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Chairman, Committee on Health, Education, Labor, and Pensions, U.S. Senate

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MENTAL HEALTH PARITY ACT

Despite New Federal Standards, Mental Health Benefits Remain Limited

GAO/HEHS-00-95

Contents

Abbreviations

APA	American Psychiatric Association
CBO	Congressional Budget Office
DSM	Diagnostic and Statistical Manual of Mental Disorders
ERISA	Employee Retirement Income Security Act of 1974
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act 1996
HMO	health maintenance organization
ICD	Internal Classification of Disease
NCSL	National Conference of State Legislatures
POS	point of service

PPO	preferred provider organization
SAMSHA	Substance Abuse and Mental Health Services Administration

Contents

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Health, Education, and
Human Services Division

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May 10, 2000

The Honorable James M. Jeffords
Chairman, Committee on Health,
Education, Labor, and Pensions
United States Senate

Dear Mr. Chairman:

An estimated 40 million American adults suffer from some type of mental illness each year, 5.5 million of them suffering from a severe mental illness such as schizophrenia or major depression. Private health insurance plans typically provide lower levels of coverage for the treatment of mental illness than for the treatment of other illnesses. Consequently, treatment for patients with severe mental illness, who often require repeat hospitalizations, can exhaust their mental health coverage.

To help address the discrepancies in coverage between mental and other illnesses, the Congress passed the Mental Health Parity Act of 1996. The law imposed new federal standards on mental health coverage offered under most employer-sponsored group health plans.[1] Specifically, the law prohibits employers from imposing annual or lifetime dollar limits on mental health coverage that are more restrictive than those imposed on medical and surgical coverage. Although the act has been in effect for just over 2 years, questions persist about the actual cost of complying with the law and the benefits it provides to consumers. Therefore, in preparation for the law's September 30, 2001, sunset and possible reauthorization, you asked us to report on

- the extent to which employers comply with the law and how they have revised their health plans,
- the law's effect on claims costs, and
- the steps federal agencies have taken to ensure compliance with the law.

[1]The Mental Health Parity Act also generally applies to certain state and local government health plans, church plans, and certain other health plans, although self-funded state and local government health plans may elect exemption from the act.

To determine employers' compliance and responses to the law, we conducted a mail survey of 1,656 employers with more than 50 employees offering mental health benefits. We obtained a response rate of 52 percent. Because our goal was to measure the effect of federal—not state—parity requirements, we surveyed employers in the 26 states and the District of Columbia that did not have state laws that were more comprehensive than the federal Mental Health Parity Act as of July 1999.[2] The survey gathered information on how employer-sponsored plans have changed since the Mental Health Parity Act was enacted, what changes can be attributed to it, and the effect of the law on claims costs. Because this survey was based on a random sample, stratified by employer size, we weighted the results so they would be statistically representative of all 103,000 employers with more than 50 employees offering mental health benefits in these 26 states and the District of Columbia. Unless otherwise indicated, the confidence intervals for our survey results are not greater than plus or minus 5 percentage points and differences we report are statistically significant. While large employers and those located in the Northeast were somewhat less likely to respond to our survey than other employers, we do not believe that this noticeably skews our results because we did not identify significant differences in the extent to which employers complied with the federal parity act by employer size or location.[3] Nonetheless, as with any survey based on a sample, appropriate caution should be used in interpreting the results, given sampling and other potential measurement errors. Appendix I provides more details about our survey's scope and methodology, and appendix II provides summary data of the survey responses.

To identify steps the federal agencies have taken to ensure compliance with the Mental Health Parity Act, we interviewed officials from the Department of Health and Human Services' (HHS) Health Care Financing Administration (HCFA) and the Department of Labor's Pension and Welfare Benefits Administration. To determine the extent to which states have

[2]These states were Alabama, Alaska, Arizona, California, Florida, Idaho, Illinois, Iowa, Kansas, Massachusetts, Michigan, Mississippi, Nevada, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Washington, West Virginia, Wisconsin, and Wyoming.

[3]The survey was stratified by employer size so that the results are weighted to be representative of small, medium-sized, and large employers' relative size in the population rather than their response rate. Further, large employers were more likely than small or medium-sized employers to provide complete responses, allowing us to determine whether they complied with the law.

passed conforming laws and regulations, we requested the National Conference of State Legislatures' (NCSL) Health Policy Tracking Service to develop a summary of each applicable state law. We conducted our work between June 1999 and March 2000 in accordance with generally accepted government auditing standards.

Results in Brief

Most employers responding to our survey reported that they are complying with the federal mental health parity law, but because of its narrow scope and reductions in mental health benefits that the employers have made to offset the required enhancements, compliance may have little effect on employees' access to mental health services. Eighty-six percent of the responding employers in the 26 states and the District of Columbia reported that as of December 1999 their plans were in compliance with the federal parity requirement that annual and lifetime dollar limits for mental health benefits be no more restrictive than those for all medical and surgical benefits. Our survey found that 14 percent of plans were noncompliant—a noncompliance rate similar to Labor's preliminary estimates based on investigations of employer-sponsored plans. In contrast, in 1996 before the parity law was enacted, only about 55 percent of responding employers reported offering parity in dollar limits. Many responding employers cited the federal Mental Health Parity Act as a significant or primary reason for changing the dollar limits in their health benefit plans.

Although most employers' plans now have parity in dollar limits for mental health coverage, 87 percent of those that comply contain at least one other plan design feature that is more restrictive for mental health benefits than for medical and surgical benefits. For example, about 65 percent of plans restrict the number of covered outpatient office visits and hospital days for mental health treatment further than those for other health treatment. In addition, many employers may have adopted newly restrictive mental health benefit design features since 1996 specifically to offset the more generous dollar limits they adopted as a result of the federal law. About two-thirds of these newly compliant employers changed at least one other mental health benefit design feature to a more restrictive one compared with only about one-fourth of the employers that did not change their dollar limits.

While most employers have not examined changes in their plans' claims costs, the federal parity law appears to have had a negligible effect on claims costs. Only about 3 percent of responding employers reported that

compliance with the law increased their claims costs, and virtually no employers have dropped their mental health benefits or health coverage altogether since the law was enacted. In addition, published estimates of the cost of federal parity are typically less than 1 percent. More comprehensive parity laws as enacted by some states are generally estimated to have higher but modest cost increases of about 2 to 4 percent.

Federal agencies have made varying progress in performing their oversight roles under the parity law. Labor is in the process of expanding its oversight role to include not only the complaint-driven approach used in its oversight of private employer-sponsored health plans but also one that in the future may include randomly selected employer investigations to gauge overall compliance with parity and other federal standards. HCFA has not yet fully determined the nature and extent of its oversight responsibilities. Before it can exercise an oversight role, it must first identify states that are not enforcing the federal standards. HCFA initially identified seven states that appeared not to have a parity law. As of May 2000, HCFA reported that four of these states are enforcing the federal standards through conforming legislation or other means and that it is still working with the three other states to assist them in enacting similar protections. HCFA has determined that laws in 20 states appear to fully conform to the federal standards and is still evaluating whether laws in the remaining 24 states fully conform to the federal standards.

Background

Private health insurance plans typically provide lower levels of coverage for the treatment of mental illness than for the treatment of other illnesses. Issuers of coverage—employers and health insurance carriers—often limit mental health coverage through the use of plan design features that can be more restrictive for mental health benefits than for medical and surgical benefits.[4] Commonly found are (1) lower annual or lifetime dollar limits on what the plan will pay for mental health benefits, (2) lower service limits for mental health benefits such as the number of covered hospital days or outpatient office visits, and (3) higher cost-sharing features for mental health benefits such as deductibles, copayments, or coinsurance. In the absence of a requirement that benefits for mental and other health coverage be equal, an employer plan might cover unlimited hospital days

[4]An employer may provide group coverage to its employees either by purchasing a group policy from an insurance carrier (fully insured coverage) or by funding its own health plan (self-funded coverage) and assuming the financial risk.

and outpatient visits and impose a lifetime limit of $1 million for medical and surgical coverage. For mental health services, that same plan might cover only 30 hospital days and 20 outpatient visits per year and impose a $50,000 lifetime limit.

Issuers provide more limited mental health coverage primarily because of cost concerns. Limits on hospital days, outpatient office visits, and annual or lifetime dollar amounts may reflect issuers' concern about the high costs associated with long-term, intensive psychotherapy and extended hospital stays. An issuer may also restrict mental health benefits to protect itself from adverse selection. That is, a plan with relatively generous mental health benefits is more likely to attract a disproportionate number of individuals with a high demand for mental health care services, thus driving up the claims and premium costs of the plan. In response to growing concern about perceived inequities in health insurance coverage for mental health treatment, the Congress passed the Mental Health Parity Act of 1996.[5] The act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act to require that annual and lifetime dollar limits for mental health coverage be no more restrictive than for all medical and surgical coverage.[6] To achieve parity in dollar limits, a plan may impose a dollar limit that does not distinguish between mental health and all medical and surgical coverage, impose a dollar limit on mental health benefits that is no lower than the limit on all medical and surgical benefits, or eliminate dollar limits entirely.[7] The law contains several exemptions. It does not apply to

- plans sponsored by an employer with 50 or fewer employees,
- group plans that experience an increase in plan claims costs of at least 1 percent because of compliance, or
- coverage sold in the individual (nongroup) market.

[5]P.L. 104-204, title VII, 110 Stat. 2847, 2944-50 (to be classified at 29 U.S.C. 1185a and 42 U.S.C. 300gg-5).

[6]Provisions implementing the Mental Health Parity Act were later added to the Internal Revenue Code of 1986 under the Taxpayer Relief Act of 1997.

[7]The law also provides that in the case of a plan under which annual or lifetime dollar limits differ for categories of medical and surgical benefits, the plan may comply by calculating a weighted average annual or lifetime dollar limit for mental health benefits based on a formula specified by the secretary of Labor.

Furthermore, the law does not require any plan to offer mental health coverage, does not cover substance abuse treatment, and does not prevent a plan from imposing more restrictive service limits (hospital days or outpatient visits) or cost-sharing provisions on mental health coverage than on medical and surgical coverage. The law became effective for group health plans for plan years beginning on or after January 1, 1998. Without legislative action, the act will sunset on September 30, 2001.

During the past decade, most states also passed laws regulating mental health benefits.[8] As of March 2000, NCSL reported that laws in effect in 43 states and the District of Columbia addressed mental health coverage in employer-sponsored group health plans.[9] More than half, or 29, of the state laws are more comprehensive than the federal parity law by requiring parity not only in dollar limits but also in service limits or cost-sharing provisions. Sixteen of these states require full parity. That is, they mandate that mental health coverage be included in all group plans sold, and they require parity in all respects, including dollar limits, service limits, and cost sharing. Laws in six states essentially parallel the federal law. Laws in eight states and the District of Columbia are more limited and might not conform to the federal law, merely requiring, for example, that plans containing mental health benefits include a nominal amount of coverage (less than $1,000 annually) for inpatient or outpatient mental health care. Seven states have no laws addressing mental health benefits. (See table 1.)

Table 1: State Laws Affecting Mental Health Benefits Compared With the Federal Mental Health Parity Act of 1996 as of March 2000

Scope of state law	State
No law	Alabama, Idaho, Iowa, Michigan, Oregon,[a] Utah, Wyoming
More limited than the federal law[b]	California,[c] District of Columbia, Illinois, Massachusetts, Mississippi, North Dakota, Ohio, Washington, Wisconsin
Meets federal law[d]	Alaska, Arizona, Florida, New Mexico,[e] South Carolina, West Virginia

[8]Tracy Delaney, *Overview of State Laws Affecting Coverage of Mental Illness and Substance Abuse Treatment* (Washington, D.C.: NCSL , Health Policy Tracking Service, Mar. 1, 2000).

[9]A smaller number of state laws also apply to coverage sold in the individual insurance market.

Scope of state law	State
Exceeds federal law[f]	Arkansas, Colorado, Connecticut, Delaware, Georgia, Hawaii, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Virginia

Note: Our survey population included all 21 states and the District of Columbia identified in the table as having no law, a law more limited than the federal law, or a law that meets the federal law. We also surveyed employers in 5 states identified in the table as exceeding the federal law. We included Nevada and Tennessee because their more comprehensive laws became effective after our sample was selected. We included Kansas and Pennsylvania because, although they require that mental health benefits be included in most coverage sold, they otherwise mirror the federal parity law by requiring parity only in dollar limits. Finally, we included New York because of unclear statutory language and HCFA's initial determination that the state may not be enforcing the minimum federal standards.

