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An Analysis of Mental Health Parity

Abstract
In lieu of an abstract, below is the first paragraph of the paper.

The issue of parity for mental health insurance coverage is a complicated one, involving not only health care, but politics, economics, and moral and ethical questions as well. From a nursing perspective, separating a patient’s mental wellness from his or her physical wellness directly contradicts the critical nursing value of holistic health care. From the perspective of mental health advocacy organizations, and from those suffering from mental health disorders, this purposeful disregard of mental illnesses is viewed as discrimination. For certain groups within the federal government and for the insurance companies, mental health parity is seen as prohibitively costly to the insurance industry and to employers. In order to sort through these different perspectives, it is helpful to look at the recent history of the mental health parity movement.
Introduction

The issue of parity for mental health insurance coverage is a complicated one, involving not only health care, but politics, economics, and moral and ethical questions as well. From a nursing perspective, separating a patient's mental wellness from his or her physical wellness directly contradicts the critical nursing value of holistic health care. From the perspective of mental health advocacy organizations, and from those suffering from mental health disorders, this purposeful disregard of mental illnesses is viewed as discrimination. For certain groups within the federal government and for the insurance companies, mental health parity is seen as prohibitively costly to the insurance industry and to employers. In order to sort through these different perspectives, it is helpful to look at the recent history of the mental health parity movement.

Brief Political History of Parity

For over ten years, legislative advocates at the federal and state levels of government have been actively pursuing parity with limited success. In 1996, U.S. Senators Paul Wellstone and Pete Domenici authored the Mental Health Parity Act (MHPA), which passed and became effective in January of 1997. This act intended to bring mental illness insurance coverage in line with that of physical illness by prohibiting the use of lifetime and annual coverage limits. It did not, however, require that the parameters for deductibles, copayments, or day/visit limits be equal to those of medical coverage (Murray & Henriques, 2004). The MHPA also had an expiration date of September 30, 2001, at which time the benefits of the bill would cease, pending passage of a new extension bill by Congress. Updated bills were proposed by the Senate and the House of Representatives incorporating equal co-pays and deductibles for mental health benefits and equal number of in-patient days and provider visits for mental illnesses as for other illnesses. They also prohibited limits set on scope or duration of treatment (Killeen, 2002).

These proposed bills were in part based on the 2001 Federal Employees Health Benefit Program (FEHBA), which required comprehensive parity coverage for mental illness following a 1999 executive order from former President Clinton. The new bills never made it out of committee, despite bipartisan support (Killeen, 2002). The 1996 bill was officially extended in 2002, preventing loss of ground in the fight for parity and, in 2003, the Paul Wellstone Mental Health Equitable Treatment Act (MHETA) was written, requiring full coverage parity (Murray & Henriques, 2004). On March 17, 2005, the Wellstone bill, numbered H.R.1402.IH, was introduced in the House of Representatives by Congressman Patrick Kennedy of Rhode Island. In late May, another bill, the Medicare Copayment Equity Act (S.1152.IS), was introduced. This was proposed by Senators Olympia Snowe and John Kerry to eliminate discriminatory rates for outpatient psychiatric services. Both bills were referred to committee and, to date, no further action has been taken (Thomas, 2005).

On November 17, 2005, Senator Barbara Boxer submitted and proposed an amendment to "provide an additional $500,000,000 for each of fiscal years 2006 through 2010, to be used for readjustment counseling, related mental health services, and treatment and rehabilitative services for veterans with mental illness, post-traumatic stress disorder, or substance use disorder" (Thomas, 2005). The amendment was rejected by the Senate and ruled out of order by the chair (Thomas, 2005).

Another federal government action which could lead to further inequality for mental health care is the recent proposal to cut Medicaid funding. According to the National Mental Health Association (2005), reductions in benefits currently provided by Medicaid would include mental health coverage, as well as adding new restrictions on amount, duration, and scope of services covered. Additionally, some individual states, such as New York, are similarly affecting health care for low-income people, by implementing caps on Medicaid spending. Other states, however, have passed some form of mental health parity legislation.

As of 2003, 34 states had passed parity laws.
Twenty-three states require complete parity allowing for coverage of all mental health and substance abuse disorders (Kjorstad, 2003). Other states have passed full parity legislation, which allows certain exemptions, while others have passed limited parity legislation. These laws would apply only to specific groups or protect against certain types of discrimination (Murray & Henriques, 2004).

Advocacy and Cost Studies

Advocacy for mental health parity and protection from discrimination comes from several directions, primarily the health care field. The National Mental Health Association, the American Psychiatric Association, the American Medical Association, the American Psychiatric Nurses' Association, the American Counseling Association, and the American Hospital Association are among the many organizations which have taken stands on the necessity for, and cost effectiveness of, mental health parity. Advocacy coalitions have been formed from many of these organizations. The Coalition for Fairness in Mental Illness Coverage helped to create and back the Mental Health Parity Act of 1996 (Greenburg & Strazzella, 2002). Thirty professional and advocacy organizations formed the Mental Health Liaison Group, which helped develop and support the Medicare Copayment Equity Act this year (Mulligan, 2005).

