Should Mental Illness and Physical Illness be Insured Equally?

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Executive Summary

Mental health care has had a significant impact on the health care industry. Approximately 1 of every 5 Americans suffer from some type of mental illness every year. However, most mental health patients face higher co-payments and deductibles. Due to a rise in mental health costs, HMOs and business groups have reduced mental health coverage by increasing deductibles and decreasing hospital visits. Through the Mental Health Parity Act of 1996, the government has regulated equal lifetime limits on mental and physical illness. However, there is no current regulation on deductibles and visits.

Mental illness has long had a stigma attached to it. As this stigma decreased, a new advancement of medications and therapies for the mentally ill emerged. Problematically, as these new innovations came along, the cost of maintaining them grew rapidly. These costs forced employers and insurance companies to reduce mental health coverage. As coverage decreased, government and consumers began to worry. Since the 1996 Act, 32 states adopted some type of mental health parity. However, these regulations do not provide much help.

There are several major stakeholders in this issue. NAMI (National Alliance for Mentally Ill) is just one of many advocates who wish to see a complete mental health parity act. ERIC (ERISA Industry Committee) is against government enforced parity. They fear it will force employers and insurance companies to reduce physical coverage or to end mental coverage completely.

The rise in mental health costs has most impacted the government. From 1986-1996, the annual average growth rate of mental health costs in the public sector was 8%. The private sector has only grown at an annual rate of 6%. This means that the government is taking on most of the mental health cost, and consumers are coming out with less treatment.
Part A

Problem

Mental health care has always been a widespread problem. Previously, the problem was that the mentally ill were treated as lunatics and outcasts. As the stigma of mental illness decreased, knowledge of mental illness and how to treat patients improved greatly(12). There are new discoveries everyday proving that mental illness has both chemical and genetic explanations. These discoveries brought about a nationwide movement for parity in the insurance coverage of mental and physical illnesses(18).

Patients treated for their mental illness usually face higher co-payments and deductibles than they do for their physical illness. They also have fewer doctor visits and hospital days(14). Currently, the Mental Health Parity Act of 1996 regulates lifetime limits on mental health care and physical illness, but there is no regulation stopping insurance companies, HMOs or employers from altering deductibles and visits. Patients and employees are tired of being discriminated against. Psychiatrists and mental health organizations want to see action against this discrimination(2). However, insurance and business groups worry that equal coverage will increase their already sky rocketing health care costs(4). Also, since insurance companies and HMO’s are reducing coverage for mental illness, the burden is left on the government, which cannot afford it(12).

Extent

“More than 80% of American employees and their families face tougher coverage for mental illness than they do for other health conditions”(19). This raises a serious problem since 1 of every 5 Americans suffer from a mental disorder over the course of a year(12). The Mental
Health Parity Act and some state parity laws try to relieve citizens from the burden of paying for treatment but still 17% of all mental health expenses are out-of-pocket(12).

Estimates were done by the Congressional Budget Office to calculate the costs of a bill that would equate limits, deductibles, and visits. It was found that premiums were increased by only 1%. This strikingly low number gave hope to advocates but actual numbers show a different story. It will cost the private sector 23 billion dollars over five years. It will cost the government 2.2 billion dollars of revenue in the next five years because workers would receive less of their compensation in taxable wages(17).

Public Policy

The issue of mental health coverage has long been in the public eye. “People who suffer from untreated mental illness are more likely to kill themselves or other people. They are also more likely to end up in an emergency room psychiatric ward, homeless on the street or caught in the revolving door of the prison system”(22). All of these are far more expensive than treating patients with drugs and therapy(22). The cost of this kind of care is placed on the government and citizens. It is the tax payers who must pay for prison cost and Medicaid bills. Although, Medicaid covers mental illness, Medicare does not. It is also the tax payers who are struggling to receive mental health care, to afford mental health care, and to provide mental health care at a reasonable price.

The most recent public policy for mental illness was an act proposed in Congress. The Domenici-Wellstone Mental Health Equitable Act of 2001 tried to fix the loopholes of the Mental Health Parity Act of 1996 by equating deductibles and visits. Many mental health organizations have lobbied for this act. Their hopes were raised when it was passed by the Senate(16). However, the House of Representatives turned it down. President Bush, who had
recently signed a parity act for Texas, also felt uneasy about the bill. “President Bush believes that people should have access to the care and treatment they need, but he is also concerned about rapidly rising health costs, which could lead to increases in the number of uninsured Americans”(16).

There was also worry about employers being able to provide the coverage required(22). This could lead to trouble for the 80% of American employees who already face tough coverage(19). Groups such as the ERISA Industry Committee fear that a parity act would cause employees to abuse mental health benefits. They told Congress “many employers are likely to comply with the parity mandate by reducing coverage for other medical and surgical benefits rather than by increasing coverage for mental health benefits”(17). The General Accounting Office estimated that 14% of employers were not even complying with the 1996 parity. In addition, ERIC employers are pre-empted from state laws(17). This means the Federal government needs to make a decision. Congress needs to decide between those who are desperately searching for care and those who are worried by the cost of it. Also, they need to form stricter regulations to make sure insurance companies, HMOs, and employers comply with the law.