[a]A law more limited than the federal law becomes effective July 2000.

[b]State law does not require parity in dollar limits but may mandate mental health benefits, impose minimum service levels, or place limits on cost-sharing features for mental health benefits.

[c]A law that exceeds the federal law becomes effective July 2000.

[d]State law requires parity in dollar limits but not in services or cost sharing.

[e]A law that exceeds the federal law becomes effective October 2000.

[f]Law requires parity in dollar limits and also imposes parity in services or cost sharing or mandates that mental health benefits be included.

Source: GAO review of data compiled by NCSL.

Appendix III describes the laws in each state that affect the terms and conditions of mental health and substance abuse benefits.

Enforcement authority for the Mental Health Parity Act is divided among federal agencies and the states. Labor is responsible for ensuring that private sector employer-sponsored group health plans comply with the law—an extension of Labor's regulatory role under ERISA.[10] In states that do not adopt and enforce statutes or regulations that meet or exceed the federal parity standards, HCFA is responsible for directly enforcing the federal standards on carriers.[11] The agency is authorized to impose a civil monetary penalty on carriers of up to $100 per day per violation for each individual affected by a carrier's failure to comply.[12] In states that have standards conforming to the federal parity law, state insurance regulators have primary enforcement authority over insurance carriers.[13]

Most Employers Report Complying With the Federal Law but Also Limit Mental Health Benefits

Most employers responding to our survey (86 percent) reported that they comply with the federal parity standards, although the 14 percent that do not comply represent 9,000 to 13,000 employers in the 26 states and District of Columbia we surveyed. However, of the plans that do comply, 87 percent contain one or more other design features such as office visit limits or hospital day limits that restrict mental health benefits to a greater extent than medical and surgical benefits. In addition, employers that newly adopted the federal standards were much more likely than other employers to also restrict mental health benefits by changing other plan features, suggesting an attempt to mitigate the effect of the parity law. Finally, other changes in the health care market besides parity laws also can affect

[10]ERISA allows employers to offer uniform national health benefits by preempting states from directly regulating employer-sponsored benefit plans. As a result, states are unable to directly regulate self-funded plans but can regulate health insurers. Under ERISA, Labor is responsible for ensuring that employer-sponsored group health plans meet certain fiduciary, reporting, disclosure, and appeal requirements related to the provision of health benefits.

[11]HCFA is also responsible for enforcing the parity standards on state and local government health plans.

[12]The Department of the Treasury also enforces the requirements for generally all nongovernmental group health plans, including church plans, by imposing an excise tax under the Internal Revenue Code as a penalty for noncompliance.

[13]This federal and state regulatory scheme applies to other federal health insurance standards, including those established under the Health Insurance Portability and Accountability Act of 1996, the Newborns' and Mothers' Health Protection Act of 1996, and the Women's Health and Cancer Rights Act of 1998. To facilitate coordination of their shared oversight responsibilities, HHS, Labor, and the Department of the Treasury entered into a memorandum of understanding effective April 21, 1999. See 64 *Fed. Reg.* 70,164 (Dec. 15, 1999).

mental health benefit designs, such as the increasing use of managed care techniques.

Most Employers Are Complying With the Law

Employers report that they are largely complying with the federal mental health parity law. That is, where employers' plans impose annual or lifetime dollar limits, the limits are at least as generous for mental health benefits as they are for all medical and surgical benefits. Eighty-six percent of employer plans we surveyed reported compliance with the federal parity requirement as of December 1999, representing about 68,000 to 74,000 employers in the 26 states and the District of Columbia we surveyed.[14] In contrast, 14 percent reported that they were noncompliant, representing about 9,000 to 13,000 employers in the 26 states and the District of Columbia.[15] Both HCFA and Labor officials found the 14 percent noncompliance rate comparable with their own assessments. For example, on the basis of a preliminary review of its findings, Labor recently determined that 12 percent of about 200 employers it investigated were out of compliance with federal parity standards. In contrast, in 1996 before the parity law was enacted, only about 55 percent of employers had parity in the annual and lifetime dollar limits for mental health and medical and surgical benefits.[16] When asked why employers changed their annual or lifetime dollar limits, more than 75 percent (plus or minus 8.6 percent) of those responding cited the federal Mental Health Parity Act as a significant or primary reason for the change. Among the employer plans in our survey that were not in compliance with the federal parity law, most had lifetime limits for mental health coverage that did not exceed $100,000, as shown in table 2.

[14]The compliance rate excludes employers that did not know their plan's annual or lifetime dollar limits or did not respond to the question. We could not determine compliance for 21 percent of employers in 1999 because their responses did not provide complete information. We were less likely to know the compliance for small employers than medium-sized and large employers.

[15]Our survey results did not find significant differences in the rate of employer noncompliance based on characteristics such as employer size, industry, or geographic region or whether the plan was fully insured or self-funded.

[16]Respondent uncertainty and item nonresponse prevented us from determining parity for 51 percent of employers in 1996. We were less likely to determine parity for both small employers and those in the South compared with employers of other sizes and in other areas of the country.

Table 2: Lifetime Dollar Limits for Noncompliant Employer Plans, 1999

Lifetime dollar limit	Percent of noncompliant plans
$25,000 or less	37 (± 9.8)
$25,001 to $100,000	25(± 8.7)
More than $100,000	12 (± 6.4)
No limit	14 (± 7.1)[a]

[a]These plans met the federal requirement for parity in lifetime dollar limits but were out of compliance because they had annual dollar limits for mental health services that were more restrictive than those for medical and surgical benefits.

Source: GAO survey of employers' mental health benefits.

Most Employers' Plans Contain Other Design Features That Are More Restrictive for Mental Health Benefits Than for Medical and Surgical Benefits

Most employers' plans we surveyed contain other plan design features that are more restrictive for mental health than for medical and surgical benefits. Typically, these features include limits on the number of covered hospital days and outpatient office visits as well as higher cost-sharing features such as copayments and coinsurance. In December 1999, 87 percent of compliant employer plans contained at least one design feature more restrictive for mental health benefits.[17] Most prevalent were restrictions on the outpatient office visit and hospital day limits, as indicated in table 3.

Table 3: Compliant Employer Plans Reporting More Restrictive Limits on Mental Health Benefits Than Medical and Surgical Benefits, 1999

Mental health plan design feature	Percent
Lower outpatient office visit limits	66
Lower hospital day limits[a]	65
Higher outpatient office visit copayments[a]	27
Higher outpatient office visit coinsurance[a]	25

[17]As of December 1999, noncompliant plans did not differ significantly from compliant plans, with about 93 percent (± 5.5 percent) of noncompliant plans also containing at least one such restriction.

Mental health plan design feature	Percent
Higher cap on enrollee out-of-pocket costs	12
Higher hospital stay coinsurance	10
Higher hospital stay copayments[a]	5

[a]The differences between compliant and noncompliant plans placing more restrictive limits on mental health services for these plan design features were not statistically significant.

Source: GAO survey of employers' mental health benefits.

In contrast, very few health plans we surveyed impose any limits on hospital days or office visits for nonmental health conditions—about 10 and 8 percent, respectively. Table 4 illustrates the variation in selected design features for the most popular health plan of employers we surveyed.

Table 4: Selected Design Features for a Typical Employer-Sponsored Group Health Plan, 1999

Design feature	Mental health	Medical and surgical
Lifetime dollar limit	$1 million combined with medical and surgical	$1 million combined with mental health
Hospital day limit	30 days	Unlimited
Outpatient office visit limit	20 days	Unlimited
Outpatient office visit coinsurance[a]	50%	20%

[a]Outpatient office visit coinsurance includes the most frequent levels for plans with coinsurance.

Source: Based on the mode of reported limits and coinsurance in GAO survey of employers' mental health benefits.

Employers' Plans That Changed Dollar Limits to Comply With the Law Were More Likely to Add Other Restrictions

According to our survey, employers that newly adopted the federal parity requirements were more likely than those that did not change dollar limits after 1996 to further restrict access to mental health coverage by tightening other design features. About 65 percent (plus or minus 8.2 percent) of employers that adopted annual or lifetime parity in dollar limits after 1996 changed at least one other mental health design feature to a more restrictive one. Most commonly changed were outpatient office visit limits and hospital day limits, as shown in table 5. Only 26 percent (plus or minus 5.2 percent) of employers that did not change dollar limits after 1996—that is, plans that were already in compliance or that remain out of

compliance—have changed at least one mental health design feature to become more restrictive. This suggests that many employers have changed mental health benefit design features in order to mitigate or offset the more generous annual and lifetime dollar limits required by the Mental Health Parity Act.

Table 5: Employers' Plans That Have Further Restricted Mental Health Benefits Since 1996

Benefit design feature change	Newly compliant	Other employers[a]
Fewer office visits covered	51% (± 9.3)	11%
Fewer hospital days covered	36 (± 8.9)	11
Increased outpatient office visit copayments[b]	20 (± 7.7)	13
Increased outpatient office visit coinsurance	11 (± 5.8)	3
Increased hospital stay coinsurance	7 (± 4.6)	2
Increased hospital stay copayments[b]	3 (± 3.4)	7
Increased cap on enrollee's out-of-pocket costs	18 (± 7.1)	7

[a]Includes employers' plans that already had parity in 1996 and those that did not have parity in 1996 and remained out of compliance in 1999.

[b]The differences in the percentage of newly compliant and other employers that increased hospital stay and office visit copayments after 1996 are not statistically significant.

Source: GAO survey of employers' mental health benefits.

Other Market Changes Also Affect Mental Health Benefit Design

Our survey results show that 89 percent of employers' most popular health plans contain managed care features. In addition, about 14 percent of the survey respondents indicated that their employee health plans contained more managed care features in 1999 than they did in 1996. Moreover, the mental health benefits in many employers' health plans are administered by a managed behavioral health organization that coordinates and manages the mental health care. The Surgeon General estimates that almost 177 million Americans with health insurance were enrolled in managed behavioral health organizations in 1999.[18] About 7 percent of employers responding to our survey reported that their mental health benefits were separately administered by a managed behavioral health care organization under a carve-out arrangement in 1999. However, the extent to which mental health benefits are carved out may be understated because employers may not have been aware whether plans they purchase from a carrier carve out the mental health benefits.

Some analysts and advocates for mentally ill persons suggest that managed care can, under certain circumstances, diminish access to mental health services. For example, the National Advisory Mental Health Council concluded in its 1997 and 1998 reports to the Congress that parity alone does not guarantee improved access to mental health care because of the counteracting effect of managed care.[19] Managed care techniques that can influence access to care include primary care gatekeepers, capitation, financial incentives to providers, the size and composition of provider networks, utilization review, and case management services.

[18]HHS, *Mental Health: A Report of the Surgeon General* (Washington, D.C.: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999).

[19]The National Advisory Mental Health Council is a congressional advisory council made up of the National Institutes of Health and the National Institute of Mental Health within HHS.

Conversely, other research suggests that managed care can have a more positive effect on access to mental health services. According to a recent study of eight large employers that insure more than 2.4 million Americans through managed-care programs for mental health and substance abuse, the employers in the study have eliminated most of the day and lifetime limits and significantly decreased copayments. Employees' use of mental health and substance abuse benefits has increased overall, with greater use of outpatient and alternative treatment settings and a decrease in inpatient care. Among factors that the study authors attributed to the success of these programs were the availability of a full continuum of treatment settings in the managed care networks and strong referral mechanisms to connect employees to appropriate services.[20]

Most Employers Are Not Aware of the Law's Effect on Claims Costs, Which Appears to Be Negligible

While most of the employers we surveyed reported that they did not know whether compliance with the law increased their plans' claims costs, early concerns that the act's passage would increase claims costs by more than 1 percent appear to have been unfounded. Our findings corroborate past studies' estimates that implementing federal parity would have a negligible effect on employers' claims costs. Researchers anticipate higher yet modest claims costs for employers in states that enact more comprehensive parity laws.