The National Alliance for Mental Illness (NAMI) advocates strongly for the rights of the mentally ill and their families, pushing for private sector healthcare reform and more responsive public sector involvement by way of equitable benefits from Medicare, Medicaid, Veterans' programs, and other government-funded programs. Part of NAMI's mission is its support of "health care for all persons with brain disorders that is affordable, nondiscriminatory, and includes coverage for effective and appropriate treatment" (National Alliance for Mental Illness, 2005, p.1). The organization also officially recognizes what parity research has begun to support: "the cost of not treating brain disorders greatly exceeds the cost of treating them" (NAMI, 2005, p.2).

Data from reports written in 2003 in South Carolina and in Vermont, states which implemented insurance parity mandates, concur with NAMI's statement. Employers and insurance companies in the two states had warned that dramatic rises in costs for insurance would result from the parity laws, but that did not occur (Hausman, 2003). South Carolina saw less than 1% of an increase in costs, an annual increase of $16.65 per insured person, in the first year of mandated parity. Vermont's two major insurance providers, Blue Cross Blue Shield and Kaiser, saw a 4% increase and a 9% decrease respectively in costs. It must be noted, however, that Vermont saw a decrease in utilization of mental health and substance abuse services in the first three years of its mandated parity, which is believed to have been responsible for Kaiser's marked decrease. This speaks to possible accessibility and discrimination problems. Overall, the data from both states indicate that a managed care approach for mental illness was effective in controlling costs, though there is concern about new plans discouraging users (Hausman, 2003).

A major four-year study of the Federal Employees Health Benefits (FEHB) program also indicates that mental health parity is affordable. The FEHB program complies with the policy requiring comprehensive parity coverage for DSM, 4th Edition-designated mental health and substance abuse problems. Since approximately 8 million people are covered by FEHB plans, this study had a wide-ranging, national scope (Mulligan, 2005). It was found that costs did increase for some FEHB plans, but only in line with increases experienced by other large employers' plans that offered some mental health services but not parity. Additionally, employee expenses for mental health services decreased more for FEHB members than for those in comparison plans, and administrative costs for two-thirds of the plans did not increase as a result of instituting parity measures. In nearly all the FEHB plans, there had been restrictions on some mental health treatment that had to change to comply with the parity policy, yet it was found that for the two types of disorders studied (major depression and substance abuse), quality of care was not negatively affected by the changes (Mulligan, 2005).

Patients and Providers

Access, affordability, and quality of care are essential parts of the parity issue. In 2003, the Bush administration created the New Freedom
Commission on Mental Health with the goal to transform the country's approach to health care. An advocacy coalition which includes NAMI and the APA, called the Campaign for Mental Health Reform, has formed to encourage the Commission's intentions. Since 2003 in the U.S., 63,000 people have died from suicide, over 200,000 mentally ill people have been incarcerated, and "more than 25,000 families have given up their children to get them mental health services...[while] juvenile detention centers have spent $200 million 'warehousing' youth instead of providing treatment" (Bristol, 2005, p.79).

The World Health Organization's 1990 Global Burden of Disease study found that, worldwide, "four of the ten leading causes of disability for people older than five are mental disorders" (National Mental Health Association, 2005, p. 1). It was also found that major depression is the main cause of disability in the U.S. (NMHA, 2005). There is a proven need for mental health and substance abuse treatment, and providers need to be free to treat patients in a way they professionally deem necessary. As has been mentioned above, not enough has been done to assure this accessibility. In addition to complete insurance parity, the inclusion of the DSM-4 diagnostic guidelines for mental illness in the legislation would be an important step in empowering the health care providers, not just the insurance providers, and in some cases the court system, to decide who is mentally ill and in need of treatment (Noel, 2003).

In many cases of implemented mandated parity, managed care is the answer for controlling cost. Requirements for submission of treatment plans and the use of carve-out contracts are managed care measures that have been used frequently at the state level and in the FEHB plans. As the literature has shown, managed care does control cost increases related to mental health parity. However, advocacy groups such as NAMI express concern that government stay accountable for equitable and good quality treatment and services, even when contracting out to private managed care organizations (NAMI, 2005). NAMI further emphasizes the fact that there are still many Americans who are uninsured and are thereby unaffected directly by any successful attempts at parity legislation. The issue of mental health parity extends into the broader issues of discrimination against the mentally ill and universal health care coverage.

The mental health parity issue can be seen as political because it involves perceived economic burdens on the insurance industry and employer, who in turn lobby legislators. Whether or not it is accepted by these public and private sector groups that the actual increases companies would bare is negligible in contrast to the benefits to society; the case will always be that certain government representatives will be in support of business and others will be in support of the "masses." Despite being primarily a bipartisan issue, at this time in our federal government, parity has seen little progress due to pressure on Republican members of both houses (Killeen, 2002). Politics and government will ultimately reflect the will, and perceptions, of the people. This is where more change is needed.

