

CRS Report for Congress

The Mental Health Parity Act: A Legislative History

January 19, 2007

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Prepared for Members and
Committees of Congress

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Summary

This report provides a detailed history of mental health parity legislation, including a discussion of bills introduced in each Congress and any accompanying legislative action, including hearings, markups, and floor votes. The legislation is in response to concerns about the coverage of mental health benefits in group health plans, which is often more restricted than the coverage of physical illness.

Some advocates for people with mental illness strongly support legislation that would require full parity, citing research that has shown the cost-effectiveness of treating mental illnesses. On the other hand, health insurance plans and employers offering self-insured plans contend that parity legislation will lead to significant increases in the cost coverage.

Generally, the term full parity is used throughout the report to mean that the treatment limitations and financial requirements on mental health coverage are the same as those for coverage of physical illnesses. Treatment limitations include restrictions on the number of visits or days of coverage, or other limits on the duration and scope of treatment. Financial requirements include deductibles, coinsurance, copayments, and other cost-sharing requirements, as well as annual and lifetime dollar limits on coverage.

Mental health parity legislation was first introduced in 1992, and the Mental Health Parity Act (MHPA) of 1996 was the first federal parity law. MHPA required partial parity by mandating only that annual and lifetime dollar limits in coverage for mental health treatment under group health plans offering mental health coverage be no less than that for physical illnesses. It also provided an exemption to employers with fewer than 25 employees, and did not apply to employers offering self-insured plans. In 2001 and subsequent years, attempts to expand MHPA to require full parity have failed. In the meantime, MHPA continues to be extended on an annual basis. In contrast, about half of the states have passed laws requiring full parity for mental health coverage.

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The Mental Health Parity Act: A Legislative History

Introduction

Private health insurers often provide less coverage of mental illnesses compared to other medical conditions. Historically, health plans have imposed lower annual or lifetime dollar limits on mental health coverage, limited treatment of mental health illnesses by covering fewer hospital days and outpatient office visits, and increased cost sharing for mental health care by raising deductibles and copayments. The lack of parity (i.e., equivalence) in insurance coverage in part reflects insurers' concerns that mental disorders are difficult to diagnose, and that mental health care is expensive and often ineffective. However, the 1999 Surgeon General's report on mental health concluded that mental illnesses are largely biologically based disorders like many other medical conditions. It found that effective treatments exist for most mental disorders.

In 1996, Congress enacted the Mental Health Parity Act (MHPA) to address concerns about the more restrictive coverage of mental health benefits in employer-sponsored group health plans. The MHPA, however, is limited in its scope. It does not compel insurers to provide mental health coverage. For group plans that choose to offer mental health benefits, the MHPA requires parity only for annual and lifetime dollar limits on coverage. Group plans may still impose more restrictive treatment limitations and cost sharing requirements on their mental health coverage. Congress recently extended the MHPA through December 31, 2007.

Full-parity legislation was first introduced in the 107th Congress and reintroduced in the 108th and 109th Congresses, but it has failed to pass despite bipartisan support from lawmakers. Under full parity, a plan must use the same treatment limitations and financial requirements in its mental health coverage as it does in its medical and surgical coverage.¹ Passage of full-parity legislation is a priority for groups that advocate on behalf of the mentally ill, but is opposed by employer and health insurance organizations because of concerns that it will drive up costs.

This report provides a legislative history of mental health parity, in anticipation of activity on this issue during the 110th Congress. For each Congress, beginning with the 102nd (1991 — 1992), there is a brief narrative summarizing the legislative

¹ Treatment limitations include restrictions on the number of visits or days of coverage, or other limits on the duration and scope of treatment. Financial requirements include deductibles, coinsurance, co-payments, and other cost sharing requirements, as well as annual and lifetime limits on the total amount of coverage.

activity, followed by a list of bills and resolutions, hearings (if any), and roll call votes (if any). **Appendix A** lists, by Congress, bills that focus solely on Medicare mental health coverage. **Appendix B** includes a map and table that summarize the state mental health parity laws. For a more detailed analysis of the issues surrounding mental health parity, see CRS report RL-31657, *Mental Health Parity: Federal and State Action and Economic Impact*.