Most Employers Have Not Examined Changes in Claims Costs but Few Report Cost Increases

About 60 percent of the responding employers did not know whether compliance with the Mental Health Parity Act increased their plans' claims costs, and about 37 percent reported that compliance had not raised their claims costs. Only about 3 percent of the respondents suggested that claims' costs increased as a result of the act.[21] However, as noted above, compliance with the act was associated with increased restrictions for other plan features, such as office visit or hospital day limits, which may

[20]Kristen Reasoner Apgar, *Report to the Office of Personnel Management: Large Employer Experiences and Best Practices in Design, Administration, and Evaluation of Mental Health and Substance Abuse Benefits—A Look at Parity in Employer-Sponsored Health Benefit Programs* (Washington, D.C.: Washington Business Group on Health, Mar. 2000).

[21]The act allows an exemption for group plans that experience an increase in health benefit costs of 1 percent or more because of compliance with the law's requirements. Federal agencies estimated that as many as 10 percent of health plans affected by the law, or 30,000 health plans, could be eligible for the exemption. However, as of March 2000, Labor officials reported that only nine employers nationally had claimed an exemption.

have limited the extent to which claims costs would increase. In addition, less than 1 percent of responding employers actually dropped coverage of mental health benefits or their health benefits plans altogether after the law was enacted, which may further illustrate the lack of employer concern about increased costs.

Several studies aimed at estimating the costs of the federal parity law concluded that requiring parity only in dollar limits would result in cost increases of less than 1 percent. For example, the Congressional Budget Office estimated that the Mental Health Parity Act would result in claims costs increases of 0.16 percent, while Coopers and Lybrand predicted claims cost increases of about 0.12 percent.[22]

More Comprehensive Parity Laws Are Expected to Have Higher Yet Modest Cost Increases

Many states have enacted mental health laws that are more comprehensive than the federal Mental Health Parity Act and thus are likely to have a greater effect on claims costs than the federal law. Unlike the federal law, these laws require parity not only in dollar limits but also in service limits, cost-sharing provisions, or both. In addition, many state laws mandate the inclusion of mental health benefits in fully insured group health plans and cover substance abuse and chemical dependency. Public and private health policy researchers have examined the estimated or actual costs resulting from more comprehensive state parity laws. In addition to estimates of increased claims costs in several states, several studies have examined the potential premium cost increases associated with full parity nationally. Most studies estimate the cost of full parity for individual states and on a national basis to be between 2 and 4 percent, as summarized in table 6.

Table 6: Estimated Cost Increases for Full Parity in Mental Health and Substance Abuse Benefits

Study	Scope	Increase[a]
Coopers and Lybrand[b]	National	3.2%
Milliman and Robertson[c]	National	3.9

[22]Coopers and Lybrand, "An Actuarial Analysis of S. 2031, 'The Mental Health Parity Act of 1996,'" n.p., Sept. 1996.

Study	Scope	Increase[a]
Congressional Budget Office[d]	National	4.0
Mathematica Policy Research[e]	National	3.6
Department of Banking, Insurance, Securities, and Health Care Administration[f]	Vermont	0-3
North Carolina Psychological Association[g]	North Carolina	[h]
Price Waterhouse Coopers[i]	16 states[j]	2.5-3.9

[a]The national figures are estimates of premium increases. The figures for the individual states represent an expected increase in claims costs. The percentages are a composite of the estimated cost increases for fee-for-service, preferred provider organization, point of service, and health maintenance organization (HMO) plans. Typically, cost estimates assume that HMO and other managed care plans have lower cost increases.

[b]Coopers and Lybrand, *An Actuarial Analysis of the Domenici-Wellstone Amendment to S. 1028 "Health Insurance Reform Act" to Provide Parity for Mental Health Benefits Under Group and Individual Insurance Plans*, for American Psychological Association (n.p.: Apr. 1996).

[c]Milliman and Robertson, *Premium Rate Estimates for a Mental Illness Parity Provision to S. 1028, "The Health Insurance Reform Act of 1995"* (n.p.: Apr. 1996).

[d]Congressional Budget Office, *CBO's Estimates of the Impact on Employers of the Mental Health Parity Amendment in H.R. 3103* (Washington, D.C.: May 1996).

[e]Mathematica Policy Research, *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits, for the Substance Abuse and Mental Health Services Administration* (Washington, D.C.: Mar. 1998).

[f]Department of Banking, Insurance, Securities, and Health Care Administration, *Report of the Department of Banking, Insurance, Securities, and Health Care Administration on Mental Health and Substance Abuse Parity (Act 25) to the Vermont General Assembly* (Washington, D.C.: Jan. 1999).

[g]North Carolina Psychological Association, *North Carolina Comprehensive Major Medical Plan for Teachers and State Employees: Data on the Mental Health Benefit* (Raleigh, N.C.: Apr. 1999).

[h]Between 1992 and June 1998, mental health payments as a percentage of total health payments for the N.C. Comprehensive Major Medical Plan for Teachers and State Employees decreased from 6.4 to 3.1 percent, representing a cumulative cost reduction of 52 percent. In this health plan, the mental health benefits are managed by a managed behavioral health care organization.

[i]Price Waterhouse Coopers is the result of a merger between Price Waterhouse and Coopers and Lybrand.

[j]Price Waterhouse Coopers estimated the claims costs increases of parity for mental health and substance abuse benefits in Arizona, California, Delaware, Kentucky, Massachusetts, Michigan, Missouri, Nebraska, New Jersey, New Mexico, Nevada, North Carolina, Ohio, Oregon, South Carolina, and Vermont.

Federal Agencies Have Made Varying Progress in Overseeing the Implementation of the Parity Law

Federal agencies have made varying progress in performing their oversight roles under the act. Labor's role is expanding from a largely complaint-driven approach to one that also uses investigations to more systematically measure employers' compliance with the law. HCFA remains in the early stages of identifying states that have not adopted conforming laws or are not otherwise enforcing the federal standards. Once these states are identified, HCFA must initiate a multistep process to establish itself as the enforcement authority for insurance carriers found not to be enforcing the federal parity standards in these states.

Labor's Oversight Activities Are Expanding

Labor has traditionally relied on a complaint-driven approach to identify noncompliance with federal health plan standards. However, with the enactment of several federal health insurance reforms since 1996, including the Mental Health Parity Act, Labor's enforcement role has significantly expanded.[23] Accordingly, the agency has undertaken several initiatives to improve and expand its oversight, customer service function, and consumer and employer education efforts.[24] On April 6, 2000, the agency published its strategic enforcement plan to make public its goals and intended approach to ensuring that employee benefit plans comply with federal standards, including mental health parity.[25]

In particular, the agency has initiated a limited number of investigations to more systematically determine health plan compliance. As of March 2000, Labor officials said they had completed investigations of approximately 200 employers that varied by size and geography. In addition to reviewing their compliance with other ERISA requirements, Labor had reviewed 215 of the plans that were subject to the Mental Health Parity Act and found 26, or 12 percent, that were not in compliance, according to officials.[26] These plans

[23]The Health Insurance Portability and Accountability Act of 1996, the Newborns' and Mothers' Health Protection Act of 1996, and the Women's Health and Cancer Rights Act of 1998.

[24]For additional information on Labor's initiatives, see *Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards* (GAO/HEHS-99-100, May 12, 1999) and *Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators* (GAO/HEHS-98-67, Feb. 25, 1998).

[25]65 *Fed. Reg.* 18,208 (Apr. 6, 2000).

[26]The number of plans that Labor reviewed is larger than the number of employers reviewed because the employers could offer more than one health plan with mental health benefits.

typically retained annual or lifetime limits that were lower for mental health coverage than for medical and surgical coverage or contained other violations of the law. The agency plans to conduct approximately 1,000 investigations annually, according to agency officials. The agency is considering developing a sampling model that it may use to help evaluate compliance.

HCFA Continues to Evaluate the Extent of Its Oversight Role

Enactment of the Mental Health Parity Act and other recent federal insurance reforms has created a broad new regulatory role for HCFA. The agency must enforce federal requirements on insurers in states where it determines that a state has not enacted legislation that meets or exceeds the federal standards or has otherwise failed to "substantially enforce" the federal standards. Its activities in support of this new role have been evolving since the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[27] On August 20, 1999, the agency issued enforcement regulations that prescribe the process by which it assumes an enforcement role in a particular state and describes regulatory responsibilities it may perform.[28]

In mid-1999, the agency undertook an initial state-by-state analysis to determine whether state laws conform to the federal standards—a precursor to determining whether the agency may be required to play an enforcement role in a particular state. Agency officials said that their preliminary examination indicated that 7 states appeared not to have laws addressing the federal parity standards, 24 states had laws about which the agency had questions concerning their conformance to the federal standards, and 20 states appeared to have laws that fully conformed to federal parity standards.

In December 1999, HCFA sent letters to the seven states without laws, indicating that it had a reasonable question about whether the states' standards substantially met the specified federal parity requirements. HCFA officials said they would accept that states meet the federal

[27]For additional information on HCFA's activities, see Implementation of *HIPAA: Progress Slow in Enforcing Federal Standards in Nonconforming State* (GAO/HEHS-00-85, Mar. 31, 2000), (GAO/HEHS-99-100), (GAO/HEHS-98-67), and *Private Health Insurance: HCFA Cautious in Enforcing Federal HIPAA Standards in States Lacking Conforming Laws* (GAO/HEHS-98-217R, July 22, 1998).

[28]64 *Fed. Reg.* 45,786 (45 C.F.R. pt. 144, 146, 148, and 150).

standards if alternatives such as regulations or advisory bulletins existed and had some statutory basis. As of May 2000, HCFA officials said that four of these states had enacted conforming laws or other directives or otherwise had demonstrated that they enforce the federal parity requirements. In states that do not meet these standards through other regulatory means, HCFA will begin its formal determination process in which it can ultimately assume direct enforcement responsibilities. As of April 2000, HCFA was still evaluating the laws in the 24 states where it had questions concerning state conformance.

Conclusions

The Mental Health Parity Act of 1996 sought to bring mental health benefits closer to other health benefits. The act requires parity only in annual and lifetime dollar limits and does not place restrictions on other plan features such as hospital and office visit limits. Therefore, the changes employers made to bring health plans into compliance with the act often included further restrictions in these other plan features that may have offset the parity achieved in dollar limits. Further, a significant minority of plans—about 14 percent in the 26 states and the District of Columbia we surveyed—continue to have lower mental health than medical and surgical dollar limits in direct contradiction of the law. The net effect is that consumers in states without more comprehensive laws have often seen only minor changes in their health benefits, resulting in little or no increase in their access to mental health services, and that the costs associated with the federal law have been negligible for most health plans.

As the Congress considers proposals that would renew the Mental Health Parity Act beyond 2001 or expand it to provide more complete parity between mental health and other health benefits, the effects of the 1996 act along with the experiences of the 29 states with more comprehensive parity laws are instructive. These more comprehensive state laws, which require parity not only in dollar limits but also in service limits, cost-sharing requirements, or both may provide information about the potential costs of extending parity—estimated to be about 2 to 4 percent. Further, the market for mental health services has continued to evolve since 1996, with managed care and carve-outs of mental health services increasingly applied. Nonetheless, despite the federal and state parity laws and market changes, many Americans are likely to remain in employer-sponsored health plans that restrict benefits for mental illness more than for other types of illnesses.

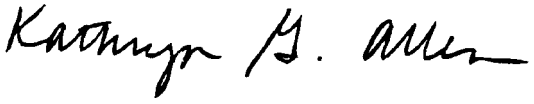
Agency Comments

HCFA and the Department of Labor commented on a draft of this report. Both generally agreed with our findings and conclusions and provided technical comments, which we have incorporated as appropriate. Appendix IV contains the comment letter from HCFA.

As we agreed with your office, unless you publicly announce this report's contents earlier, we plan no further distribution of it until 30 days after its issue date. We will then send copies to the Honorable Donna E. Shalala, Secretary of Health and Human Services; the Honorable Nancy-Ann Min DeParle, Administrator of HCFA; the Honorable Alexis M. Herman, Secretary of Labor; the Honorable Leslie B. Kramerich, Acting Assistant Secretary for the Pension and Welfare Benefits Administration; and other interested congressional committees and members and agency officials. We will also make copies available to others on request.

