A Family Perspective of the Mental Health Parity Act

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Abstract:

Recognizing the important link between mental and physical health and the tendency to focus resources on improving physical health, Congress approved the Mental Health Parity Act (MHPA) in 1996 and states began implementation in 1998. The MHPA legislation focuses on catastrophic benefits, which means that it prevents insurance companies from setting limits on annual or lifetime coverage for the treatment of mental illness that differ from the limits on physical illness. Because financial, emotional, and other responsibilities come into play in treating the mentally ill, analyzing the MHPA for its family impact sheds light on the degree to which the legislation is supportive of the many functions that families perform for their members. The intended purpose of the 1996 Mental Health Parity Act was to address the inequities of mental health insurance coverage where it exists, not to address the thorny question the scope or adequacy of mental health insurance coverage. While the MHPA ensures that insurance companies cannot discriminate between mental and physical health coverage in setting lifetime limits, it does little to address larger, more troubling questions of meeting the mental health care needs of many families.

Introduction

According to a study commissioned by the World Health Organization and the World Bank, “Four of the ten leading causes of disabilities among individuals five years and older are mental health disorders” (Murray & Lopez, 1996). Recognizing the important link between mental and physical health and the tendency to focus resources on improving physical health, Congress approved the Mental Health Parity Act (MHPA) in 1996 and states began implementation in 1998.

The MHPA legislation focuses on catastrophic benefits, which means that it prevents insurance companies from setting limits on annual or lifetime coverage for the treatment of mental illness that differ from the limits on physical illness. Although passage of the MHPA in 1996 put mental health care concerns “on the map” for policy makers, many families dealing with mental health issues continue to face limited access to care and financial options (US Department of Health and Human Services, 1999). Using the Family Impact Checklist this paper focuses specifically on the ways the Mental Health Parity Act may impact families.

Background

Epidemiological surveys indicate that in any given year 20% of Americans suffer from a mental disorder and 15% of the adult population use mental health services. Among developed nations, major depression is the leading cause of disability, and untreated or under-treated mental illness is one of the leading causes of preventable death worldwide (US Department of Health and Human Services, 1999).

In 1996, the cost for direct treatment of mental disorders for Americans totaled $69 billion. With the implementation of managed health care, mental health care spending has declined as a percentage of overall health care in the past decade. One the one hand, this decline has been due to improvement in the efficiency of mental health care delivery. Yet spending decreases have resulted in increased barriers to service access and subsequent reliance on non-mental health public human services (US Department of Health and Human Services, 1999).

Currently, in the United States, diagnosis and treatment for mental health disorders are outpacing the ability to deliver care to all those who might benefit from it. Inequities in insurance coverage for mental health care and the long-standing stigma associated with mental health disorders have prompted legislation directed at producing changes in the way mental health care is financed in the attempt to create parity with the way physical health care is handled.

Legislation

Although the Mental Health Parity Act (MHPA) requires parity with regard to setting lifetime coverage limits, it does not require group health plans or those who issue insurance to these plans to provide mental health coverage. Employers with fewer than 50 employees are also exempt from the law. In addition, parity provisions do not apply to other forms of benefit limits, such as per episode limits on length of stay or visit limits, co-payments deductibles. Lastly, the MHPA allows an insurer to apply for exemption if implementation causes the insurer to experience more than a 1% rise in premiums (US Department of Health and Human Services, 1999).

State efforts in dealing with mental health parity have paralleled those at the federal level. States that have enacted parity statutes to match the Federal Mental Health Parity Act include Arizona, Delaware, Louisiana, Montana, Nevada, and Tennessee. However, 33 states have implemented parity in a variety of ways, including staged implementation. To give a sense of the breadth and range of programming variability across the U.S., consider, for example, that state parity legislation has been constructed to include only individuals suffering from severe mental disorders or “biologically-based brain disorders,” while other legislation includes parity for treatment of substance abuse. Some states have separated care for mental illness from care for substance abuse and mandated parity for both. Lastly, while some states have focused on broadly insured populations, others have focused on a single population (Bazelon Center for Mental Health Law, 2000; US Department of Health and Human Services, 1999). Thus, there is clearly room for the intent of the federal law to be interpreted and implemented in varying ways.