102nd Congress (1991 — 1992)

Mental health parity legislation was first introduced in the Congress in 1992 by Senators Domenici and Danforth (see below). That same year the Senate Appropriations Committee instructed the National Advisory Mental Health Council to prepare a report on the cost of mental health parity. The following language appeared in the committee report to accompany the FY1993 Labor-HHS appropriations bill:²

The Committee appreciates the report of the National Advisory Mental Health Council entitled, "Mental Illness in America: A Series of Public Hearings," which includes a special recommendation on the need to provide coverage for severely mentally ill Americans under national health care reform. The Committee requests that the Council prepare a report on the cost of covering medical treatment for severe mental illness commensurate with other illnesses and an assessment of the efficacy of treatment of severe mental illness....The Committee further requests that this report be transmitted to the Committee prior to next year's hearings as authorized under section 406(g) of the Public Health Service Act.

The Council's report was published in the October 1993 issue of the *American Journal of Psychiatry*. The report concluded that with advances in the field of psychiatry, mental illnesses are now treatable, and that treatment of mental illness is cost-effective. Those arguments continue to be used by advocates for the mentally ill.

Bills and Resolutions.

S. 2696 (Equitable Health Care for Severe Mental Illnesses Act of 1992). Introduced by Senators Domenici and Danforth on May 12, 1992. S. 2696 stated that "persons with severe mental illnesses must not be discriminated against in the health care system; and health care coverage ... must provide for the treatment of severe mental illnesses in a manner that is equitable and commensurate with that provided for other major physical illnesses." To be considered nondiscriminatory and equitable, the bill mandated mental health coverage that "is not more restrictive than coverage provided for other major physical illnesses, provides adequate financial protection to the person requiring the medical treatment for a severe mental illness, and is consistent with effective and common methods of controlling health care costs for other major physical illnesses."

² S.Rept. 102-397, p. 96.

H.Con.Res. 296. Introduced by Representative Mike Kopetski on March 19, 1992. Expressed the sense of the Congress that equitable mental health benefits must be included in any health care reform legislation passed by the Congress.

S.Con.Res. 126. Introduced by Senator Shelby on June 24, 1992. Expressed the sense of the Congress that equitable mental health care benefits must be included in any health care reform legislation passed by the Congress.

Congressional Hearings.

No hearings were conducted.

Roll Call Votes.

No roll call votes were conducted.

103rd Congress (1993 — 1994)

Congressional lawmakers addressed mental health parity during the debate on the Clinton Administration's health care reform proposal in the 103rd Congress. The Clinton plan (introduced as H.R. 3600 and S. 1757) provided for limited coverage of mental illness as part of its benefit package, but included a phase-in of full parity by January 1, 2001. The bills reported by the Senate Committee on Labor and Human Resources (S. 2296) and the Senate Committee on Finance (S. 2351) both included provisions for establishing full parity, as did legislation reported by the House Committee on Education and Labor (H.R. 3600). Attempts to enact comprehensive health care reform ended on the Senate floor in August 1994. The full House did not debate health care reform legislation.

In 1993, Senator Domenici testified on discrimination in mental health coverage before the Senate Committee on Labor and Human Resources.

Congressional Hearings.

Senate Committee on Labor and Human Resources, May 13, 1993, Coverage of Mental and Addictive Disorders in Health Care Reform. Testimony by Tipper Gore (Chairperson, Mental Health Working Group, President's Health Care Reform Task Force), Senator Domenici, and health insurance representatives. [S.Hrg. 103-211]. In addition, the following five hearings held during the congressional debate on the Clinton health plan included testimony on mental health coverage and parity.

House Committee on Ways and Means, October 26, 1993. Testimony by the American Psychological Association. [Serial No. 103-90, pp. 245-294]

Senate Committee on Labor and Human Resources, November 8, 1993. Testimony by Representative Mike Kopetski and mental health professionals. [S.Hrg. 103-216, Pt. 2, pp. 104-156]

House Committee on Energy and Commerce, December 8, 1993. Testimony by mental health advocates and health insurance representatives. [Serial No. 103-91, pp. 232-286]

House Committee on Education and Labor, February 3, 1994. Testimony by the Bazelon Center for Mental Health Law. [Serial No. 103-62, pp. 22-73]

Senate Committee on Labor and Human Resources, March 8, 1994. Testimony by former First Ladies Betty Ford and Rosalynn Carter. [S.Hrg. 103-216, Pt. 4, pp. 562-581]

Roll call votes.

No roll call votes were conducted.