Please call me at (202) 512-7114 if you have any questions. Other contacts and major contributors are listed in appendix V.

Sincerely yours,



Kathryn G. Allen
Associate Director, Health Financing
and Public Health Issues

Survey Scope and Methods

To determine employers' compliance and responses to the Mental Health Parity Act of 1996, we conducted a mail survey of employers in selected states between November 1999 and February 2000. We sent the survey to a random sample of employers, stratified by size, in the District of Columbia and 28 states initially identified as having mental health parity laws similar to the federal law or that had no parity law of their own (and thus the federal act was in effect). [1] The survey collected information about

1. the current most popular health plan that contains mental health benefits;

2. the same plan in 1996, if available then, or the most popular health plan containing mental health benefits offered in 1996 and how it compares with the current plan; and

3. the cost of changes made to mental health benefits as a result of the law.

To develop the questions we used in our survey, we reviewed the requirements of the law as well as the existing research addressing the issue of mental health parity. In addition, representatives from the Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA), the Washington Business Group on Health, and Mercer/Foster Higgins reviewed a draft of the survey and provided us with comments. We pretested the survey with five private employers of varying sizes in California, Illinois, Michigan, and the District of Columbia.

[1]Our survey results are based on responses from surveys sent to employers in the District of Columbia and the following 26 states: Alabama, Alaska, Arizona, California, Florida, Idaho, Illinois, Iowa, Kansas, Massachusetts, Michigan, Mississippi, Nevada, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Washington, West Virginia, Wisconsin, and Wyoming. The initial sample also included Kentucky and Louisiana, but these states were later removed from the sample after further review of state laws.

Sample Design

We selected our sample to be representative of employers subject to the law—private employers with more than 50 employees who offer medical benefits, including mental health benefits, to their employees. We excluded public employers (state and local governments) because their plans are allowed to elect exemption from the federal mental health parity law.[2] In addition, because our goal was to measure the effect of federal rather than state parity, we excluded states that had mental health parity laws that exceeded the parity requirements of the federal law in order to avoid confounding our results. On the basis of a preliminary review of state laws that we requested from the National Conference of State Legislators (NCSL) in July 1999, we initially identified 28 states and the District of Columbia as eligible for inclusion in our survey.

Using our list of eligible states, Dun and Bradstreet identified all private employers' headquarters offices with more than 50 employees in its database of U.S. businesses.[3] In addition, because certain aspects of health benefits may vary depending on employer size and because more small employers exist than larger ones, we divided the employers into three strata by size before sampling in order to improve the precision of our estimates. The three strata were

1. small employers, with 51 to 100 employees;
2. medium-sized employers, with 101 to 200 employees; and
3. large employers, with more than 200 employees.

Response Rate and Adjustments to Population and Sample Sizes

The initial sample, drawn by Dun and Bradstreet, consisted of 2,500 employers in 28 states and the District of Columbia. Further review of state laws revealed that Kentucky and Louisiana had mental health parity laws that were more comprehensive than the federal law. Employers in these states were removed from the sample (102 cases).

[2]As of April 2000, 530 self-insured state and local government plans had filed for an exemption from the federal parity standards.

[3]We included only single-site firms and the headquarters offices of multisite businesses in the survey. We drew our population and sample from Dun and Bradstreet's database of 11 million U.S. businesses, a source commonly used for employer surveys.

We received responses from 1,212 of the remaining 2,398 employers, and 102 were deemed undeliverable.[4] We conducted three follow-up attempts to increase the response rate—a second mailing of the survey to all nonrespondents, a letter encouraging participation, and telephone calls to about 63 percent of randomly selected nonresponding employers.

We adjusted the population and sample sizes for employers that we determined were not subject to the federal law for the following reasons:

- they did not offer a health plan or had health plans without mental health benefits for their employees (279 cases) or
- they reported having fewer than 50 employees (70 cases).

In adjusting both the population and sample sizes, we assumed that the proportion of employers who were incorrectly identified as eligible for our survey was the same for both responding and nonresponding employers and we adjusted both the sample and population sizes accordingly. A total of 863 eligible responses were obtained out of an adjusted sample of 1,648 employers, for an overall response rate of 52 percent. See table 7 for details of the population and sample sizes, number of responses received, adjustments made, and response rates per strata.

Table 7: Selected Survey Sample and Response Data

Size of business	Initial population size	Initial sample size	Total number of responses[a]	Adjusted population size	Adjusted sample size[b]	Number of eligible responses	Adjusted response rate[c]
Small	79,320	1,263	636	44,664	711	392	55%
Medium	37,150	592	283	26,038	407	216	53
Large	40,531	645	293	32,709	530	255	48
Total	**157,001**	**2,500**	**1,212**	**103,483**	**1,648**	**863**	**52%**

[a]Includes both ineligible and eligible responses.

[b]Sample was adjusted based on proportion of ineligible responses.

[c]Response rate was based on eligible responses and adjusted sample size.

[4]About 126 employers provided summary plan descriptions that we abstracted in order to complete the questionnaire, as applicable.

Sampling Error

Because we used a sample to develop our estimates, our results contain sampling error that occurs from not collecting data from all employers subject to the federal law in the states we surveyed. Sampling error indicates how closely we can reproduce from a sample the results that we would expect to obtain if we were to survey all eligible employers.

The sampling errors for the point estimates used in this report are based on the design of the survey and the response-adjusted sample weights. These sampling errors were used to calculate 95 percent confidence intervals around our estimates, which means that the chances are about 19 in 20 that the actual percentage being estimated falls within the range defined by our estimate, plus or minus the sampling error. Unless otherwise indicated in the report, the sampling error for the survey results presented in this report is no greater than 2.5, for a confidence interval of plus or minus 5 percentage points. Sampling errors were larger for some analyses of subgroups, such as employers that were newly compliant with the federal law. All differences we report are statistically significant unless we note otherwise.[5] Statistical significance means that the differences observed between the subgroups are unlikely to be attributed to chance.

Analysis of Survey Nonresponses

To identify potential biases in the responses we received that may occur when certain employers respond and others do not, we compared key characteristics—size of business, geographic region, and type of industry—of employers that responded to the survey with those that did not. We found that large employers were less likely to participate in the survey than small and medium-sized firms. In addition, employers in the Northeast were less likely to respond to the survey while those in the Midwest were more likely to participate. Despite these differences, compliance with the mental health parity law among responding employers did not vary significantly by employer size, type of industry, or geographic region. However, we were unable to determine whether the compliance of nonresponding employers differed significantly from that of those participating in the survey. Where differences exist, the estimates could incorrectly attribute the characteristics of the responding employers to the nonresponding employers. For example, if employers with noncompliant

[5]Statistical significance was measured at the 95 percent confidence level ($p \leq .05$), which means that the probability of detecting a difference between subgroups where none exists is no greater than 5 percent.

plans were less likely to respond to the survey, our compliance estimate would underestimate the portion of noncompliant employer plans.

Limitations

We weighted the results so they would be statistically representative of private employers with more than 50 employees who offer mental health benefits in the District of Columbia and the 26 states. The results of our survey cannot be generalized to employers with fewer than 50 employees, government employers, or private employers in states other than those we surveyed.

As with all surveys that rely on self-reported data, some degree of measurement error—error that occurs when the responses received do not accurately reflect reality—exists in the results. Measurement error may have occurred in our survey if respondents either misunderstood a question or used outdated information, such as old summaries of their health plan, to answer a question. We contacted some employers by telephone to obtain, clarify, or verify information related to certain problematic responses. To ensure completeness and accuracy in the contractor keypunched data, we independently verified 3 percent of the surveys, or 38, for keypunch accuracy.

Finally, not every respondent answered every question. Relatively high item nonresponse included questions pertaining to the health plan in place in 1996. To see how item nonresponse may affect two of our key results—parity in annual and dollar limits for 1999 and 1996—we tested to see if there were significant differences between employers for whom we could determine the parity of their benefits and those for whom we could not. Employers were compared on size, geographic region, and type of industry. Our ability to determine parity in 1999 varied only by employer size, for which item nonresponse meant that we could not determine compliance for 24 percent of small employers. Our ability to determine parity in 1996 varied by both employer size and geographic region. Item nonresponse for 1996 health plan data meant that we could not determine parity for 58 percent of small employers and 60 percent of respondents from the South.

Summary of Survey Responses

Following are the responses we received to our survey of employers' mental health benefits. The sum of the combined responses may not equal 100 percent because of rounding. In addition, because not every employer responded to each question, we have provided the total number of responses for each question. As with the survey, we divided the summary of responses into three parts:

- Information about the employer's current health plan that both covers the largest number of lives and contains mental health benefits.
- Information about the same plan in 1996 or the most popular health plan containing mental health benefits offered in 1996 compared with the 1999 plan.
- Information about the cost of changes made to mental health benefits as a result of the Mental Health Parity Act.

The Employer's Current Health Plan That Covers the Largest Number of Lives and Contains Mental Health Benefits

Table 8: Mental Health Benefits Offered Now

Are mental health benefits included in any of the health plans offered employees? (n = 1,097)	
Response	**Percent**
Yes	79
No	15
No health plan offered	6

Table 9: Mental Health Benefits Ever Offered Since December 1996

Have mental health benefits ever been included in any of the health plans offered employees since Dec. 1996? (n = 125)[a]	
Response	**Percent[b]**
Yes	4
No	61
No health plan offered	35

[a]Question applies only to employers indicating mental health benefits are not included in any of their health plans.

[b]Confidence intervals ranged from ±3.3 to ±8.4 percent.

Table 10: Number of Lives Benefits Cover

How many lives are covered by the plan that has the largest number of covered lives and contains mental health benefits? *(Please include active and retired employees and their dependents.)* (n = 745)	
Median	122
Range	2-333,652

Table 11: Plan Insurance

Is this health plan fully insured or self-insured? (n = 848)	
Response	**Percent**
Fully insured	64
Self-insured or self-funded	32
Don't know	4

Table 12: Plan Type

What type of plan is this health plan? (n = 837)	
Response	**Percent**
Conventional indemnity	8
Preferred provider organization (PPO)	45
Point-of-service (POS)	12
Health maintenance organization (HMO)	32
Other	4

Table 13: Administered by a Managed Behavioral Health Care Company

Does your organization contract with a managed behavioral health care company for separate administration of mental health benefits? (n = 846)	
Response	**Percent**
Yes	7
No	86
Don't know	6

Table 14: Financial Risk of Administering Organization

What level of risk does the organization administering the mental health benefits bear? (n = 59)[a]	
Response	**Percent[b]**
Bears no financial risk	41
Bears some financial risk	10
Bears all financial risk	10
Don't know	38

[a]Question applies only to employers contracting with a managed behavioral health care company for the administration of their mental health benefits.

[b]Because only a subset of respondents answered this question, the confidence intervals ranged from ±7.4 to ±12.5 percent.

Table 15: Plan Design Features for Current Plan

What is the amount of the limit or cost-sharing feature that applies to the following plan design features?

	Mental health benefit[a]			Medical surgical benefit[a]		
Plan design feature	**Number of responses**	**Percent with limit**	**Median amount for plans with limit (25th-75th quartile)**	**Number of responses**	**Percent with limit**	**Median amount for plans with limit (25th-75th quartile)**
Annual dollar limit	572	28%	$6,300 (1,500-1,000,000)	593	16%	$1,000,000 (5,000-2,000,000)
Lifetime dollar limit	658	54	$1,000,000 (1,000,000-2,000,000)	708	54	$1,000,000 (1,000,000-2,000,000)
Annual out-of-pocket maximum	660	62	$1,000 (750-1,500)	718	73	$1,000 (800-1,500)
Annual deductible	757	47	$250 (200-300)	771	51	$250 (200-300)
Inpatient hospital care copayment	642	22	$100 (50-240)	671	24	$100 (75-240)
Inpatient hospital care coinsurance	720	51	20% (10-20)	725	45	20% (10-20)
Annual inpatient hospital days	726	76	30 days (30-30)	679	10	30 days (30-70)
Outpatient office visit copayment[b]	710	70	$15 (10-20)	723	78	$10 (10-15)
Outpatient office visit coinsurance[b]	707	49	30% (20-50)	674	35	20% (10-20)
Annual outpatient office visit	747	75	20 visits (20-30)	683	8	20 visits (20-30)

[a]All data reflect plan feature for in-network benefits, as applicable. Estimates reflect plans that apply design features both to mental health and medical surgical services combined and to those that apply a separate limit or amount for mental health services and for medical surgical services.