Mental health advocacy groups, individuals suffering from mental health problems, and health care providers have witnessed the discrimination surrounding the issue of mental illness. At the core of the political debate are moral and ethical questions. Are those with mental health problems less deserving of treatment than those with physical illness? Are the mentally ill somehow lacking in moral character or fortitude, rather than being simply ill? Is it too embarrassing to acknowledge the pervasiveness of mental illness in our country? Is it too daunting a task to reevaluate the core values of our society? Is it too daunting to reevaluate our health care system? Morally speaking, the question of mental health parity represents what we hold as a cultural value. Dependence and ambiguity are not, as a rule, valued in our society, and physical illnesses tend to come with clearer causes, interventions, and outcomes than do mental health problems. NAMI has begun using the term "brain disorders" in place of mental illness, perhaps in order to more closely align mental illness with physical illness and to lessen the stigma around mental problems. Changing the terminology is a step in the direction of educating the public and leaders on the origin of many mental illnesses, but it seems there is more work to be done.

To move out of the more absolutist, or deontological, way of thinking about what constitutes illness, we as a society need to
embrace the gray area in which the concepts of health and illness reside. There is neither absolute health nor an absolute state of illness. When evaluating the well-being of a patient with renal failure, a health care provider cannot separate the kidney from the person. Dialysis treatment will involved the whole person. A severely depressed person may become unable to fulfill her duties as a mother or as an employee. The effects of her disease move out into her family and into her workplace. If society can accept the concept of holism, for the individual, the family, and the community, then there will be a place for holism in health care. And, in turn, if health care promotes holism as a value, then the concept will filter out into the community.

Health care providers have the opportunity and the responsibility to play a role in shifting the awareness in our society toward holism. Bioethics presents four fundamental principles by which health care workers should practice: autonomy, justice, beneficence, and nonmaleficence (Aiken, 2004). By advocating for a patient's wish to live a more mentally stable life, a nurse is supporting his right to self-determination. If an insurance company allows a primary care physician to refer a patient to a cardiologist for her heart disease, but does not allow referral for psychological treatment for another patient for clinical depression, justice is not served. A nurse cannot competently help a patient whose struggle for breath is compounded by his anxiety if she ignores the man's anxiety disorder. Failure on the part of health care providers to consider the patients' mental health along with their physical health subjects the patients to harm.

Nurses, according to the American Nurses Association's Code of Ethics for Nurses, have roles and responsibilities well suited for moving the country toward a holistic view of health and incorporating mental health into that picture. Provision One of the Code instructs nurses to respect the "inherent dignity, worth, and uniqueness of every individual unrestricted by considerations of social or economic status, personal attributes, or the nature of the health problem" (American Nurses Association, 2005). Provision Eight discusses the importance of promoting the health, welfare, and safety of all people. The provision's points most relevant to mental health parity encourage awareness of human rights violations, inequitable distribution of nursing and health care resources, and lack of access to health care (ANA, 2005). And regarding the nurse's role in bettering society's perception of mental health, Provision Nine discusses the responsibility for "articulating nursing values, maintaining the integrity of the profession and its practice, and for shaping public policy" (ANA, 2005). It is difficult to maintain the integrity of the profession if one's hands are tied by policy and finances and one's ability to provide complete nursing care is restricted. Parity in health care coverage would further empower nurses to carry out their ethical duties.

Conclusion

Insurance disparity is certainly not the only reason the vast majority of people in need of mental health care don't seek it out, but it is a significant one. Additionally, by insurance not covering mental health disease, other factors like stigma and the lack of knowledge of the disease and the treatments are perpetuated. Having insurance coverage, either through government mandates or by employers' own will, would be a significant step toward integrating mental health issues and care in to our population's consciousness. This would lead to better-educated consumers and more acceptance of the mentally ill people with whom we live, work, worship, shop, and recreate.

Nurses do not only have the role of advocate, but of educator and role model, and the mental health parity movement needs strong players for these roles. The education of fellow members of society in the importance of fair and equitable dispersion of care, high quality care, and access to care for all people will benefit everyone. It is time to integrate mental health into our overall perception of ourselves as healthy Americans. We get cold viruses at times, and we get depressed at times. Some of us develop diabetes, others develop bipolar disorder, and some may suffer from both. Some people will die of cancer, some will die by their own hand due to poorly treated schizophrenia. Treatment, wherever it falls on the intensity or invasiveness scales, is rarely denied for the physical problems we suffer. It is time to recognize our susceptibility to the stigma of "not feeling well" emotionally or
mentally, and move on to a realistic version of health care. When our citizens and legislators become accepting of a holistic health model, insurance companies and employers will realize the benefit of operating in a manner consistent with the society’s beliefs.

References