104th Congress (1995 — 1996)

Senators Domenici and Wellstone reintroduced the Equitable Health Care for Severe Mental Illnesses Act (S. 298) on January 31, 1995. Similar language was approved by the Senate on April 18, 1996, as an amendment to S. 1028, the Health Insurance Reform Act. The amendment was later dropped in conference. The conferees also rejected a partial parity amendment offered by Senators Domenici and Wellstone covering only annual and lifetime dollar limits. The legislation was signed into law, without any mental health parity provisions, as the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191).

On August 2, 1996, Senators Domenici and Wellstone introduced the Mental Health Parity Act (MHPA, S. 2031), which required parity only for annual and lifetime dollar limits. The bill, which included an exemption for employers with 25 or fewer employees, did not mandate mental health coverage. The parity provisions applied only to those group health plans that chose to provide mental health coverage. On September 5, 1996, Senators Domenici and Wellstone offered the MHPA as an amendment to the FY1997 VA-HUD appropriations bill (H.R. 3666). By voice vote, the Senate approved a second degree amendment offered by Senator Gramm, which exempted health plans from the MHPA parity requirement if the cost of compliance exceeded the original cost of coverage by 1%. The Senate approved the Domenici-Wellstone amendment, as amended, on a 82-15 vote. During conference, the House conferees agreed to the parity amendment. MHPA became Title VII of the FY1997 VA-HUD appropriation bill, which was signed into law on September 26, 1996 (P.L. 104-204). MHPA amended both the Employee Retirement Income Security Act (ERISA) and the Public Health Service (PHS) Act.³ During the 105th Congress (discussed below), the MHPA provisions were added to the Internal Revenue Code (IRC) by the Taxpayer Relief Act of 1997. By amending all three federal statutes (i.e., ERISA, the PHS Act, and the IRC), the MHPA standards apply to a broad range of group health plans, as well as state-licensed health insurance organizations. More details on the parity legislation and related roll call votes in the 104th Congress are provided below.

³ P.L. 104-204, Title VII, codified at 29 U.S.C. 1185a and 42 U.S.C. 300gg-5.

Bills and Resolutions.

S. 298 (Equitable Health Care for Severe Mental Illnesses Act of 1995). Introduced by Senators Domenici and Wellstone on January 31, 1995. Required that “persons with severe mental illnesses must not be discriminated against in the health care system, and health care coverage ... must provide for the treatment of severe mental illnesses in a manner that is equitable and commensurate with that provided for other major physical illnesses.”

S. 2031 (Mental Health Parity Act of 1996). Introduced by Senators Domenici and Wellstone on August 2, 1996. Required parity for annual and lifetime dollar limits on coverage in group health plans that offer mental health benefits.

H.R. 4045 (National Mental Health Parity Act of 1996). Introduced by Representative Pete Stark on September 10, 1996. Amended the IRC to require group health plans to provide full parity for coverage of all conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV).⁴ Amended the Medicare statute to restructure the mental health benefit.

H.R. 4058 (Mental Health Parity Act of 1996). Introduced by Representative Marge Roukema on September 11, 1996. Same provisions as S. 2031, plus the 1% compliance cost exemption.

H.R. 4135 (Newborns and Mothers Health Protection and Mental Health Parity Implementation Amendments of 1996). Introduced by Representatives Bill Thomas and Pete Stark, September 24, 1996. Amended the IRC to incorporate the MHPA provisions.

Congressional Hearings.

No hearings were conducted.

Roll Call Votes.

April 18, 1996. On a vote of 30-68 the Senate rejected an amendment by Senator Kassebaum to table the Domenici parity amendment to S. 1028. The Domenici amendment was subsequently adopted by voice vote.

September 5, 1996. The Senate voted 82-15 to adopt the Domenici parity amendment to the FY1997 VA-HUD appropriations bill (H.R. 3666). Note: immediately prior to this vote the Senate had voted 75-22 to table a second-degree amendment to the Domenici amendment offered by Senator Brown.

August 1, 1996. On a vote of 198-228 the House rejected a motion by Representative Pete Stark to recommit the conference report for H.R.3103 (i.e.,

⁴ The DSM, produced by the American Psychiatric Association, is a comprehensive system of diagnosis for psychiatric conditions. The fourth and current edition was published in 1995 and is available at [<http://www.psych.org/research/dor/dsm/index.cfm>].

HIPAA) to the committee, with instructions to the House managers to improve mental health coverage while minimizing the impact on the cost or availability of insurance.