Part B

Question Statement

Should Mental Illness and Physical Illness be insured equally?

Emergence

Various government organizations have declared the 1990s as “the Decade of the Brain.” During this time, the law having the most impact was the Mental Health Parity Act of 1996(21). The law requires that private medical plans equate yearly and lifetime payment limits for both
mental and physical illnesses. For corporations, the law applies to employers who offer mental health coverage and have 50 or more employees(8).

Mental illness has been an issue in the US since the 17th and 18th centuries. Then, the problem was constant institutionalization of mental patients. There was a stigma behind mental illness marking it as an inhumane disease amongst many people. Over the years, there has been a movement of public awareness. A big leap was made in 1946 with the creation of the National Institute of Mental Health(23). With this, a new advancement of medications and therapies for the mentally ill emerged. Problematically, as these new innovations came along, the cost of maintaining them was growing rapidly.

The rising cost of mental illness has been recognized since the late 1970s and 1980s. At this time, costs were rising at almost double the rate of other illnesses. Insurers decided to enforce several deductibles, co-payments, and lowered hospital days(13). This left patients and employees having to rely on the government and their own earnings.

Since the 1960s, both Medicaid and Medicare played a factor in mental health. Medicaid is a major source of funding for mental health, especially since it covers those who are unemployed due to their mental illness. The growth of funds for Medicaid is aided by funding given to states by the federal government. Medicare has some coverage for mental illness, but limits the coverage to “certain illnesses”(12).

Throughout the 1990s, managed care organizations have created a huge impact on mental health care. “Health insurance companies and HMO’s increasingly scrutinize the effectiveness of various psychotherapies and drug treatments and put stricter limits on mental health care”(8).

State governments contributed greatly to the change in mental health parity. Even before the 1996 Mental Health Parity Act, there were 8 different states with some type of mental health
parity. After the 1996 parity, the total states rose to 32(21). President Clinton made many initiatives towards parity. He addressed it in his 1994 Health Security Act and then again in the Mental Health Parity Act of 1996. Mental Health was also an issue on President Bush’s platform(12).

Chronology

1946 NIMH created(23).

1950s Medications progress as primary treatments(23).

1960s Medicare and Medicaid programs provide additional funding for mental health(23).

1970s President Carter appoints Presidential Commission of Mental Health Medicaid Expansions(23).

1980s Decrease in funding for mental health services(decrease in social services) (23).

1990s HMO’s “carve-out” mental health services and delegate responsibility to others(13).


1996 Mental Health Parity Act of 1996- mandate equal coverage, with several exceptions(20).

1997 Five more states add parity laws, some more restrictive than others(21).

1998 Substance Abuse Treatment Act-tries to stop insurers from placing caps or restrictions on treatment for substance abuse(20).

1999 Mental Health Equitable Treatment Act-tries to fill loopholes of 1996 Act, same act as 2001(21). Twelve states and Two territories add parity laws(21).


2000 Four more states add mental health parity laws(21).

2001 Mental Health Equitable Treatment Act(1).
Trends

Access- As the public awareness of mental illness grew, so did access to services. However, as access to treatments and medications grew, so did the cost of care. Realizing the costs, employers, HMOs, and insurance companies enforced higher deductibles and co-payments. Some companies even decided to “carve-out”, or eliminate, mental health coverage from their health plans(5). This left a huge burden on the government and forced them to make restrictions of their own. “The number of public mental hospital beds in the United States has declined over time, from 560,000 in 1955 to approximately 77,000 today”(7). But the number of private mental hospitals more than tripled between 1970 and 1992. This left patients, not including the severely ill, without reliable coverage and with high out-of-pocket costs(7).

Cost- “Between 1986 and 1996, mental health expenditures grew at an average annual growth rate of more than 7%(12)”. The fastest growing portion of this cost was from prescription drugs, which grew from $33million in 1985 to $46 million in 1994(12). This rising cost created a “carve-out” of mental health care by many employers and HMOs(5). By doing so, it placed the cost of mental health care on the government and consumers. It especially affected the public sector whose cost grew about 8% per year during that time(12).

Quality- The quality of mental health coverage has wavered over time. With increases in quality through medications and treatments, there came decreases in quality through cut backs in coverage. Even with the help of the 1996 Act, HMOs and employers found ways around the mandate. Between 1988 and 1997, the proportion of such plans with day limits increased from 38% to 57%(12). This decreased satisfaction amongst patients and employees. Also, it decreased the quality of mental health coverage since it is being withheld.
Part C – Major Stakeholders

The issue of mental health coverage has been plaguing the health care industry for years. Numerous arguments exist between stakeholders on whether or not mental health coverage should be the same as physical health coverage. There are several influential groups, organizations, and legislators on both sides of this issue. Two main stakeholders, with very contrasting views, are the ERISA Industry Committee (ERIC) and the National Alliance for the Mentally Ill (NAMI).