In October 2001, the U.S. Senate accepted the provisions of S.543, the Mental Health Equitable Treatment Act, as an amendment to the FY 2002 Labor-HHS-Education Appropriations bill (H.R. 3061). The sponsors of the parity amendment, Senators Pete Domenici (R-NM), Paul Wellstone (D-MN), Ted Kennedy (D-MA), and Harry Reid (D-NV), sought to extend the protections and close the loopholes in the 1996 Mental Health Parity Act by preventing insurers from establishing higher deductibles or co-payments for mental health benefits than for other medical conditions.

The sponsors also made an effort to prohibit restrictions on the number of outpatient visits and length of hospital stays. The amendment failed to pass a House-Senate conference committee. A major stumbling block for the proposed amendment was determining which mental illnesses should be covered: should the law include all mental illness or only severe mental illness? Lawmakers agreed to an amendment that extends the current 1996 Mental Health Parity Act for one year and in April 2002, President Bush called on Congress to approve a mental health parity bill within the year.

Family Impact Analysis

Mental illness and treatment are issues that impact not only the individual affected, but often extend to a larger network of familial connections. Because financial, emotional, and other responsibilities come into play in treating the mentally ill, analyzing the MHPA for its family impact may shed light on the degree to which the legislation is supportive of the many functions that families perform for their members. The Family Criteria (Ad Hoc) Task Force of the Consortium of Family Organizations (COFO) developed a checklist for assessing the intended and unintended impact of public policies, proposals, and social programs on families. This checklist, which was later revised by the Policy Institute for Family Impact Seminars (see Bogenschneider, 2002), outlines six principles to guide analyses of the family supportiveness of policies and programs: 1) Family support and responsibilities, 2) Family membership and stability, 3) Family involvement and interdependence, 4) Family partnership and empowerment, 4) Family diversity, and 5) Support of vulnerable families (Bogenschneider, Friese, & Mills, 2001).

Principle #1-Family support and responsibilities

- Does the policy support and supplement parents' and other family members' ability to carry out their responsibilities?

The Mental Health Parity Act may have a positive impact on parents' and other family members' ability to carry out their responsibilities to one another. By prohibiting insurance companies from setting limits on coverage for treatment of mental illness different from those for physical illness, MHPA may allow families more leeway to seek treatment for family members with mental illness without the fear of the financial repercussions of catastrophic medical costs. Although the Mental Health Parity Act is directed toward individual family members, it can be argued that families as a whole can benefit. Enforcement of this act may enable parents to provide economic support and adequate protection for their children in the event of mental illness in the family.

This being said, exemptions to the Mental Health Parity Act may play an important role in the impact mental illness and its treatment has on families. For example, one of the key exemptions of the legislation is that employers who provide health care coverage for their employees and insurance companies who write health care insurance policies are not required to offer mental health care coverage. Although some physical illnesses are exempt from health insurance coverage, these are usually a single illness and not an entire group of illnesses.

Families may be forced to pay large out-of-pocket fees for members who suffer from mental illness if there is no insurance coverage for treatment, thus putting the family at financial risk. The associated emotional and psychological strain of both living with and treating mental illness in the family may have a profound impact on family members' ability to care for one another, and may place substantial stress on family relationships.

A second exemption places no requirement for employers of 50 workers or less to offer mental health coverage to their employees. Individuals who work for small companies may face grave financial consequences if they become mentally ill. In turn, families who depend on the contributions of the wage earner may face increased financial difficulty if the wage earner or a family member requires treatment for a mental illness and no coverage is offered. These two exemptions may set unrealistic expectations for families to assume financial responsibilities for the person with mental illness.

In addition, parity provisions do not apply to benefit limits set on per episode, length of stay, co-payment, or deductibles. While individuals with physical illnesses can visit their health care provider as many times as is deemed necessary, individuals with mental illness may be restricted in the number of visits they can make to a health care provider or the length of time they can be treated in an inpatient setting. If an individual family member is suffering from a mental illness and restricted or denied access to proper treatment because of mental health insurance coverage limits, there may be unrealistic expectations placed of families to assume caregiving responsibilities for the seriously ill family member.

Principle #2-Family membership and stability

- Does the policy strengthen marital commitment or parental obligation?