[b]Copayment and coinsurance reflect amount for tenth visit.

The Current Plan or the Most Popular Health Plan Containing Mental Health Benefits Offered in 1996, Compared With the 1999 Plan

Table 16: Current Plan in 1996

Were mental health benefits offered through your current health plan at any time in December 1996? (n = 802)	
Response	**Percent**
Yes	62
No, organization did not exist in December 1996	5
No, plan was not available or did not contain mental health benefits	17
Don't know	17

Table 17: Mental Health Benefits in Any Plan

Were mental health benefits offered through any of the plans that you offered in December 1996? (n = 268)[a]	
Response	**Percent[b]**
Yes	36
No	11
Don't know	53

[a]Question applies only to employers whose current plan was not offered or did not contain mental health benefits in 1996.

[b]Confidence intervals ranged from ±3.8 to ±6.0 percent.

Table 18: Plans Covering the Most Lives in December 1996

Please identify the type of plan in place in December 1996 that covered the most lives and contained mental health benefits. (n = 94)[a]	
Response	**Percent[b]**
Conventional indemnity	16
Preferred provider organization (PPO)	41
Point-of-service (POS)	9
Health maintenance organization (HMO)	30
Other	4

[a]Question applies only to employers whose current plan was not offered or did not contain mental health benefits in 1996.

[b]Confidence intervals ranged from ±4.2 to ±9.9 percent.

Table 19: Plan Design Features in December 1996

For the health benefits plan that was available in December 1996, what was the amount of the limit or cost-sharing feature applied to the following plan design features?

	Mental health benefit[a]			Medical surgical benefit[a]		
Plan design feature	Number of responses	Percent with limit	Median amount for plans with limit (25th-75th quartile)	Number of responses	Percent with limit	Median amount for plans with limit (25th-75th quartile)
Annual dollar limits	379	51%[b]	$5,250 ($1,500-15,000)	370	18%	$1,000,000 ($200,000-1,000,000)
Lifetime dollar limits	413	66	$50,000 ($25,000-1,000,000)	442	58	$1,000,000 ($1,000,000-2,000,000)
Annual out-of-pocket maximum	391	59	$1,000 ($700-1,500)	431	72	$1,000 ($750-1,500)
Annual deductible	464	50	$200 ($100-250)	471	55	$200 ($100-250)
Inpatient hospital care copayment	398	19	$100 ($50-250)	414	20	$100 ($50-240)
Inpatient hospital care coinsurance	448	52	20% (10-20)	456	46	20% (10-20)
Annual inpatient hospital days	430	63	30 days (30-30)	429	8	60 days (30-120)
Outpatient office visit copayment[c]	419	58	$20 ($10-25)	433	67	$10 ($10-15)
Outpatient office visit coinsurance[c]	456	55	50% (20-50)	435	39	20% (10-20)
Annual outpatient office visit	442	60	20 days (20-30)	428	6	20 days (20-25)

[a]All data reflect plan feature for in-network benefits, as applicable. Estimates reflect plans that apply design features both to mental health and medical surgical services combined and to those that apply a separate limit or amount for mental health services and for medical surgical services.

[b]Confidence interval ±5.0 percent.

[c]Copayment and coinsurance reflect amount for tenth visit.

Table 20: Reasons for Benefit Changes After December 1996, Part 1

Where differences exist in the design features for mental health benefits in your current plan and those available in December 1996, please indicate which factors other than the Mental Health Parity Act influenced your decision to change these features. *(Check all that apply.)* (n = 652)

Response	Percent
No changes made	36
Employee needs or preferences	5
Cost containment efforts	15
Market trends in health plan benefits	8
Increased availability of managed health care services	5
State statutes or regulations	9
Don't know	11
Other	10

Table 21: Reasons for Benefit Changes After December 1996, Part 2

Where differences exist in the design features for mental health benefits in your current plan and those available in December 1996, please indicate whether changes were made primarily in response to the Mental Health Parity Act or primarily for the other reasons checked in the question in table 20. *(Check all that apply.)*

Plan design feature	Number of responses	No change	Primarily or more in response to the act	About as much in response to the act as for other reasons	Primarily or more for reasons other than the act	Don't know
Annual dollar limit	513	48%	25%	2%	9%	16%
Lifetime dollar limit	517	51	22	1	10	16
Annual out-of-pocket maximum	501	61	7	2	14	16
Annual deductible	500	64	5	1	16	14
Inpatient hospital care copayment	502	67	4	1	14	14
Inpatient hospital care coinsurance	500	64	6	2	14	15
Annual inpatient hospital days	506	57	14	2	12	15
Outpatient office visit copayment	501	61	6	1	18	14
Outpatient office visit coinsurance	502	62	8	1	14	15
Annual outpatient office visit	506	54	17	2	13	15

Table 22: Administered by a Managed Behavioral Health Care Company in 1996

Did your organization contract with a managed behavioral health care company for separate administration of mental health benefits in December 1996? (n = 577)	
Response	**Percent**
Yes	5
No	90
Don't know	5

Table 23: Managed Care in Current Plan Compared With December 1996

Were more managed care features (such as case management, utilization review, precertification, provider networks, or individualized treatment plans) implemented in your current plan for mental health benefits than in the one available in December 1996? (n = 566)	
Response	**Percent**
Yes, implemented more managed care features	14
No, did not implement more managed care features	65
Don't know	22

Table 24: Employees' Access to Benefits

In your view, have the changes made to your mental health benefits since December 1996 affected employees' access to mental health services?

Type of access	Number of responses	Greatly or somewhat increased	Neither increased nor decreased	Greatly or somewhat decreased
Access to inpatient services	501	13%	84%	2%
Access to outpatient services	500	16	80	4
Access to preventive services	496	13	86	1
Access to mental health services overall	501	17	81	3

Table 25: Employee Eligibility for Coverage

In considering all of the health plans offered by your organization since December 1996, would you say that the proportion of your employees who are eligible to enroll in a health plan that contains mental health benefits has changed?

	Number of responses	Greatly or somewhat increased	Neither increased nor decreased	Greatly or somewhat decreased
Employees eligible to enroll	522	8%	91%	2%

The Cost of Changes to Mental Health Benefits as a Result of the Mental Health Parity Act

Table 26: Exemption Filed

A provision of the Mental Health Parity Act allows an exemption for employers who can demonstrate that compliance has resulted in an increase in total claims costs of 1 percent or more. Has your organization filed for an exemption from the Mental Health Parity Act? (n = 791)

Response	Percent
Yes	1
No	78
Don't know	21

Table 27: Reasons Exemption Not Filed

Below are reasons why an organization might not file for an exemption from the Mental Health Parity Act. Please indicate the reasons your organization did not apply for an exemption. *(Check all that apply.)*

Response	Number of responses	Percent
No changes were necessary to comply with the act	620	32%
Not aware of exemption	619	28
Claims costs did not increase at least 1 percent	619	15
Changed benefit design to mitigate the cost of the act	619	5
Preferred to have employees benefit from the law	619	9
Did not examine changes in costs	619	18
Other	620	5
Don't know	620	11

Table 28: Compliance and Claims Costs

Has compliance with the act increased your health benefit plan's claims costs? (n=772)	
Response	**Percent**
Yes	3
No	37
Don't know	60

Table 29: Claims Cost Increases

By about what percentage did your total health benefit claims costs increase from complying with the act? (n = 33)[a]	
Response	**Percent[b]**
Less than 1 percent	19
1 to 2 percent	17
3 to 5 percent	22
More than 5 percent	15
Don't know	27

[a]Question applies only to employers indicating that compliance with the act increased their health benefit plan's claims costs.

[b]Because only a subset of respondents answered this question, the confidence interval ranged from ±12.1 to ±15.1 percent.

State Laws on Mental Illness and Substance Abuse Treatment

NCSL's Health Policy Tracking Service tracks state laws regulating private health insurance coverage. At our request, NCSL undertook a comprehensive review of the state laws that affect mental illness and substance abuse coverage and prepared a summary as of March 1, 2000. That summary is the basis for table 30. Identified in the table are whether each state has an applicable law, its effective date, the type of coverage (for example, group or health maintenance organization (HMO) or individual market), the illnesses whose treatments are covered (for example, mental illness or substance abuse), and the scope of benefits. In addition, the "type of benefit mandate" is specified, which describes the extent to which each law requires that a benefit be covered. For example, a "mandated benefit" clause within a law addressing the coverage of mental health benefits requires that all coverage sold in the applicable market contain mental health benefits that comply with the terms of the law. A "mandated offering" clause generally requires that the terms of the law apply only if mental health coverage is included in the health plan. Finally, with respect to the requirements of the law as they pertain to the scope of benefits offered in a health plan, the table indicates whether the law requires that certain elements of coverage—inpatient benefits, outpatient benefits, cost-sharing, or dollar limits—be provided on a par with benefits for medical and surgical coverage or specifies that minimum levels of coverage must be offered.

Table 30 shows that as of March 1, 2000, laws in effect in 43 states and the District of Columbia addressed mental health coverage in employer-sponsored group plans and, to a lesser extent, coverage sold in the individual market. With regard to group plans, more than half, or 29, of the state laws are more comprehensive than the federal law in that they require parity not only in dollar limits but also in service limits or cost-sharing provisions. In addition, many of these also mandate that mental health benefits be included in all plans sold. Laws in 6 states essentially parallel the federal law. Laws in 8 states and the District of Columbia are more limited and may not conform to the federal law, while 7 states have no laws addressing mental health benefits. Unlike the federal law, most states, or 41, and the District of Columbia either explicitly include substance abuse within the scope of their mental health benefit laws or have separate statutes addressing substance abuse coverage. However, 13 of these state laws cover only alcoholism.

State laws also define mental illness differently. For example, some state laws define mental illness narrowly to include only specified mental illnesses. Commonly specified are schizophrenia, schizoaffective disorder,

bipolar affective disorder, major depression, obsessive compulsion, and panic disorder. Other state laws define mental illness more broadly, generally including the conditions classified as mental illness by the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM). In addition, many state laws do not define mental illness or do so in broad, nonspecific terms.

Table 30: State Laws Addressing Coverage of Mental Illness and Substance Abuse as of March 1, 2000

			Scope of benefits			
Type of insurance affected	**Illness covered[a]**	**Type of benefit mandate[b]**	**Inpatient (hospitalization)**	**Outpatient services**	**Cost sharing: copayments and coinsurance**	**Dollar limits: annual and lifetime[c]**
Alabama						
1979						
Group and HMO	Alcoholism	Mandated offering	30 days	1 inpatient day can be converted to 3 outpatient sessions	Not specified	Not specified
Alaska						
1997[d]						
Group. Exemption if cost increase of 1% or more or small employer with 50 or fewer employees	Mental illness, excluding alcoholism and drug abuse	Mandated offering	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	Must be equal to other illnesses
1997						
Group. If 5 employees or fewer, exempt; if 20 or fewer, must offer coverage	Alcoholism and drug abuse	Minimum mandated benefits or mandated offering for small group	Not specified	Not specified	Must be equal to other illnesses	At least $9,600 every 2 years; $19,200 lifetime

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits			
			Inpatient (hospitalization)	Outpatient services	Cost sharing: copayments and coinsurance	Dollar limits: annual and lifetime[c]
Arizona						
1998						
Group. Exemption if cost increase of 1% or more or small employer with 50 or fewer employees	Mental illness, excluding alcoholism and drug abuse	Mandated offering	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	Must be equal to other illnesses
Arkansas						
1997						
Group. Exemption if cost increase of 1.5% or more or small employer with 50 or fewer employees	Mental illness and developmental disorders[e]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
1987						
Group and HMO	Alcoholism and drug dependency	Mandated offering	Not less favorable generally than to other illnesses	Not less favorable generally than to other illnesses	Not less favorable generally than to other illnesses	$6,000 every 2 years; $12,000 lifetime
California						
1974						
Group	Mental or nervous disorders	Mandated offering	Not specified	Not specified	Not specified	Not specified
July 2000						
Group, individual, and HMO	Severe mental illness[f]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
1990						
Group	Alcoholism	Mandated offering	Not specified	Not specified	Not specified	Not specified