September 11, 1996. The House voted 392-17 to adopt a motion by Representative Louis Stokes to instruct the House conferees for H.R. 3666 (i.e., FY1997 VA-HUD appropriations), among other things, to agree to the Senate mental health parity provisions.

105th Congress (1997 — 1998)

On June 24, 1997, during the Senate floor debate on the Balanced Budget Act of 1997 (P.L. 105-33; August 5, 1997), Senators Wellstone and Domenici introduced an amendment requiring State Childrens' Health Insurance Plan (SCHIP) plans that offer mental health benefits to provide full-parity coverage. The amendment was agreed to by voice vote, but later rejected in conference. However, the conferees accepted language requiring all SCHIP plans and Medicaid managed care plans to meet the requirements of the MHPA.⁵

Section 1531(a)(4) of the Taxpayer Relief Act of 1997 (P.L. 105-34; August 5, 1997) added the MHPA provisions to the Internal Revenue Code (IRC).⁶ Two parity bills were introduced in the House (see below), but there was no further legislative activity nor any hearings on mental health parity during the 105th Congress.

Bills and Resolutions.

H.R. 621 (National Mental Health Parity Act of 1997). Introduced by Representative Pete Stark on February 5, 1997. Same language as H.R. 4045 in the 104th Congress.

H.R. 3568 (Mental Health and Substance Abuse Parity Amendments of 1998). Introduced by Representative Marge Roukema on March 26, 1998. Amended the MHPA provisions in ERISA, the IRC and the PHS Act to require full parity for mental health and substance abuse benefits in group health plans that offer such coverage.

Congressional Hearings.

No hearings were conducted.

Roll Call Votes.

No roll call votes were conducted.

⁵ P.L. 105-33, Sections 4704(a) and 4901, codified at 42 U.S.C. 1396u-2(b)(8) and 42 U.S.C. 1397cc(f)(2), respectively.

⁶ P.L. 105-34, Section 1531(a)(4), codified at 26 U.S.C. 9812.

106th Congress (1999 — 2000)

Four mental health parity bills were introduced (or reintroduced) during the 106th Congress, but none saw any legislative action. In 1999, President Clinton directed the Office of Personnel Management (OPM) to implement full parity for mental health benefits in health plans offered under the Federal Employees Health Benefits Program (FEHBP). This required plans participating in FEHBP to cover medically necessary treatment for all categories of mental illness listed in the DSM-IV. The Senate Committee on Health, Education, Labor, and Pensions held a parity hearing on May 18, 2000.

Bills and Resolutions.

S. 796 (Mental Health Equitable Treatment Act of 1999). Introduced by Senators Domenici and Wellstone on April 14, 1999. Amended the MHPA provisions in ERISA and the PHS Act to require parity with respect to the number of inpatient days and outpatient visits covered for mental illness, but to require full parity for a categorical list of severe biologically based mental illnesses.

H.R. 1515 (Mental Health and Substance Abuse Parity Amendments of 1999). Introduced by Representative Marge Roukema on April 21, 1999. Same language as H.R. 3568 in the 105th Congress.

H.R. 2445 (Mental Health Parity Enhancement Act of 1999). Introduced by Representative Carolyn Maloney on July 1, 1999. Amended the MHPA provisions in ERISA, the IRC and the PHS Act to require parity with respect to treatment limitations.

H.R. 2593 (National Mental Health Parity Act of 1999). Introduced by Representative Pete Stark on July 22, 1999. Same language as H.R. 621 in the 105th Congress.

Congressional Hearings.

Senate Committee on Health, Education, Labor, and Pensions, May 18, 2000, Mental Health Parity. Witnesses included Senator Wellstone, Government Accountability Office (Report GAO/HEHS-00-95), and the National Institute of Mental Health. [S.Hrg. 106-582]

Roll Call Votes.

No roll call votes were conducted.

107th Congress (2001 — 2002)

With MHPA due to sunset on September 30, 2001, Senators Domenici and Wellstone reintroduced the Mental Health Equitable Treatment Act (S. 543) on March 15, 2001. S. 543 amended the MHPA provisions in ERISA and the PHS Act,

requiring full parity for all DSM-IV diagnoses. The Senate HELP Committee held a hearing on mental health parity on July 11, 2001, at which Senator Wellstone testified. On August 1, 2001, the Committee approved unanimously a substitute version of S. 543 that included compromise language protecting the ability of health plans to use managed care techniques and raising the small-employer exemption from 25 to 50 workers (same as MHPA). On October 30, 2001, Senators Domenici and Wellstone offered S. 543, as reported, as an amendment (S.Amdt. 2020) to the FY2002 Labor-HHS appropriations bill (H.R. 3061), which the Senate approved by voice vote.

