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Access to Mental Health Care: A Civil Rights Issue

Due to insurance company regulations, current restrictions on access to mental health care prevent many from obtaining needed care.

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In remarks nearly a year and a half ago, the president of the United States called on the country to "make a commitment" to Americans with mental illnesses. He said, "they deserve a health care system that treats their illness with the same urgency as a physical illness" [1]. He noted that new drugs and therapies have vastly improved the outlook for millions of Americans with mental illnesses but acknowledged that a "major obstacle to effective mental health care is the often unfair treatment limitations placed on mental health in insurance coverage" [1]. President Bush stated that "insurance plans too often place greater restrictions on the treatment of mental illness than on treatment of other medical illnesses," and called on Congress to pass legislation that would eliminate those restrictions—and provide "parity" between mental health and medical and surgical benefits. Congress has yet to respond, and it is not apparent that the president has renewed his call.

Health insurance plan-limits on access to needed mental health care are pervasive. According to a recently published article on mental health benefits, although most workers with insurance were offered some coverage for mental health services in 2002, 74 percent of covered workers were subject to annual outpatient visit limits and 64 percent were subject to annual inpatient day limits. Forty-eight percent of these workers were enrolled in plans that subjected them to both day and visit limits as well as higher cost-sharing for mental health benefits. Only 8 percent of workers were in plans with none of these restrictions. No comparable restrictions were imposed on medical or surgical coverage.

The health insurance industry's pervasive practice of restricting access to mental health care is profoundly inequitable and fundamentally irrational. Mental illnesses are reliably diagnosed and, for virtually every mental disorder, there is a range of treatments and services that has been shown to be effective. The longstanding call for legislation to end health insurance practices that penalize people for their mental illness stems not only from the fundamental unfairness of these discriminatory practices but the tragic harm they cause. People with mental illnesses too often do not get needed treatment even when they have "good" insurance. Arbitrary, discriminatory insurance barriers to needed mental health treatment stand in the way and wreak havoc with American families. Consider, for example, the impact of insurance plans that impose a *lifetime* cap on the number of outpatient mental health visits, regardless of the individual's need for treatment. Rigid insurance limits on access to needed mental health treatment take a severe toll on families—in unemployment, broken homes, other health problems, poor school performance, custody relinquishment to secure needed mental health care, and even suicide.

More than 30 states have already passed and implemented laws that require insurers to provide parity between mental health and other medical coverage. But state parity laws vary widely in scope. Some cover only state employees, others are limited to specified diagnoses, while a number of states have relatively comprehensive measures. But because of overriding federal legislation that protects employer benefit packages (ERISA), no state parity law can regulate self-insured employer health plans, making it critical that Congress pass a federal law.

In fact, Congress has already passed legislation aimed at ending this discrimination against people with mental illnesses. That measure, the Mental Health Parity Act of 1996, established the principle that mental health coverage and coverage for medical and surgical care should be on par, and it requires that large-employer health plans may not

impose stricter annual or lifetime dollar limits on mental health care than on medical or surgical care. While that "parity law" represents an important milestone, it has not produced fundamental change. As the General Accounting Office (GAO) reported in May 2000, people with mental illness still face widespread, arbitrary discrimination in health insurance coverage. In studying the law's implementation, GAO found that 86 percent of employers surveyed reported that they had complied with the 1996 parity law. But the vast majority of those employers substituted *new* restrictions on mental health benefits, thereby evading the spirit of the law. The lack of real protection under current law and the loss of life and health attributable to insurance barriers make it critical that Congress take up and enact a comprehensive mental health parity law soon.

The lead sponsors of the original parity legislation, Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN), set out to close the loopholes in current law. Years have passed, but the bill has not. Many had anticipated that Senator Wellstone's death a year ago would spur Congress to pass this legislation which had already won broad bipartisan support in both the Senate and House. But while the bill was reintroduced and named for the late champion, and has again received the cosponsorship of a bipartisan majority in the House of Representatives and two-thirds of the members of the Senate, the bills have languished in committees in both chambers.

What are the obstacles to passage of the Domenici-Wellstone bill, or any other parity legislation? Parity legislation has provoked strong opposition in the business community. Opponents have mounted many arguments, but each has a common thread–a studied avoidance of the profound impact of sharply restricted access to needed care on the individual and his or her family. Instead, opponents assert baldly that parity will be "costly," or raise the illusory threat that enactment of parity legislation would lead legions of people to abandon health insurance coverage. Underlying these and other arguments, one suspects, is resistance to *any* legislation. Study after study has documented that the cost of parity would be modest, and, in fact, is likely to be offset by such factors as increased employee productivity and reduced sick leave. But business sees the precedent of parity legislation as potentially damaging, even if the measure itself is relatively benign. And many lawmakers are all too receptive to a "no new mandates" mantra.

One is left to speculate on how legislators would respond to the imposition of similar restrictions on any other chronic illness. How would Congress react if health insurers were to impose strict limits on treatments for chronic pain, for example? Would it accept the argument that such limits are necessary and appropriate because of the subjective nature of pain, an argument employed for stricter limits on mental health care than any other illness? One suspects that such limitations would provoke outrage and that Congress would not wait long before passing remedial legislation.

Ironically, congressional leaders who have elected to deny both House and Senate members a chance to vote on mental health parity legislation already enjoy the protection that legislation would provide their constituents. Their own health plans, under the auspices of the Federal Employee Health Benefits Program, have provided them, their families, and their staffs mental health parity since January 1, 2001. Talk about unfairness.

It's late, but it is not too late to pass this legislation. Let lawmakers know how you want them to vote on mental health parity legislation [3].

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