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits: Inpatient (hospitalization)	Scope of benefits: Outpatient services	Scope of benefits: Cost sharing: copayments and coinsurance	Scope of benefits: Dollar limits: annual and lifetime[c]
Colorado						
1992						
Group	Mental illness, excluding autism	Mandated benefits	45 days	Covered under major medical, not less than $1,000 per year	Shall not exceed 50% of the payment; deductible shall not differ from that for other illnesses	Not specified
1998						
Group	Biologically based mental illness[g]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
1994						
Group	Alcoholism	Mandated offering	45 days	$500 annually	Shall not exceed 50% of the payment; deductible shall not differ from that for other illnesses	Not specified
Connecticut						
Jan. 2000						
Group and individual	Mental or nervous conditions, including alcoholism and drug addiction[h]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
Delaware						
1997[d]						
Group. Exemption if cost increase of 1% or more or small employer with 50 or fewer employees	Mental illness, excluding alcoholism and drug abuse	Mandated offering	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	Must be equal to other illnesses
1999						
Group and individual	Serious mental illness[i]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits: Inpatient (hospitalization)	Scope of benefits: Outpatient services	Scope of benefits: Cost sharing: copayments and coinsurance	Scope of benefits: Dollar limits: annual and lifetime[c]
District of Columbia						
1997						
Group, individual, HMO, and state employee plans	Mental illness and alcohol and drug abuse[j]	Mandated offering for individual plans; mandated benefits for all others	45 days for mental illness; 12 days of detoxification and 28 days for alcoholism and drug abuse	75% for first 40 visits and 60% for visits exceeding 40 for mental illness; 30 visits for alcoholism and drug abuse	Deductibles, copayments, and limits on total amounts payable to an individual in a calendar year may be applied	Lifetime limit of no less than $80,000 or one-third of the lifetime maximum for other illness, whichever is greater
Florida						
1992						
Group and HMO	Mental and nervous disorders[k]	Mandated offering	30 days	$1,000 per benefit year	May be different after minimum benefits are met	May be different after minimum benefits are met
1998[d]						
Group. Exemption if cost increase of 1% or more or small employer with 50 or fewer employees	Mental illness, excluding alcoholism and drug abuse	Mandated offering	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	Must be equal to other illnesses
1993						
Group and HMO	Substance abuse	Mandated offering	Not specified	44 visit maximum, $35 maximum reimbursement per visit	Not specified	Annual limits not specified; minimum lifetime benefit of $2,000
Georgia						
1998						
Group and individual	Mental disorders, including substance abuse[e]	Mandated offering	30 days	48 visits	Must be equal to other illnesses	Must be equal to other illnesses
Hawaii						
1988						
Group, individual, and HMO	Mental illness[l]	Mandated benefits	30 days	30 visits	Must be comparable to other illnesses	Must be comparable to other illnesses
1999						

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits: Inpatient (hospitalization)	Scope of benefits: Outpatient services	Scope of benefits: Cost sharing: copayments and coinsurance	Scope of benefits: Dollar limits: annual and lifetime[c]
Group and individual. Small-employer exemption if 25 or fewer employees	Serious mental illness[m]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
1988						
Group, individual, and HMO	Alcohol and drug dependence	Mandated benefits	No less than two treatment episodes per lifetime	No less than two treatment episodes per lifetime	Must be comparable to other illnesses	Must be comparable to other illnesses
Idaho						
No law						
Illinois						
1991						
Group	Mental, emotional, or nervous disorders	Mandated offering	Not specified	Not specified	Insured may be required to pay up to 50% of expenses	Annual benefit may be limited to the lesser of $10,000 or 25% of the lifetime policy limit
1995						
Group	Alcoholism	Mandated benefits	Not specified[n]	Not specified	Not specified	Not specified
Indiana						
1997[d]						
Group. Exemption if cost increase of 1% or more or small employer with 50 or fewer employees	Mental illness, excluding alcoholism and drug abuse	Mandated offering	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	Must be equal to other illnesses
Jan. 2000						

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits: Inpatient (hospitalization)	Scope of benefits: Outpatient services	Scope of benefits: Cost sharing: copayments and coinsurance	Scope of benefits: Dollar limits: annual and lifetime[c]
Group, individual, and state employees. Exemption if cost increase of 4% or more or small employer with 50 or fewer employees	Mental illness[o]	Mandated offering; mandated benefits for state employee plans	Must be equal to other illnesses for plans that offer coverage; mandated benefits for state employee plans	Must be equal to other illnesses for plans that offer coverage; mandated benefits for state employee plans	Must be equal to other illnesses for plans that offer coverage; mandated benefits for state employee plans	Must be equal to other illnesses for plans that offer coverage; mandated benefits for state employee plans
Iowa						
No law						
Kansas						
1997[d]						
Group. Exemption if cost increase of 1% or more or small employer with 50 or fewer employees	Mental illness, excluding alcoholism and drug abuse	Mandated offering	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	Must be equal to other illnesses
1998						
Group, individual, HMO, and state employee plans	Mental conditions, alcoholism, or drug abuse[p]	Mandated benefits	30 days	Not less than 100% of the first $100, 80% of the next $100, and 50% of the next $1,640 per year and not less than $7,500 per lifetime	Not specified	Specified only for outpatient treatment
Kentucky						
1986						
Group	Mental illness[q]	Mandated offering	To the same extent as coverage for other illness	To the same extent as coverage for other illness	To the same extent as coverage for other illness	To the same extent as coverage for other illness
1980						
Group	Alcoholism	Mandated offering	Emergency detoxification: 3 days reimbursed at $40 per day	10 visits reimbursed at $10 per visit	Not specified	Not specified

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits: Inpatient (hospitalization)	Scope of benefits: Outpatient services	Scope of benefits: Cost sharing: copayments and coinsurance	Scope of benefits: Dollar limits: annual and lifetime[c]
Louisiana						
1982						
Group, self-insured, and state employee plans	Mental illness	Mandated offering	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
1997[d]						
Group. Exemption if cost increase of 1% or more or small employer with 50 or fewer employees	Mental illness, excluding alcoholism and drug abuse	Mandated offering	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	Must be equal to other illnesses
Jan. 2000						
Group, HMO, and state employee plans	Serious mental illness[r]	Mandated benefits	45 days	52 visits; 1 day of inpatient benefits can be converted to 4 outpatient visits	Must be equal to other illnesses	Must be equal to other illnesses
1982						
Group	Alcoholism and drug abuse	Mandated offering	Not specified	Not specified	Not specified	Not specified
Maine						
1996						
Group. Exemption if small employer with 20 or fewer employees	Mental illness[s]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
1996						
Individual	Mental illnesss	Mandated offering	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
1984						

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits: Inpatient (hospitalization)	Scope of benefits: Outpatient services	Scope of benefits: Cost sharing: copayments and coinsurance	Scope of benefits: Dollar limits: annual and lifetime[c]
Group. Small employer exemption if 20 or fewer employees	Alcoholism and drug dependency	Mandated benefits	Not specified	Not specified	May place a maximum limit on benefits as long as they are consistent with the law	May place a maximum limit on benefits as long as they are consistent with the law
Maryland						
1994						
Group and individual	Mental illness, emotional disorder, drug abuse disorder, or alcohol abuse disorder	Mandated benefits	Must be equal to other illnesses	Unlimited visits but subject to different copayments: 80% for visits 1-5, 65% for visits 6-30, and 50% for 31 or more per year	Must be equal to other illnesses	Must be equal to other illnesses
Massachusetts						
1996						
Group, individual, and HMO	Mental or nervous conditions[t]	Mandated benefits	60 days in a mental hospital	$500 per year	Not specified	Lifetime maximum must be equal for inpatient treatment
1991						
Group, individual, and HMO	Alcoholism	Mandated benefits	30 days	$500 per year	Not specified	Not specified
Michigan						
1988						
Group for inpatient; group and individual for other levels. Exemption for cost increase of 3% or more	Substance abuse	Mandated offering of inpatient and mandated benefits for other levels	To the extent agreed upon	$1,500 per year for outpatient and intermediate treatment	Charges, terms, and conditions shall not be less favorable	$1,500 per year for outpatient and intermediate treatment
Minnesota						
1995						
Group, individual, and HMOs	Mental health and chemical dependency	Mandated benefits for HMOs; otherwise, mandated offering	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
1986						

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits: Inpatient (hospitalization)	Scope of benefits: Outpatient services	Cost sharing: copayments and coinsurance	Dollar limits: annual and lifetime[c]
Group and individual	Alcoholism, chemical dependency, or drug addiction	Mandated benefits	At least 20% of the total days allowed but not less than 28 days per year	At least 130 hours of treatment per year	Not specified	Not specified
Mississippi						
1994						
Group and individual	Mental illness	Mandated offering	Services certified as necessary	Services certified as necessary	Not specified	Not specified
1975						
Group	Alcoholism	Mandated benefits	Not specified	Not specified	Not specified	Annual limit of $1,000 per year; lifetime limit not specified
Missouri						
1997						
Group, individual, and HMO	Recognized mental illness and chemical dependency[u]	Mandated offering	90 days for mental illness, 6 days for detoxification	Must be equal for mental illness; 26 visits for chemical dependency	Must be equal for mental illness and chemical dependency	Must be equal for mental illness; chemical dependency may be limited to not less than 10 episodes of treatment
Jan. 2000						
Group, individual, and HMO	Mental illness, including alcohol and drug abuse[v]	Mandated offering	Equal for mental illness; at least 30 days for alcohol and drug abuse if offered	Equal for mental illness; at least 20 visits for alcohol and drug abuse if offered	Shall not be unreasonable in relation to the cost of services provided	A lifetime limit equal to four times the annual limit may be imposed for alcohol and drug abuse
1995						
Group and individual	Alcoholism, chemical dependency, and drug addiction	Mandated benefits for alcoholism; mandated offering for others	30 days for alcoholism; 80% of reasonable charges up to $2,000 maximum	30 days for all levels of care	Not specified	Not specified
Montana						
1997[d]						

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits: Inpatient (hospitalization)	Scope of benefits: Outpatient services	Scope of benefits: Cost sharing: copayments and coinsurance	Scope of benefits: Dollar limits: annual and lifetime[c]
Group. Exemption if cost increase of 1% or more or small employer with 50 or fewer employees	Mental illness, excluding alcoholism and drug abuse	Mandated offering	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	Must be equal to other illnesses
1997; exemptions expire Oct. 2001						
Group. Exemption if cost increase of 1% or more or small employer (number not specified)	Mental illness, alcoholism, and drug addiction	Mandated benefits	21 days with $4,000 maximum every 2 years; $8,000 lifetime maximum for alcohol and drug addiction only	No less than $2,000 per year for mental illness and $1,000 per year for alcohol and drug addiction	No less favorable generally than for other illnesses up to maximums	See specified maximums under inpatient and outpatient benefits. Aggregate limits may not be imposed more restrictively
Jan. 2000						
Group and individual	Severe mental illness[w]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
Nebraska						
Jan. 2000						
Group and HMO. Exemption if small employer with 15 or fewer employees	Serious mental illness[x]	Mandated offering	Must be equal to other illnesses	Must be equal to other illnesses	May be different from that for other illnesses	Must be equal to other illnesses
1989						
Group and HMO	Alcoholism	Mandated offering	30 days per year with at least 2 treatment periods in a lifetime	60 visits during the lifetime of the policy	No less favorable generally than for other illness	No less favorable generally than for other illness
Nevada						
1997[d]						