The House version of H.R. 3061 did not include any parity language. On December 18, 2001, the House conferees rejected on a party-line vote Representative Patrick Kennedy's motion to accept the Domenici-Wellstone mental health parity amendment. However, the conference approved a motion by Representative Duke Cunningham to include language in the bill reauthorizing the MHPA through December 31, 2002. Conferees added language to the conference report (H.Rept. 107-342; December 19, 2001) "strongly urging the committees of jurisdiction in the House and Senate to convene early hearings and undertake swift consideration of legislation to extend and improve mental health parity protections during the second session of the 107th Congress."

During 2002, both the House Committee on Education and the Workforce and the Committee on Energy and Commerce held hearings on mental health parity, but there was no further action taken on the three parity bills introduced in the House (see below). In two separate legislative actions, Congress reauthorized the MHPA through December 31, 2003. Section 610 of the Job Creation and Worker Assistance Act of 2002 (H.R. 3090, P.L. 107-147) amended the MHPA provisions in the IRC, and the Mental Health Parity Reauthorization Act of 2002 (H.R. 5716, P.L. 107-313) reauthorized the MHPA provisions in ERISA and the PHS Act. H.R. 5716 was introduced by Representative John Boehner on November 13, 2002, and approved without objection by the full House on November 15, 2002. That same day the Senate received and passed the measure by unanimous consent.

Bills and Resolutions.

S. 543 (Mental Health Equitable Treatment Act of 2001). Introduced by Senators Domenici and Wellstone on March 15, 2001. Senate HELP Committee hearing on July 11, 2001. Committee markup, August 1, 2001, at which the committee approved a substitute version of the bill by a vote of 21-0 (S.Rept. 107-61, Sept. 6, 2001).

H.R. 162 (Mental Health and Substance Abuse Parity Amendments of 2001). Introduced by Representative Marge Roukema on January 3, 2001. Same language as H.R. 1515 in the 106th Congress.

H.R. 2992 (Mental Health Parity Enhancement Act of 2001). Introduced by Representative Carolyn Maloney on October 2, 2001. Same language as H.R. 2445 in the 106th Congress.

H.R. 4066 (Mental Health Equitable Treatment Act of 2002). Introduced by Representative Marge Roukema on March 20, 2002. Same language as S. 543, as reported by committee.

Congressional Hearings.

Senate Committee on Health, Education, Labor, and Pensions, July 11, 2001, Achieving Parity for Mental Health Treatment. Witnesses included the American Psychiatric Association, Magellan Health Services, and the Office of Personnel Management. [S.Hrg. 107-184]

House Committee on Education and the Workforce, Subcommittee on Employer-Employee Relations, March 13, 2002, Assessing Mental Health Parity: Implications for Patients and Employers. Witnesses included Representatives Marge Roukema and Patrick Kennedy, the American Managed Behavioral Healthcare Association, and the ERISA Industry Committee (ERIC). [Serial No. 107-51]

House Committee on Energy and Commerce, Subcommittee on Health, July 23, 2002, Insurance Coverage of Mental Health Benefits. Witnesses included the American Psychiatric Association, the American Association of Health Plans, and the National Association of Manufacturers. [Serial No. 107-118]

Roll Call Votes.

No roll call votes were conducted.

108th Congress (2003 — 2004)

The 108th Congress extended the MHPA through the end of 2005. First, the Mental Health Parity Reauthorization Act of 2003 (S. 1929, P.L. 108-197) reauthorized the MHPA through December 31, 2004. The bill was introduced by Senator Gregg on November 21, 2003, approved in the Senate by unanimous consent the same day, and passed the House without objection on December 8, 2003. It amended the MHPA provisions in ERISA and the PHS Act, but not the IRC. Secondly, Section 302 of the Working Families Tax Relief Act of 2004 (H.R. 1308, P.L. 108-311) reauthorized the MHPA through December 31, 2005. P.L. 108-311 amended the MHPA provisions in all three statutes.

Bills and Resolutions.