NAMI (National Alliance for the Mentally Ill)

“NAMI is a non-profit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses” (11). The group tries to educate the public and raise money for research on mental illnesses. NAMI has carefully watched all legislation dealing with mental health insurance coverage. Recently, they have been following the Domenici-Wellstone Mental Health Equitable Treatment Act (S.543), which would revise the Mental Health Parity Act of 1996. The act would mandate equal mental and physical coverage (11).

Position

NAMI favors any type of insurance coverage for mental illness, whether public or private. They see mental illnesses as physical brain diseases, which are both “blameless” and treatable (11). “The issue is not just about health care. It’s about the kind of stigma and discrimination that sometimes leads to the death of innocent people,” says Richard C. Birkel Ph.D., executive director of NAMI (10).

Resources

NAMI, founded in 1979, consists of 1200 state and local affiliates in the U.S., several
sister locations, and 210,000 members. In 2000, NAMI’s budget consisted of support, revenue and gains of $30,825,449 and total assets of $11,887,848(9). The NAMI E-Newsletter delivers the latest in federal action alerts, legislative and policy updates, and press releases. NAMI sends the newsletter to policy makers, legislators, media providers, and health care experts (11).

**Government Actions**

NAMI’s advocacy efforts include numerous draft proposals and intense lobbying in Congress and Senate. In addition, they have worked with Senator Domenici, Senator Wellstone, and other key legislators to try and develop a mental health parity. Also, NAMI’s influence is strengthened by their newsletter, which is sent out to Congress and NAMI members(11).

**Success**

NAMI continues to push and lobby for equal mental health insurance coverage. They believe that, “the parity will never go away”(11). They are encouraged because 32 states now have parity laws. The organization plans to monitor state and federal governments to ensure that these parity laws are enforced. “NAMI continues to seek out legislative leaders to sponsor parity bills of all types in the states with the ultimate goal of ending all insurance discrimination against those who suffer from mental illness”(11).

**ERIC (The Erisa Industry Committee)**

“The Erisa Industry Committee is a non-profit association committed to the advancement of employee retirement, health, and welfare benefit plans of America’s largest employers”(3). The association keeps watch of any legislation that would alter their member’s needs and wants. They want to lessen government interference on any regulation that would hurt employers’ efforts to provide benefits to their employees (3).
Position

ERIC strongly opposes any act in favor of equal mental and physical health coverage (3). They believe that an act like this would “lead to misuse and overuse of mental health benefits” (15). They feel that any mental health equitable mandate would raise costs for employers who voluntarily offer mental health benefits (3). Also, ERIC says that “many employers are likely to comply with the parity mandate by reducing coverage for other medical and surgical benefits, rather than by increasing coverage for mental health benefits” (15).

Resources

For more than 25 years, ERIC has worked hard to fight for employers’ interests. ERIC covers several different major employers, who pay annual dues of $15,000. Most of ERIC’s budget comes from the $15,000 they collect from their members (3). They also cover 25 million active and retired workers. ERIC makes their policies and beliefs known by publishing a biweekly newsletter, the ERIC executive report. It is sent out to their members, the media, and legislators. ERIC also holds monthly briefings with Washington Representatives to create an important link between them and Congress. In addition, they hold quarterly meetings so that their members have a chance to speak out (3).

Government Actions

ERIC aggressively lobbies for employers’ interest. They have been actively encouraging Congress not to mandate mental health benefits. ERIC has also been researching the consequences of what a mental health mandate would do and informing policy makers of these results (3).

Success

Recently, ERIC’s efforts helped persuade Congress to vote down the newly proposed
Domenici-Wellstone Mental Health Parity Act. ERIC believes they played a large part in the declining of this bill. They plan to keep up their lobbying for employers’ rights and plan to keep mental health coverage choices in the hands of their employees (3).

Part D Trends

Between 1986 and 1996, mental health expenditures grew at an annual rate of 7% (12). The public sector felt the greatest impact from these increases. According to Appendix Figure 2, net total costs of the public sector grew by an annual average rate of 8% (12). Medicaid and Medicare costs both grew by an annual rate of 9% (12). As shown in Appendix Figure 3, the impact of mental health cost on the government is shown by the large decrease in public health beds. The number of beds went from 560,000 in 1955 to approximately 77,000 in 2000 (7).

Problematically, the need for services increased from 1.7 million patients in 1955 to 8.6 million patients in 1990, as seen in Appendix Figure 4 (23). According to Appendix Figure 1, the private insurance sector grew at an annual average rate of 9% (12). However, managed care plans and cost containment efforts have limited the total net private costs to 6%. Consumer’s out-of-pocket expenses grew by only 3% (12). This means that consumers are either not seeking treatment or are relying on the government for spending. Neither the government nor the private sector can afford to cover these costs. Employers and insurance companies have already taken measures to reduce coverage costs by increasing deductibles and lowering hospital visits.

If the trends from 1986-1996 remain the same, the government’s mental health costs will continue to increase. Also with decreased spending from the private sector, patient’s cost of care will increase and their access to care will decrease.
CITATIONS


(NAMI)


23) Yesalis, Charles Dr. MENTAL HEALTH. Lecture Notes Spring Semester 2001.