			Scope of benefits			
Type of insurance affected	**Illness covered[a]**	**Type of benefit mandate[b]**	**Inpatient (hospitalization)**	**Outpatient services**	**Cost sharing: copayments and coinsurance**	**Dollar limits: annual and lifetime[c]**
Group. Exemption if cost increase of 1% or more or small employer with 50 or fewer employees	Mental illness, excluding alcoholism and drug abuse	Mandated offering	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	Must be equal to other illnesses
Jan. 2000						
Group and individual. Exemption if cost increase of 2% or more or small employer with 25 or fewer employees	Severe mental illness[y]	Mandated benefits	40 days	40 visits	Must not be more than 150% of out-of-pocket expenses required for medical and surgical	Must be equal to other illnesses
1997						
Group, individual, and HMO	Abuse of alcohol or drugs	Mandated benefits	$9,000 inpatient and $1,500 for detoxification per year	$2,500 per year	Must be paid in same manner	Must be paid in same manner to maximum benefit; lifetime maximum not specified
New Hampshire						
1993						
Group, individual, and HMO. Different benefits for mental illness specified under major medical and nonmajor medical plans	Mental or nervous conditions	Mandated benefits	Ratio of benefits substantially the same as benefits for other illnesses under nonmajor medical plans and $3,000 per year and $10,000 per lifetime under major medical plans	Ratio of benefits substantially the same as benefits for other illnesses under nonmajor medical plans and not less than 15 hours per year under major medical plans	Ratio of benefits substantially the same as benefits for other illnesses	Ratio of benefits substantially the same as benefits for other illnesses under nonmajor medical plans and $3,000 per year and $10,000 per lifetime under major medical plans
1995						
Group and HMO	Biologically based mental illness[z]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
New Jersey						
1999						

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits: Inpatient (hospitalization)	Scope of benefits: Outpatient services	Scope of benefits: Cost sharing: copayments and coinsurance	Scope of benefits: Dollar limits: annual and lifetime[c]
Group and individual	Biologically based mental illness[aa]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
1985						
Group and individual	Alcoholism	Mandated benefits for care prescribed by a doctor	Must be equal to other illnesses	Must be equal to other illnesses	Benefits provided to the same extent as benefits for any other sickness	Benefits provided to the same extent as benefits for any other sickness
New Mexico						
1998[d]						
Group. Exemption if cost increase of 1% or more or small employer with 50 or fewer employees	Mental illness, excluding alcoholism and drug abuse	Mandated offering	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	Must be equal to other illnesses
Oct. 2000						
Group. Exemption if cost increase of 1.5% or more for small employer with 49 or fewer employees or 2.5% or more for larger employers	Mental health benefits[bb]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
1987						
Group	Alcoholism	Mandated offering	30 days per year, limited to no less than two episodes per lifetime	30 visits per year, limited to no less than two episodes per lifetime	Consistent with cost sharing imposed on other benefits	Consistent with dollar limits imposed on other benefits
New York						
1998						

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits: Inpatient (hospitalization)	Scope of benefits: Outpatient services	Scope of benefits: Cost sharing: copayments and coinsurance	Scope of benefits: Dollar limits: annual and lifetime[c]
Group	Mental, nervous, or emotional disorders and alcoholism and substance abuse	Mandated offering	30 days mental illness, 30 days alcoholism or substance abuse, and 7 days detoxification	$700 mental illness and 60 visits for alcoholism or substance abuse	As deemed appropriate by the superintendent and consistent with cost sharing for other benefits	As deemed appropriate by the superintendent and consistent with dollar limits for other benefits
North Carolina						
1997						
State employee plans	Mental illness and chemical dependency[cc]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
1997[d]						
Group. Exemption if cost increase of 1% or more or small employer with 50 or fewer employees	Mental illness, excluding alcoholism and drug abuse	Mandated offering	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	Must be equal to other illnesses
1985						
Group	Chemical dependency[cc]	Mandated offering	$8,000 per year and $16,000 per lifetime	$8,000 per year and $16,000 per lifetime	Same as for other illness generally	$8,000 per year and $16,000 per lifetime
North Dakota						
1995						
Group and HMO	Mental disorders, alcoholism, and drug addiction	Mandated benefits	45 days for mental illness and 60 days for substance abuse	30 hours for mental illness and 20 visits for substance abuse	No deductible or copayment for first 5 hours or visits, not to exceed 20% for remaining hours or visits	Lifetime and annual dollar limits not specified
Ohio						
1987						
Group and self-insured	Mental or nervous disorders and alcoholism	Mandated offering; mandated benefits for alcoholism	At least $550 for mental illness and $550 for alcoholism per year	At least $550 for mental illness and $550 for alcoholism per year	Benefits may be subject to reasonable deductibles and coinsurance	Lifetime dollar limits not specified
Oklahoma						
Jan. 2000						

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits: Inpatient (hospitalization)	Scope of benefits: Outpatient services	Cost sharing: copayments and coinsurance	Dollar limits: annual and lifetime[c]
Group. Exemption if cost increase of 2% or more or small employer with 50 or fewer employees	Severe mental illness[dd]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
Oregon						
July 2000						
Group and HMO	Mental or nervous conditions, including alcoholism and chemical dependency[ee]	Mandated benefits	$5,000 for adults and $7,500 for children per 24 months for mental health; $5,625 for adults and $5,000 for children for substance abuse	$2,500 for both adults and children per 24 months for mental health; $1,875 for adults and $2,500 for children for substance abuse	No greater than for the treatment of other illnesses	Payments for all treatment for mental health and substance abuse are $13,125 for adults and $15,625 for children. Payments for substance abuse only are $8,125 for adults and $13,125 for children per 24 months
1981						
Individual	Alcoholism	Mandated offering	$4,500 in a 24-month period	$4,500 in a 24-month period	Coverage must be no less than 80% of total	Lifetime, not specified
Pennsylvania						
1999						
Group and HMO. Small-employer exemption if 50 or fewer employees	Serious mental illness[i]	Mandated benefits	30 days	60 visits; 1 day of inpatient can be converted to 2 visits	Must not prohibit access to care	Must be equal to other illnesses
Rhode Island						
1995						
Group, individual, HMO, and self-insured	Serious mental illness[ff]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits: Inpatient (hospitalization)	Scope of benefits: Outpatient services	Cost sharing: copayments and coinsurance	Dollar limits: annual and lifetime[c]
1995						
Group, individual, HMO, and self-insured	Substance dependency and abuse[gg]	Mandated benefits	Three episodes of detoxification or 21 days, whichever comes first, per year	30 hours for each individual under treatment and 20 hours for family per year	Not specified	Not specified
South Carolina						
1994						
Group	Psychiatric conditions, including substance abuse[hh]	Mandated offering	$2,000 per year overall total	$2,000 per year overall total	May be different	$2,000 annual; $10,000 lifetime maximum
1997[d]						
Group. Exemption if cost increase of 1% or more or small employer with 50 or fewer employees	Mental illness, excluding alcoholism and drug abuse	Mandated offering	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	Must be equal to other illnesses
South Dakota						
1998						
Group, individual, and HMO	Biologically based mental illness[ii]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
1979						
Group, individual, and HMO	Alcoholism	Mandated offering	30 days overall each 6 months; 90 days lifetime	30 days overall each 6 months; 90 days lifetime	On the same basis as benefits provided for other illnesses	On the same basis as benefits provided for other illnesses
Tennessee						
1997[d]						
Group. Exemption if cost increase of 1% or more or small employer with 50 or fewer employees	Mental illness, excluding alcoholism and drug abuse	Mandated offering	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	Must be equal to other illnesses

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits: Inpatient (hospitalization)	Scope of benefits: Outpatient services	Cost sharing: copayments and coinsurance	Dollar limits: annual and lifetime[c]
Jan. 2000						
Group. Exemption if cost increase of 1% or more or small employer with 25 or fewer employees	Mental or nervous conditions[k]	Mandated benefits	20 days	25 visits	Must be equal to other illnesses	Must be equal to other illnesses
1982						
Group and HMO	Alcohol and drug dependency	Mandated offering	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
Texas						
1991						
State employee plans only	Biologically based mental illness[jj]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
1997						
Group and HMO. Small-employer exemption if 50 or fewer employees	Serious mental illness[kk]	Mandated benefits with a mandated offering for small groups of 50 or fewer	45 days	60 visits; medication checks are not counted toward the limit	Must be equal to other illnesses	Must be equal to other illnesses
1981						
Group, HMO, and self-insured. Exemption for self-insured plans of 250 or fewer members	Chemical dependency[ll]	Mandated benefits with a mandated offering for self-insured plans of 250 or fewer members	Lifetime maximum of three separate series of treatments, including all levels of medically necessary care in each episode	Lifetime maximum of three separate series of treatments, including all levels of medically necessary care in each episode	Must be sufficient to provide appropriate care	Must be sufficient to provide appropriate care
Utah						
1994						
Group	Alcohol and drug dependency	Mandated offering	Not specified	Not specified	Not specified	Not specified

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits: Inpatient (hospitalization)	Scope of benefits: Outpatient services	Scope of benefits: Cost sharing: copayments and coinsurance	Scope of benefits: Dollar limits: annual and lifetime[c]
Vermont						
1998						
Group and individual	Mental health condition, including alcohol and substance abuse[mm]	Mandated benefits	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses	Must be equal to other illnesses
Virginia						
Jan. 1, 2000, to July 1, 2004						
Group and individual. Small-group exemption if 25 or fewer members	Biologically based mental illness, including drug and alcohol addiction[nn]	Mandated benefits	Must be equal to achieve the same outcome as treatment for any other illness	Must be equal to achieve the same outcome as treatment for any other illness	Must be equal to achieve the same outcome as treatment for any other illness	Must be equal to achieve the same outcome as treatment for any other illness
Washington						
1987						
Group and HMO	Mental health treatment	Mandated offering	Not specified	Not specified	Reasonable deductible and copayments	Not specified
1990						
Group and HMO	Chemical dependency	Mandated benefits	Not specified	Not specified	Not specified	Not specified
West Virginia						
1997[d]						
Group. Exemption if cost increase of 1% or more	Mental illness, excluding alcoholism and drug abuse	Mandated offering	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	May impose terms and conditions, including cost sharing and limits on the number of visits or days covered	Must be equal to other illnesses
1998						
Group and individual. Exemption for a cost increase of 1%	Mental or nervous conditions	Mandated offering	45 days in a mental hospital; must be equal in a general hospital	50% of the eligible expenses up to $500 per year; must not exceed 50 visits in 12 months	Not specified	Lifetime and aggregate limits must be equal to other illnesses

Type of insurance affected	Illness covered[a]	Type of benefit mandate[b]	Scope of benefits: Inpatient (hospitalization)	Scope of benefits: Outpatient services	Cost sharing: copayments and coinsurance	Dollar limits: annual and lifetime[c]
1998						
Group	Alcoholism[oo]	Mandated offering	30 days	Not specified	Must be equal up to 30 days; cannot exceed 50% for outpatient	Not less than $750 per year and not less than an amount equal to the lesser of $10,000 or 25% of the lifetime policy limit
Wisconsin						
1981						
Group and HMO	Mental disorders and alcohol and drug abuse	Mandated benefits	The lesser of 30 days or $7,000 minus a copayment of up to 10% for group plans and $6,300 for HMOs	$2,000 per year minus a copayment of up to 10% for group plans and $1,800 for HMOs	Copayment of up to 10%	Lifetime limits not specified
Wyoming						
No law						

Note: Years below state names are years laws became effective, based on the most recent major amendments to statutes.

[a]Illnesses that health plans subject to the law must cover. APA's DSM IV defines 13 diagnoses that mental health providers and consumer organizations commonly refer to as biologically based mental illnesses. Between 3 and 13 of these diagnoses are referred to in various state parity laws concerning mental illness.

[b]Decribes the extent to which the law requires that a mental health benefit be included. A mandated benefit clause requires that all coverage sold in the applicable market contain the mental health benefits that complies with the terms of the law. A mandated offering clause could require that (1) mental health coverage, if offered, complies with the terms of the law or (2) each issuer offer mental health coverage that meets the terms of the law in at least one of its plans or as a separate rider. In either case, the issuer may charge more for the plan with the mental health benefits or the rider.

[c]Annual and lifetime dollar limits are the amounts of health coverage that an insurer will cover per individual.

[d]Year the law was adopted.

[e]As defined in the Internal Classification of Disease (ICD) manual and DSM.

[f]In California, severe mental illness is defined as (1) schizophrenia, (2) schizoaffective disorder, (3) bipolar disorder (manic-depressive illness), (4) major depressive disorders, (5) panic disorder, (6) obsessive compulsive disorder, (7) pervasive developmental disorder or autism, (8) anorexia nervosa, and (9) bulimia nervosa.