S. 10 (Health Care Coverage Expansion and Quality Improvement Act of 2003). Introduced by Senator Daschle on January 7, 2003. Title II incorporated the Mental Health Equitable Treatment Act (same language as S. 543, as reported by committee, in the 107th Congress).

H.R. 953/S. 486 (Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003). Introduced by Representatives Patrick Kennedy and Jim Ramstad and by Senators Domenici and Kennedy on February 27, 2003. Same language as S. 543, as reported by committee, in the 107th Congress.

S. 1832 (Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003). Introduced by Senator Daschle on November 6, 2003. Same language as S. 486.

Congressional Hearings.

No hearings were conducted.

Roll call Votes.

No roll call votes were conducted.

109th Congress (2005 — 2006)

The 109th Congress further extended the MPHA through the end of 2007. In the first session of the 109th Congress, the Employee Retirement Preservation Act (H.R.4579, P.L. 109-151) extended the provisions requiring mental health parity in ERISA, the PHS Act, and the IRC through 2006. H.R. 4579 passed the House by voice vote on December 17, 2005, and passed the Senate by unanimous consent on December 22, 2005. In the second session, Section 115 of the Tax Relief and Health Care Act of 2006 (H.R. 6111, P.L. 109-432) extended the MPHA provisions in all three statutes through 2007.

Bills and Resolutions.

H.R. 1402 (Paul Wellstone Mental Health Equitable Treatment Act of 2005). Reintroduced by Representatives Patrick Kennedy and Jim Ramstad on March 17th, 2005. No legislative action was taken on this bill, and no corresponding legislation was introduced in the Senate.

Congressional Hearings.

No hearings were conducted.

Roll call Votes.

No roll call votes were conducted.

Appendix A. Medicare Mental Health Legislation

This section lists bills that focus solely on Medicare mental health. None of these bills became law.

95th Congress

H.R. 13460 (Mental Health Amendments of 1978). Introduced by Representative Claude Pepper on July 13, 1978. Provided coverage for mental illness on the same basis as coverage for physical illness under Medicare and provided coverage for certain psychologic services under the supplementary medical insurance benefits program.

96th Congress

H.R. 640 (Mental Health Amendments of 1979). Introduced by Representative Claude Pepper on January 15, 1979. Provided coverage for mental illness on the same basis as coverage for physical illness under Medicare and provided coverage for certain psychologic services under the supplementary medical insurance benefits program.

104th Congress

H.R. 1456 (Medicare Mental Health Improvement Act). Introduced by Representative Pete Stark on April 6, 1995. Provided expanded coverage of mental health and substance abuse services under Medicare.

106th Congress

S. 3233 (Medicare Mental Health Modernization Act of 2000). Introduced by Senator Wellstone on October 25, 2000. Replaced the 50% coinsurance for outpatient psychiatric services with the 20% coinsurance required for all other Medicare part B services. Added community-based and residential services to the Medicare mental health benefit package and expanded the number of mental health professionals eligible to provide services through Medicare to include clinical social workers and licensed professional mental health counselors.

107th Congress

H.R. 1522/S. 690 (Medicare Mental Health Modernization Act of 2001). Introduced by Representative Pete Stark and Senator Wellstone on April 4, 2001. Replaced the 50% coinsurance for outpatient psychiatric services with the 20% coinsurance required for all other Medicare part B services. Added community-based and residential services to the Medicare mental health benefit package and expanded the number of mental health professionals eligible to provide services through Medicare to include clinical social workers and licensed professional mental health counselors.

108th Congress

H.R. 1340/S. 646 (Medicare Mental Health Modernization Act of 2003). Introduced by Representative Pete Stark and Senator Corzine on March 18, 2003. Replaced the 50% coinsurance for outpatient psychiatric services with the 20% coinsurance required for all other Medicare part B services. Added community-based and residential services to the Medicare mental health benefit package and expanded the number of mental health professionals eligible to provide services through Medicare to include clinical social workers and licensed professional mental health counselors.

H.R. 2787/S. 853 (Medicare Mental Health Copayment Equity Act of 2003). Introduced by Representative Ted Strickland on July 17, 2003, and by Senator Snowe on April 10, 2003. Replaced the 50% coinsurance for outpatient psychiatric services with the 20% coinsurance required for all other Medicare part B services.