The focus of the MHPA is to assure individuals, who may be members of families, that there would be no discrimination in limits on benefits paid for mental health care that differed from those for physical health care. Complete mental health parity could support family stability by providing the same level of coverage for the treatment of mental illness that is provided for treatment of physical illness. Adequate mental health care coverage may assist in keeping the family together by easing some of the financial burden families experience when a family member is diagnosed and treated for a mental illness.

According to a report by the American Academy of Pediatrics, 66% of children under 21 are privately insured by plans purchased by their families (AAP, 2001). If insurers set limits on mental health coverage for these dependents, families with mentally ill children could experience both financial and emotional difficulty. By requiring parity, the MHPA may assist in maintaining family stability in the face of such situations.

Principle #3-Family involvement and interdependence

- To what extent does the policy recognize the reciprocal influence of family needs on individual needs, and the influence of individual needs on family needs?

Insurance policies which set limits on number of visits made to mental health care providers, or limit the number of days a mentally ill individual can be hospitalized may not recognize the complexity and responsibility involved in caring for a family member with special needs. There is no provision in the Mental Health Parity Act that provides for any assistance to families who are caring for a member with mental illness when an imposed limit has been met. In the case of individuals with mental illness who may become violent to others or themselves, limiting access to care may place the safety of the family and the public in jeopardy.

Family members caring for an individual with mental illness may find it difficult to assess and balance the competing needs, rights, and interests of other family members; this in turn can impact family stability. When treatment sessions are limited, options for caring for an individual family member with mental illness become restricted. These restrictions may come at a high personal cost for other family members. In addition, charging co-payment or deductible fees that differ from those charged for physical illnesses may financially destabilize the family.

The Mental Health Parity Act makes no provisions to involve immediate and extended families in caring for the mentally ill, which is one indicator of family-friendliness. Additionally, it does not provide resources or incentives for building informal support networks to assist mentally ill individuals and their families.

Because the act is focused on individuals, it does little to address the rights and safety of families, nor to recognize the reciprocal influence of family needs on individuals and vice versa. The conflict between individuals and families can be particularly important if legislation covers some mental health services (e.g., institutionalization) and not others (e.g., day treatment). Family involvement is essential for mental health decisions like compliance with mental health treatment or institutionalization. Carefully designed legislation that magnifies rather than minimizes family involvement can help reduce the mistakes made half a century ago in the treatment of mental illness. Child therapists wrote of their frustration when they would cure a child's emotional problems and then send the child home to the family and neighborhood that had contributed to the problem in the first place (Bogenschneider, Smalls and Riley, 1990). Allowing coverage for family-oriented interventions and family therapy may prove a wise and cost-effective investment. All of these elements contribute to family involvement and interdependence, and are subject to strain without adequate attention or support.

This may potentially be an important omission given evidence on the value of social support. Social ties, particularly marriage and family relationships, benefit health (Doherty, 2002). The absence of social support has been shown to have as potent an effect on health as cigarette smoking (House et al, 1988). In fact, social isolation has proven to be one of the strongest predictors of child abuse (Werner and Smith, 1982). Policies can create formal structures to encourage people to develop and rely on their own sources of

social support, which in the future could render the formal programs less necessary (Bronfenbrenner and Weiss, 1983).

Principle #4-Family partnership and empowerment

- In what specific ways does the policy or program provide full information and a range of choices to families? In what ways does it prevent participating families from being devalued, stigmatized, or subjected to humiliating circumstances?

Mental illness does not occur in a vacuum any more than does physical illness. Families affect and are affected by mental illness. The Mental Health Parity Act can assist individuals and families with the choices they make about long-term care by insisting that annual and lifetime coverage is the same as treatment for physical illness. Since length of treatment for mental illness is as difficult to predict as for chronic physical illness, families who have mental health care coverage can be assured that the family member with mental illness will be provided care until a certain monetary limit has been reached. This may allow time to develop alternative treatment plans.

However, the Mental Health Parity Act does little to prevent families from feeling devalued or stigmatized. Although insurance companies or employers who provide this coverage cannot discriminate against individuals in setting annual or lifetime mental health care coverage, exemptions to the act do nothing to remove the stigma placed on individuals with mental illness and their families. Not requiring employers to cover mental health care, setting co-pay and deducible fees higher than fees for physical illness, and setting limits on health care visits may serve to devalue the individual with mental illness and the family who provides care.

Where family representatives were included in the development of the Mental Health Parity Act is unclear. Because the act will be reconsidered this year, one way to ensure that family concerns are represented would be to include patients and their families in the development and planning for proposed policy changes.