[g]In Colorado, biologically based mental illness is defined as (1) schizophrenia, (2) schizoaffective disorder, (3) bipolar affective disorder, (4) major depressive disorder, (5) specific obsessive compulsive disorder, and (6) panic disorder.

[h]In Connecticut, mental and nervous conditions are defined as mental disorders, as defined in the most recent edition of DSM, and include alcoholism and drug addiction as defined by DSM.

[i]Serious mental illness means any of the following: (1) schizophrenia, (2) bipolar disorder, (3) obsessive compulsive disorder, (4) major depressive disorder, (5) panic disorder, (6) anorexia nervosa, (7) bulimia nervosa, (8) schizoaffective disorder, and (9) delusional disorder.

[j]In the District of Columbia, mental illness is defined as any psychiatric disease identified in the most recent edition of ICD or DSM. Alcohol abuse and drug abuse are defined as any pattern of the pathological use of alcohol or a drug that causes impairment in social or occupational functioning or that produces physiological dependency as evidenced by physical tolerance or by physical symptoms when it is withdrawn.

[k]As defined by DSM.

[l]In Hawaii, mental illness is defined as a syndrome of clinically significant psychological, biological, or behavioral abnormalities that results in personal distress or suffering, impairment of capacity for functioning, or both.

[m]In Hawaii, serious mental illness is defined as (1) schizophrenia, (2) schizoaffective disorder, and (3) bipolar mood disorder, as defined in the most recent edition of DSM, that is severe enough to result in substantial interference with the activities of daily living.

[n]The Illinois statute reads: “no policy of group accident and health insurance delivered in this state which provides inpatient hospital coverage for sickness shall exclude from such coverage the treatment of alcoholism.” No further specifications are provided.

[o]Indiana defines “coverage for services for mental illness” to include benefits with respect to mental health services as defined by the contract, policy, or plan for health services. However, the term does not include services for the treatment of substance abuse or chemical dependency.

[p]In Kansas, nervous and mental conditions are defined as disorders specified in DSM IV but not conditions not attributable to a mental disorder that are a focus of attention or treatment.

[q]In Kentucky, mental illness is defined as psychosis, neurosis, or any emotional disorder.

[r]In Louisiana, severe mental illness includes (1) schizophrenia or schizoaffective disorder, (2) bipolar disorder, (3) pervasive developmental disorder or autism, (4) panic disorder, (5) obsessive compulsive disorder, (6) major depressive disorder, (7) anorexia and bulimia, (8) Asperger’s disorder, (9) intermittent explosive disorder, (10) posttraumatic stress disorder, (11) psychosis not otherwise specified when diagnosed in a child younger than 17 years old, (12) Rett syndrome, and (13) Tourette syndrome.

[s]In Maine, mental illness is defined as (1) schizophrenia, (2) bipolar disorder, (3) pervasive developmental disorder or autism, (4) paranoia, (5) panic disorder, (6) obsessive compulsive disorder, and (7) major depressive disorder.

[t]Massachusetts defines mental and nervous conditions as they are defined by APA’s standard nomenclature.

[u]In Missouri, recognized mental illness is defined as conditions classified as “mental disorders” in DSM but does not include mental retardation. Chemical dependency is defined as the psychological or physiological dependence on and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

[v]In Missouri, mental illness is defined as the following disorders in ICD: (1) schizophrenic disorders and paranoid states (295 and 297, except 297.3); (2) major depression, bipolar disorder, and other affective psychoses (296); (3) obsessive compulsive disorder, posttraumatic stress disorder, and other major anxiety disorders (300.0, 300.21, 300.22, 300.23, 300.3, and 309.81); (4) early childhood psychoses and other disorders first diagnosed in childhood or adolescence (299.8, 312.8, 313.81, and 314); (5) alcohol and drug abuse (291, 292, 303, 304, and 305, except 305.1); (6) anorexia nervosa, bulimia, and other severe eating disorders (307.1, 307.51, 307.52, and 307.53); and (7) senile organic psychotic conditions (290).

[w]In Montana, severe mental illness is defined as the following disorders as defined by APA: (1) schizophrenia, (2) schizoaffective disorder, (3) bipolar disorder, (4) major depression, (5) panic disorder, (6) obsessive compulsive disorder, and (7) autism.

[x]In Nebraska, serious mental illness before January 1, 2002, is defined as (1) schizophrenia, (2) schizoaffective disorder, (3) delusional disorder, (4) bipolar affective disorder, (5) major depression, and (6) obsessive compulsive disorder. Serious mental illness on and after January 1, 2002, is defined as any mental health condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the serious mental illness. Serious mental illness includes but is not limited to (1) schizophrenia, (2) schizoaffective disorder, (3) delusional disorder, (4) bipolar affective disorder, (5) major depression, and (6) obsessive compulsive disorder.

[y]In Nevada, severe mental illness is defined as any of the following mental illnesses that are biologically based and for which diagnostic criteria are listed in DSM IV: (1) schizophrenia, (2) schizoaffective disorder, (3) bipolar disorder, (4) major depressive disorders, (5) panic disorder, and (6) obsessive compulsive disorder.

[z]In New Hampshire, biologically based mental illnesses are defined as (1) schizophrenia, (2) schizoaffective disorder, (3) major depressive disorder, (4) bipolar disorder, (5) paranoia and other psychotic disorders, (6) obsessive compulsive disorder, (7) panic disorder, and (8) pervasive developmental disorder or autism.

[aa]In New Jersey, biologically based mental illnesses are defined as mental or nervous conditions that are caused by a biological disorder of the brain and that result in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of a person with an illness including, but not limited to, (1) schizophrenia, (2) schizoaffective disorder, (3) major depression, (4) bipolar disorder, (5) paranoia and other psychotic disorders, (6) obsessive compulsive disorder, (7) panic disorder, and (8) autism.

[bb]In New Mexico, mental health benefits means the mental health benefits described in the group health plan or group health insurance offered in connection with the plan but does not include substance abuse benefits or gambling addiction.

[cc]In North Carolina, mental illness is defined as (1) an illness that, when applied to adults, so lessens their capacity to use self-control, judgment, and discretion in the conduct of their affairs and social relationships as to make it necessary or advisable for them to be under treatment, care, supervision, guidance, or control and (2) a mental condition, other than mental retardation alone, that, when applied to minors, so impairs their capacity to exercise age-adequate self-control or judgment in conducting their activities and social relationships that they are in need of treatment. North Carolina defines chemical dependency as the pathological use or abuse of alcohol or other drugs in a manner or to a degree that impairs personal, social, or occupational functioning and that may, but need not, include a pattern of tolerance and withdrawal.

[dd]In Oklahoma, severe mental illness is defined as (1) schizophrenia, (2) bipolar disorder, (3) major depression, (4) panic disorder, (5) obsessive compulsive disorder, and (6) schizoaffective disorder as defined in the most current edition of DSM.

[ee]In Oregon, chemical dependency is defined as an addictive relationship with any drug or alcohol that is either physical or psychological or both and that interferes recurringly with an individual's physical, psychological, or social adjustment to common problems. Chemical dependency does not include addiction to or dependency on tobacco, tobacco products, or foods. The Oregon law does not provide a specific definition for mental or nervous conditions.

[ff]In Rhode Island, serious mental illness is defined as any mental disorder that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of a person with the illness. The term includes but is not limited to (1) schizophrenia, (2) schizoaffective disorder, (3) delusional disorder, (4) bipolar affective disorders, (5) major depression, and (6) obsessive compulsive disorder.

[gg]In Rhode Island, substance dependency and substance abuse are a pattern of pathological use of alcohol or other psychoactive drugs characterized by impairments in social or occupational functioning, debilitating physical condition, inability to abstain from or reduce consumption of the substance, or the need for daily use of the substance for adequate functioning.

[hh]In South Carolina, psychiatric conditions are defined as mental and nervous conditions, drug and substance addiction or abuse, alcoholism, or other conditions that the most current edition of DSM defines, describes, or classifies as psychiatric disorders or conditions.

[ii]In South Dakota, biologically based mental illness is defined as (1) schizophrenia and other psychotic disorders, (2) bipolar disorder, (3) major depression, and (4) obsessive compulsive disorder.

[ij]In Texas, biologically based mental illness is defined as a serious mental illness that current medical science affirms is caused by a physiological disorder of the brain that substantially limits the life activities of the person afflicted with the illness and includes (1) schizophrenia, (2) paranoid and other psychotic disorders, (3) bipolar disorders (manic-depressive disorders), (4) major depressive disorders, and (5) schizoaffective disorders.

[kk]In Texas, serious mental illness is defined as the following psychiatric illnesses as defined by DSM: (1) schizophrenia, (2) paranoid and other psychotic disorders, (3) bipolar disorders (hypomanic, manic, depressive, and mixed), (4) major depressive disorders (single episode or recurrent), (5) schizoaffective disorders (bipolar or depressive), (6) pervasive developmental disorders, (7) obsessive compulsive disorder, and (8) depression in childhood and adolescence.

[ll]In Texas, chemical dependency is defined as the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

[mm]In Vermont, mental health condition is defined as any condition or disorder involving mental illness or alcohol or substance abuse that falls under any of the diagnostic categories listed in the mental disorders section of ICD as periodically revised.

[nn]In Virginia, biologically based mental illness is defined as any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits a person's functioning. The following diagnoses are specifically defined as biologically based mental illness as they apply to adults and children: (1) schizophrenia, (2) schizoaffective disorder, (3) bipolar disorder, (4) major depressive disorder, (5) panic disorder, (6) obsessive compulsive disorder, (7) attention deficit hyperactivity disorder, (8) autism, and (9) drug and alcoholism addiction.

[oo]In West Virginia, alcoholism is defined as a chronic disorder or illness in which the individual is unable, for psychological or physical reasons or both, to refrain from the frequent consumption of alcohol in quantities sufficient to produce intoxication and, ultimately, injury to health and effective functioning.

Source: Tracy Delaney, *Overview of State Laws Affecting Coverage of Mental Illness and Substance Abuse Treatment* (Washington, D.C.: NCSL, Health Policy Tracking Service, Mar. 1, 2000).

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: MAY 3 2000

TO: Kathryn G. Allen
Associate Director, Health Financing and Public Health Issues

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: General Accounting Office (GAO) Draft Report: "Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited"

Thank you for the opportunity to review your draft report to Congress concerning our enforcement function in States that fail to substantially enforce the provisions contained in the Mental Health Parity Act of 1996 (MHPA). We appreciate GAO's recognition that the Health Care Financing Administration's (HCFA's) activities have been evolving since the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

HCFA is well underway with its efforts to determine those States in which it will be necessary for HCFA to directly enforce MHPA with respect to issuers. In 1999, HCFA reviewed the laws of all 50 States and the District of Columbia, and identified 7 States that appeared to have no law addressing mental health parity. HCFA confirmed its findings with officials in each of those 7 States, and in December 1999 sent those States a notice that HCFA had a reasonable question as to whether they are substantially enforcing MHPA. The 7 states responded to our notice, and we have been working with each of them to assure that individuals within those States are afforded the protections embodied in MHPA. As a result of our efforts, 4 of these States have enacted conforming laws or other directives or otherwise have demonstrated that they enforce the requirements set forth in MHPA. We are working with the remaining 3 States to assist them in enacting similar protections.

The scope and manner of HCFA's enforcement authority with respect to MHPA mirrors that established for HCFA earlier in 1996 by HIPAA, which aims to ensure the availability of health coverage for certain people who change or lose their jobs, and to small businesses. The basic HIPAA enforcement approach applies to MHPA. Specifically, HCFA is to enforce MHPA with respect to non-Federal governmental plans in all States. HCFA also is to enforce MHPA with respect to health insurance issuers in

Page 2 - Kathryn G. Allen

States that are not substantially enforcing the provisions and requirements contained in MHPA ("direct-enforcement" States). HCFA ultimately has the authority to levy civil money penalties against non-Federal governmental plans, and against issuers in direct-enforcement States, when such plans and issuers fail to comply with MHPA. However, our enforcement focus is to work with plans and issuers to bring them into compliance.

Attached are specific comments on the sections in the report dealing with HCFA's actions under MHPA and our current efforts to meet its statutory obligations.

Attachment

GAO Contact and Staff Acknowledgments

GAO Contact

John Dicken, (202) 512-7043

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