109th Congress

H.R. 1946/S. 927 (Medicare Mental Health Modernization Act of 2005). Introduced by Representative Pete Stark and Senator Corzine on April 27, 2005. Eliminates lifetime limit on inpatient mental health services, provides for parity in treatment for outpatient mental health services, coverage of intensive residential services under Medicare part A (Hospital Insurance) and of intensive outpatient services under Medicare part B (Supplementary Medical Insurance); excludes clinical social worker services from coverage under the Medicare skilled nursing facility prospective payment system. Added coverage of marriage and family therapist services and mental health counselor services under Medicare.

H.R. 1125/S.1152 (Medicare Mental Health Copayment Equity Act of 2005). Introduced by Representative Ted Strickland on March 3, 2005, and by Senator Snowe May 26, 2005. Provides for a gradual reduction (from 50 percent to the standard 20 percent) by 2009 of copayment rates for outpatient psychiatric services under the Medicare program.

Table 1 compares the state parity laws with FEHBP, and includes the following information. First, it summarizes the type of parity law (full parity, minimum mandated, or mandated offering). States that have full parity require annual and lifetime limits, treatment limitations, and coinsurance and copayments for mental health coverage to be on par with that for other physical illnesses. Second, the table compares the kinds of health insurance plans that are covered by the different states' parity laws. They could include health maintenance organizations (HMO), groups plans, individual plans, and state employee plans⁷. In 4 states, mental health parity laws apply only to plans that cover state employees. Third, the table compares the types of mental illness covered by the states' parity laws. Some states require coverage for all illness listed in the DSM-IV. Others require coverage for biologically based mental illness, severe mental illness, or serious mental illness.⁸ Fourth, the table summarizes whether the financial and treatment limitations on mental health coverage are required to be equal to that for other physical illnesses. Finally, the table lists criteria under which certain employers and insurers may be exempt from the requirements of the state parity laws. Not all state statutes specify all the requirements compared in the table. In instances where the criteria are unspecified, this information is noted in the table.

⁷ **HMOs** are managed care organizations that provide health insurance coverage through hospitals, doctors, and other providers with which the HMO has a contract.

Group Insurance: A group is the master insured and the insurance company contracts with the group. Insurance certificates, issued to participating members, act as their policy.

Individual Insurance: Individual plans are those purchased by an individual directly with the insurance company.

State Employee Plan: Plan that covers state employees.

⁸ **Biological:** There are 13 DSM-IV diagnoses commonly referred to as biologically-based mental illnesses by mental health providers and consumer organizations. However, DSM-IV itself does not distinguish between biologically-based and other types of mental illness.

Severe Mental Illness: Different states define this term slightly differently. Most include, under this category, schizophrenia, schizoaffective disorder, bipolar mood disorder, major depression, obsessive compulsive disorder, and delusional disorder.

Serious Mental Illness: Mental illnesses which are of sufficient severity to result in substantial interference with the activities of daily living. This includes schizophrenia, schizoaffective disorder, and bipolar mood disorder.

