

Coalition for Fairness in Mental Illness Coverage

MYTH versus FACT END DISCRIMINATORY MENTAL HEALTH COVERAGE

Myth 1. H.R. 953 and S.486 are unduly restrictive and intrusive.

The Reality. Far from being restrictive, the legislation gives employers great latitude to design coverage and contain costs, specifying that they: (1) are not required to provide specific mental health services; (2) are not required to provide coverage unless services are medically necessary; (3) get to define what constitutes medically necessary treatment; (4) are free to employ managed care techniques (including prior authorization and retrospective utilization review); (5) are not required to provide parity for out-of-network services; and (6) are not required to provide mental health coverage. It should be clear that this legislation strikes a careful balance between protecting people in need of mental health care from discriminatory barriers and protecting employers from unreasonable mandates, costs, or burdens.

Myth 2. Discriminatory, severely limited coverage of mental health care must be employed to protect against overutilization.

The Reality. Citing a “growing body of research and actual industry experiences,” the Office of Personnel Management found that state parity laws have had only a small effect on premiums due primarily to careful management of mental health services. (www.opm.gov/insure/health/parity/qanda.htm) The legislation makes it crystal clear that the full panoply of managed care techniques can be brought to bear, including retrospective utilization review and utilization management practices. There is no foundation, therefore, to suggest that arbitrary, discriminatory limits on treatment or disparate cost-sharing must be imposed to insure against overutilization.

Myth 3. The legislation is unreasonably broad.

The Reality. Opponents imply, without any foundation in the legislation, that the measure requires coverage for any psychiatric diagnosis. In ridiculing a handful of obscure diagnoses, opponents selectively ignore the clear import of this legislation: parity is required only as to services that are medically necessary under the plan or issuer’s criteria and then only if the services are part of an authorized treatment plan that is in accordance with standard treatment protocols. Clearly those writing insurance coverage can readily protect against unwarranted costs. Opponents’ suggestion that the legislation should be narrowed to cover only the “most serious” conditions highlights the invidious problem this legislation aims to end.

Myth 4. Simply extending the 1996 Mental Health Parity Act would resolve the problem.

The Reality. The 1996 law has been only minimally effective in ending discriminatory insurance practices. As the General Accounting Office documented in a report to Congress (May 2000), many of the opponents of this legislation completely circumvented the 1996 law by erecting new barriers (in the form of discriminatory limits on numbers of covered outpatient visits and days of hospitalization as well as higher cost-sharing burdens). In so evading the spirit of the 1996 Act, parity opponents continue to deny people access to needed mental health care. Congress should not reward efforts to frustrate its intent by re-enacting a law so readily circumvented.

Mental illness coverage. It’s time to be fair by treating it equally in health care.

1000 Wilson Blvd., Suite 1825, Arlington, VA 22209
Phone: 703-907-8643 Fax: 703-907-1083

March 24, 2003

Myth 5. Parity will be unduly costly.

The Reality. The Congressional Budget Office (CBO) has projected that enactment of H.R. 953 and S. 486 would result in premium increases of only 0.9%. Experience in the many states which have passed parity laws closely mirrors the CBO projections. The Office of Personnel Management characterized the argument that the cost of mental health parity is prohibitive and would result in fewer people having insurance as an “apparent myth.” (www.opm.gov/insure/health/parity/qanda.htm) Clearly, these **CBO projections; the experience both of states which have enacted parity laws and of the Federal Government in implementing parity in the Federal Employee Health Benefits Program; and the many studies on the subject belie the bold claim that enactment of this measure would be costly.**

Myth 6. Parity will be harmful.

The Reality. Such a claim, based on the myth that parity will be costly, simply ignores the facts. **Opponents ignore entirely both the compelling data on how little parity costs and the reality that workers with untreated or undertreated mental illness add some \$70 billion annually to employer costs through absenteeism, turnover and retraining expenses, lower productivity, and increased medical costs.** Enactment of mental health parity legislation, rather than having an adverse impact, can be expected to increase productivity and economic gain.

Myth 7. Employers need to be exempted from parity requirements if their health plan premiums increase by more than one percent.

The Reality. **Such a cost exemption is a formula for gutting this legislation.** Since premiums are expected to increase on average by only 0.9% under the legislation, exempting employers whose costs increase only marginally above 1% would mean **most American workers would be denied the protections of this law.** It would be untenable to provide for an outright exemption based on costs and thereby free an employer from ANY obligation under the Act. Establishing such an exemption would mean, for example, that an employer that was required to provide parity as to lifetime and annual dollar limits (under the 1996 mental health parity law) would be freed of even that obligation by virtue of some demonstration of a modest increase in costs resulting from new parity requirements.

Myth 8. Now is not the time to enact parity.

The Reality. Mental health parity is not a new concept. We have the benefit of years of experience and available cost data in the 32 States which have enacted and implemented mental health parity legislation. That experience informed the Federal government and enabled it on January 1, 2001 to implement mental health parity for all Federal employees and their dependents, including Members of Congress and their staff – with minimal cost impact -- through the Federal Employee Health Benefits Program. **Parity has undergone years of study.** It is time for jurisdictional concerns to yield to the needs of children and adults with mental health disorders. It is time to recognize that this issue has had ample study. It is time to act.

All the parity legislation would do is extend to American workers the same parity protection which the Federal Government has provided all Federal employees and their dependents including Members of Congress and their staffs. It is time to enact the mental health parity legislation overwhelmingly adopted by the Senate – now more than ever.

Please do not allow these myths to cloud the reality that the legislation is a carefully crafted, balanced measure, which is long overdue and will contribute to our economic well-being and benefit American workers and their families.

Mental illness coverage. It's time to be fair by treating it equally in health care.

1000 Wilson Blvd., Suite 1825, Arlington, VA 22209
Phone: 703-907-8643 Fax: 703-907-1083

March 24, 2003