, Indiana, Kentucky, Maryland, Minnesota, Mississippi, New Mexico, North Carolina, Rhode Island, Tennessee, and Utah.
- DSM-IV criteria are included in Medicare, virtually all state Medicaid laws and the Federal Employees Health Benefits Program. DSM-IV criteria are used by the FDA and the legal system throughout the country.
- Virtually all managed behavioral health companies use the DSM-IV to determine whether mental health treatment is medically necessary.

Will One-Tenth of One Percent Really Break the Bank?

Opponents claim the proposed legislation goes beyond a "common-sense" definition of mental illness. They say a "more expansive" definition caused by reliance on the DSM will significantly increase health care premiums so much so that employers will have to drop or reduce health insurance coverage for their employees. **CBO has projected that S. 543 would increase, on average, insurance premiums by a mere 0.9%.** A SAMHSA/Mathematica Policy Research report states that treatment of severe mental illnesses (SMI) represents 89% of the increase in expenditures for all mental health diagnoses due to parity. Thus, **the addition of DSM diagnoses other than severe mental illnesses would result in a premium increase of a meager .099% or less than 1/10 of one percent.** Those costs do not take into account the employer cost savings associated with treating these illnesses, which -- left untreated -- cost employers tens of billions annually. One-tenth of one percent is hardly enough to cause employers to drop or decrease employee health insurance coverage.

End the Discrimination:

While parity opponents claim that the bill's reference to the DSM-IV would require plans to pay for treating minor life problems, the determination that an individual has a disorder listed in the DSM-IV does NOT in itself mean that that individual is in need of treatment.

To achieve parity, it is important that this bill rule out discrimination by diagnosis and -- as with medical and surgical coverage – have health plans determine care on the basis of the need for treatment not on the basis of the diagnosis or specific label assigned a disorder.

Mental illness coverage. It's time to be fair by treating it equally in health care.

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IMPROVING ACCESS TO QUALITY MENTAL HEALTH CARE

Today's Presidential Action

- In a speech at the University of New Mexico, President Bush today announced his plans to improve access to quality, effective mental health care. The President announced that he will work to pass federal mental health parity legislation to eliminate disparities in the coverage of mental health benefits.
- The President also announced the formation of the President's New Freedom Commission on Mental Health to develop recommendations on improving the nation's mental health service delivery system.

Background on Today's Presidential Action

- Each year, millions of Americans suffer from mental illness. Many adults and children are significantly disabled by severe and persistent mental illness. Untreated mental illness is a great national problem.
- The stigma of mental illness often discourages patients from seeking care despite the existence of new drugs and therapies that have vastly improved the chances for effective treatment and recovery. Without access to necessary and effective quality care, far too many Americans will live with untreated mental illness that too often can lead to homelessness, drug and alcohol addiction or incarceration.

Parity in Mental Health Benefits

- Despite the advances that have been made in the science of mental health treatment, many health plans unfairly treat coverage for mental health benefits by imposing copayments, deductibles or limits on outpatient visits that are more restrictive than those placed on physical illness.
- The President has a history of supporting parity legislation. In 1997 as Governor of Texas, he signed legislation into law that required plans to provide fair treatment to patients with severe mental illnesses.
- The President will work with Senator Domenici and other leaders in the House and Senate to reach an agreement on mental health parity legislation that can pass Congress and be signed into law. The legislation must prevent plans from applying less generous treatment or financial limitations on mental health benefits than are imposed on medical or surgical benefits.

The President's New Freedom Commission on Mental Health

- Currently, numerous Federal, State and local government entities oversee mental health programs, policy, funding and the diverse network of public and private providers. More efficient organization and coordination could assist these providers in ensuring effective treatment is received by those in need.
- To address this issue, President Bush is establishing the President's New Freedom Commission on Mental Health. The Commission will be composed of fifteen members, appointed by the President, and seven ex-officio members from executive branch agencies. The Commission will identify the needs of patients, the barriers to care, and investigate community-based care models that have success in coordinating and providing mental health services. The Commission will have one year to recommend immediate improvements that can be implemented by all aspects of the public and private mental health system to improve coordination and quality of services with existing resources.

For more information on the President's initiatives, please visit www.whitehouse.gov

**Kaiser Daily Health Policy Report
Wednesday, May 15, 2002**

**Behavioral Health Case Study Shows
Large Employer's Use of MCO to Provide
Mental Health and Substance Abuse Benefits Lowered Costs**

A case study appearing in the new issue of Health Affairs concludes that one large employer's decision to use a separate managed care organization to provide equal coverage for mental health and substance abuse services led to lower costs. The study, led by Samuel Zuvekas of the Agency for Healthcare Research and Quality, examined the impact of a state mental health parity law on a large employer, which chose to comply with the law by using a managed care "carve-out" arrangement to provide mental health and substance abuse benefits through a separate managed care organization. Because of confidentiality issues, researchers did not disclose the name of the employer, the state involved or the specific years of the study. They found that from the 12 months prior to the implementation of the carve-out to the three years afterward, the employer's mental health treatment costs declined by nearly 40% even though the number of workers treated for mental illnesses rose almost 50%.

For employers and spouses, costs remained steady, while expenses for children and adolescents dropped 64%. The study attributed the decline in costs to shorter lengths of stay for inpatient mental health treatment. It also found that managed care did not restrict access to outpatient treatment; the number of people using such treatment increased nearly 50% "with no change in the average number of visits" (AHRQ release, 5/14). The study concludes, "Clearly, increased management of health services offset parity's increase in benefits" (Zuvekas et al., Health Affairs, May/June 2002). Last month President Bush endorsed federal mental health parity legislation, although he did not clarify whether he supports covering all disorders or only the most severe. Business groups and insurers have raised concerns that mental health parity would lead to increased health costs (Kaiser Daily Health Policy Report, 4/30).

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