Principle #5-Family diversity

- How does the policy or program identify and respect the different values, attitudes, and behavior of families from various racial, ethnic, religious, cultural, and geographic backgrounds that are relevant to program effectiveness?

The Mental Health Parity Act is focused on the individual and does not intentionally discriminate against any particular type of family structure. However, exemptions to the act can pose increased stress on certain types of families. The Mental Health Parity Act is designed to help employed persons, persons who are employed by large companies, and persons with mental health coverage. Yet the law's insufficient attention to the web of relationships in which individuals live may mean that both the well-being of individuals and their families receives inadequate consideration. For example, a single parent who is the sole support of the family and works for a small company (<50 employees) may not receive any personal mental health coverage, even though adequate treatment might ensure both financial and emotional support for the child. By extension, a child showing

signs of mental distress who is being cared for by parents without mental health coverage may not be able to obtain the necessary treatment that could improve the child's quality of life, help avert a more serious condition, and indirectly improve the families' quality of life.

Principle #6-Support of vulnerable families

- Does the policy or program give support to families who are most vulnerable to breakdown and have the fewest resources?

One apparent shortcoming of the Mental Health Parity Act is its failure to recognize the needs of the most vulnerable families. For those families with greatest economic or social needs or those without insurance, the MHPA may do little to support family strength or functioning. For example, the act does not address the needs of families whose parents are unemployed or under-employed, who work for small companies, or for companies that do not provide mental health care benefits. The Mental Health Parity Act does not take into account families living in poverty or just above the poverty line. Poverty brings with it a plethora of social needs and families may become vulnerable to breakdown. The Mental Health Parity Act provides no resources to prevent family problems from becoming serious crises or chronic situations. While the MPHA is intended to assist a segment of the population receiving health care benefits, it thus does little for those who might need this type of support the most.

Policy Considerations:

With President Bush's recent support for mental health parity, policymakers, policy implementers, and other professionals will all be looking more closely at the issue of how best to design and implement new federal legislation. This family impact analysis has highlighted some of the areas where family strength, stability, and functioning may be impacted by aspects of the current Mental Health Parity Act.

1. *Cost*: Health care costs have risen dramatically in the past several years, and many states are struggling to address the health care needs of their citizens. Requiring companies and insurers to provide parity in mental health coverage will mean substantial increases in cost, and states will likely want guidance from the federal level as to how best to handle this situation and resources to help generate state involvement in this issue.

2. *Eligibility*: One of the chief issues states will face in designing and implementing their own mental health parity statutes is determining eligibility. The preceding analysis has shown that limiting coverage to a narrow population may negatively affect not only individuals suffering from mental illness, but also their immediate and extended families. The consequences of insufficient mental health coverage may include financial constraints and emotional stress for spouses, children, parents, or other relatives. For families already at risk due to unemployment or underemployment, these potential burdens may be compounded, as current eligibility requirements provide only for those employed by large companies.

3. *Mental health care for the uninsured:* Nothing in the MHPA addresses the larger issue of the mental health needs of the population lacking insurance coverage. From a family perspective, the mental well-being of individuals has a profound impact on the financial and emotional conditions of the family. Without a larger plan to address adequate care for those who work for small companies, the risk to those in greatest need of assistance may be compounded.

4. *Family and community involvement:* Reauthorization may provide the opportunity to consider innovative ways to involve families and communities in mental health treatment that are less costly than relying solely on the health care system. For example, research has shown that providing families of schizophrenics with therapy, support and education helps prevent patient relapse by 19-27%. Family support costs are thus offset by the decreased use of mental health services (COFO, 1992).

The intended purpose of the 1996 Mental Health Parity Act was to address the inequities of mental health insurance coverage where it exists, not to address the thorny question of the scope or adequacy of mental health insurance coverage. While the MHPA ensures that insurance companies cannot discriminate between mental and physical health coverage in setting lifetime limits, it does little to address larger, more troubling questions of meeting the mental health care needs of many families.

Although this act should be applauded for attempting to address a single inequity in mental health insurance coverage for individuals, a family impact analysis reveals ramifications of this act extend to family members. In developing plans for the amended version of upcoming legislation on mental health parity, greater attention to the broader context of family impact may assist in supporting and strengthening families' well-being.

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