

P E R S P E C T I V E

After Parity—What's Next

Now that the federal law has passed, educational efforts are needed to ensure that mental health is viewed as central to physical health.

by **David L. Shern, Kirsten K. Beronio, and Henry T. Harbin**

ABSTRACT: A new law prohibiting unequal treatment limits and financial requirements for mental health and substance abuse (MH/SA) benefits establishes critical protections for 113 million Americans. The new parity law doesn't mandate coverage for MH/SA treatment and anticipates management of the benefit. Given these features, clear regulations mapping the intent of the law are critical. Education regarding the costs of untreated or ineffectively treated MH/SA conditions is needed to encourage comprehensive coverage, because academic performance and worker productivity are at stake. As health care reform proceeds, we must use the new law to reinforce the centrality of mental health to overall health. [*Health Affairs* 28, no. 3 (2008): 660–662; 10.1377/hlthaff.28.3.660]

E NACTMENT OF THE Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (PL 110-343) on 3 October 2008 rewarded a decade of advocacy to end discriminatory insurance coverage for mental health and substance abuse (MH/SA) conditions. It was a major victory in our ongoing battle to normalize treatment for these common, chronic, and disabling conditions. This law establishes new coverage requirements for 113 million Americans in group health plans, including 82 million who are not protected by state MH/SA parity laws. It also will extend parity benefits to Medicaid managed care plans, greatly expanding coverage for poor and underserved children.

■ **A new era.** However, enactment of the legislation also signals the beginning of a new era, with new challenges. The two most pressing are to ensure effective implementation of

the law and to educate consumers, employers, purchasers, and clinicians regarding the benefits of identifying and treating MH/SA conditions.

Cost containment in MH/SA benefits will undoubtedly be a major concern in implementation. The law anticipates managed mental health services and requires insurers to provide explicit criteria for providing care. It does not mandate inclusion of treatment for MH/SA disorders or require that specific diagnoses be included if MH/SA services are offered. But it prohibits employers with more than fifty employees that offer MH/SA benefits from imposing financial requirements (such as copayments, deductibles, or out-of-pocket expenses) or treatment limitations (such as number of visits or days of coverage) that are more burdensome or restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical

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and surgical benefits covered by the plan.

Given these features of the new law, advocates must move assertively to promote the law's protective intent and patient/consumer focus in its implementation. Attention must be given to the development of regulations ensuring that a meaningful range of evidence-based interventions (including psychosocial services) are covered that fully anticipate the disabling features of MH/SA conditions. Advocates should also develop guidelines for the definition of *medical necessity* that consumers and other purchasers can consult in selecting plans.

Quality assurance measures must be established and implemented to provide incentives for the use of best practices and to identify consumers who are not receiving care that complies with guidelines. Implementation of secure health information technology (IT) may broaden awareness of best practices while also helping monitor routine service delivery against quality assurance standards.

■ **Employers' role.** The new parity law doesn't mandate group health plans to cover MH/SA treatment, trusting that most employers will continue to cover care for these conditions. Thus, advocates must increase awareness among employers, policymakers, and the general public that behavioral health conditions are among the most prevalent and disabling chronic illnesses and that they can be prevented and effectively treated.

Untreated MH/SA conditions can greatly affect employees' productivity and attendance. Moreover, if left unaddressed, these conditions can become extremely disabling and costly. In fact, the World Health Organization has pronounced mental health disorders to be the most burdensome health conditions in the United States.¹ Severe mental illnesses alone cost the United States \$193 billion in lost wages in 2002.²

However, we have an armamentarium of ef-

fective treatments, and most people with MH/SA conditions will improve with effective care. It is clearly in employers' self-interest to cover behavioral health care and to appropriately manage these benefits, to improve overall worker productivity. The indirect cost increases caused by eliminating MH/SA benefits or limiting coverage to certain diagnoses would greatly outweigh any slight increased cost from complying with the new parity requirements. Through our public education ef-

forts, we must ensure that employers and other purchasers understand the bottom-line benefits of covering services for mental and addictive disorders and enabling those services to be used effectively.

■ **Connection with overall health.** In general, the new parity law strengthens our campaign to recognize that mental health is integral to overall health. MH/SA conditions should not be treated separately from general

health. These false distinctions discourage people from seeking help and encourage health care payers and plans to limit coverage. In reality, failure to adequately cover these health conditions results in much greater costs in terms of disability and lost productivity and also in terms of the impact these conditions have on other chronic illnesses. Prevalence studies have found depression to be commonly associated with diabetes, asthma, heart disease, and obesity, and research even indicates that depression contributes to the risk of heart disease as much as diabetes, high cholesterol, or obesity does.³ People with these other chronic conditions who also have a mental disorder, such as depression, will experience greater functional disability, a poorer quality of life, increased medical spending, and, in some instances, higher mortality, than people who have chronic conditions without mental disorders.⁴ People with severe mental illnesses served in the public system die twenty-five years prematurely as a result of other co-

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occurring conditions including diabetes, heart disease, cancer, and asthma.⁵ Thus, it is clear that increased integration of mental health and addiction treatment into general health care must be a core component of any health care reform initiative.

AS THE NATION ENTERS serious debate about reforming our health care system, passage of the Domenici-Wellstone parity bill provides a platform for the full and effective integration of behavioral health services into the heart of reform strategies that are aimed at containing costs and improving population health. Our challenge is to ensure that our educational and implementation activities secure true parity in coverage for MH/SA conditions while increasing awareness of the centrality of mental health to overall health.

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NOTES

1. World Health Organization, *World Health Report 2004: Changing History*, Annex Table 3: Burden of Disease in DALYs by Cause, Sex, and Mortality Stratum in WHO Regions, Estimates for 2002 (Geneva: WHO, 2004).
2. R.C. Kessler et al., "Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results from the National Comorbidity Survey Replication," *American Journal of Psychiatry* 165, no. 6 (2008): 663-665.
3. J.F. Scherrer et al., "Depression Is a Risk Factor for Incident Heart Disease in a Genetically Informative Twin Design" (Paper presented at the Annual Meeting of the American Psychosomatic Society, Chicago, Illinois, 4-7 March 2009).
4. M. Von Korff, K. Scott, and O. Gureje, eds., *Global Perspectives on Mental Disorders and Physical Illness in the WHO World Mental Health Surveys* (New York: Cambridge University Press, forthcoming).
5. J. Parks et al., *Morbidity and Mortality in People with Serious Mental Illness* (Alexandria, Va.: National Association of State Mental Health Program Directors, 2006).