Table B: Comparison of FEHB and State Parity Laws

State	Type of Benefit	Plans Covered ^a	Illnesses Covered	Lifetime/Annual Limits	Copayments & Coinsurance	Treatment Limits Inpatient Outpatient		Exemptions ^b
FEHB	Full Parity	1,2	DSM-IV	Equal	Equal	Equal	Equal	2
AR	Full Parity	1,2	DSM-IV	Equal	Equal	Equal	Equal	1,2
AL	Mandated Offering	1	DSM-IV	Equal	Equal	Equal	Equal	1
AK	Minimum Mandated	2	DSM-IV	Equal	Equal	Equal	Equal	1,2
AZ	Mandated Offering	1,2,3,4	DSM-IV	Equal	Unequal	Unspecified	Unspecified	
CA	Full Parity	1,2,3	Severe Mental Illness	Equal	Equal	Equal	Equal	
CO	Full Parity	2	Biological	Equal	Equal	Equal	Equal	
CT	Full Parity	2,3	DSM-IV	Equal	Equal	Equal	Equal	
DE	Full Parity	1,2,3,4	Serious Mental Illness	Equal	Equal	Equal	Equal	
DC	Mandated Offering	2,3	DSM-IV	Equal	Equal	Equal	Equal	2
FL	Mandated Offering	1,2	DSM-IV	Unspecified	Unspecified	Unequal	Unequal	
GA	Mandated Offering	2,3	DSM-IV	Equal	Equal	Unequal	Unspecified	
HI	Full Parity	2,3	DSM-IV	Equal	Equal	Equal	Equal	
ID	Full Parity	4	Serious Mental Illness	Equal	Equal	Equal	Equal	
IL	Full Parity	2	Serious Mental Illness	Equal	Equal	Equal	Equal	1
IN	Mandated Offering	1,2,3,4	DSM-IV	Equal	Equal	Equal	Equal	2
IA	Full Parity	2	Biological	Equal	Equal	Equal	Equal	1
KS	Mandated Offering	1,2,4	DSM-IV	Unspecified	Equal	Unequal	Unspecified	
KY	Mandated Offering	2	DSM-IV	Equal	Equal	Equal	Equal	1
LA	Mandated Offering	1,2,4	DSM-IV	Equal	Equal	Unequal	Unequal	1,2
ME	Full Parity	1,2	DSM-IV	Equal	Equal	Equal	Equal	1
MD	Minimum Mandated	1,2,3	DSM-IV	Equal	Equal	Equal	Unequal	
MA	Full Parity	1,2,3,4	Biological	Equal	Equal	Equal	Equal	1
MI	Minimum Mandated	1,2,3	DSM-IV	Unspecified	Equal	Unequal	Unequal	2
MN	Full Parity	1	DSM-IV	Equal	Equal	Equal	Equal	
MS	Mandated Offering	2,3	DSM-IV	Equal	Equal	Unequal	Unequal	2
MO	Mandated Offering	1,2,3	DSM-IV	Unequal	Unequal	Unequal	Unequal	
MT	Full Parity	2,3	Severe Mental Illness	Equal	Equal	Equal	Equal	
NE	Mandated Offering	1,2	Serious Mental Illness	Equal	Equal	Unequal	Unequal	1,2
NV	Minimum Mandated	1,2,3	Severe Mental Illness	Equal	Unequal	Equal	Unspecified	1,2
NH	Full Parity	1,2,3,4	Biological	Equal	Equal	Equal	Equal	
NJ	Full Parity	2,3,4	Biological	Equal	Equal	Equal	Equal	
NM	Mandated Offering	2	Biological	Equal	Equal	Equal	Equal	
NY	Full Parity	1,2,3	Biological	Equal	Equal	Equal	Equal	1,2
NC	Full Parity	2	DSM-IV	Equal	Equal	Equal	Equal	
ND	Minimum Mandated	4	DSM-IV	Unequal	Unspecified	Unequal	Unequal	
OH	Full Parity	2,3	Biological	Unspecified	Unequal	Equal	Equal	2
OK	Full Parity	2	Severe Mental Illness	Equal	Equal	Equal	Equal	1,2
OR	Minimum Mandated	1,2,3	DSM-IV	Unequal	Unequal	Unequal	Unequal	
PA	Minimum Mandated	1,2	Serious Mental Illness	Equal	Unequal	Unequal	Unspecified	1
RI	Full Parity	1,2,3	Serious Mental Illness	Equal	Equal	Equal	Equal	
SC	Full Parity	4	DSM-IV	Equal	Equal	Equal	Equal	
SD	Full Parity	1,2,3	Biological	Equal	Equal	Equal	Equal	
TN	Minimum Mandated	2	DSM-IV	Equal	Equal	Unequal	Unequal	1,2
TX	Minimum Mandated	1,2,4	Serious Mental Illness	Equal	Equal	Unequal	Unspecified	1
UT	Mandated Offering	1,2	DSM-IV	Unequal	Unequal	Unspecified	Unspecified	
VT	Full Parity	2,3,4	DSM-IV	Equal	Equal	Equal	Equal	
VA	Full Parity	2,3	Biological	Equal	Equal	Equal	Equal	
WA	Full Parity	1,2	DSM-IV	Equal	Equal	Equal	Equal	
WV	Full Parity	4	DSM-IV	Equal	Unspecified	Equal	Equal	1,2
WI	Mandated Offering	2	DSM-IV	Unequal	Unequal	Unequal	Unequal	
WY	No parity law							

Table Notes:

a. Plans covered by state law.

1 = Health Maintenance Organizations (HMO)

2 = Group Insurance

3 = Individual Insurance

4 = State Employee Plans

b. Exemptions.

1 = Small employer: Employers with fewer than a given number of employees, which ranges from 10 to 51, may be exempt from the mental health parity requirements.

2 = Increases cost by a given %: If a health plan demonstrates that providing parity mental health coverage raises the premium cost by more than a given %, they may be exempt from the mental health parity requirements