Mental Health Parity: Is It Really Just Another Insurance Mandate?

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As a society, we treat mental illnesses as completely separate from purely physical illnesses. Studies suggested a correlation between mental illness and chronic physical diseases and those demonstrating some biochemical source of mental illnesses have done nothing to change this.

In this situation, governmental actions support the words of the public. Responding to these feelings and fears from the public (and within themselves), every state has enacted involuntary commitment laws and laws regarding forced medication for the mentally ill, something we refuse to do to people with physical illnesses. The eye is on the prize – protecting the public from people with mental illnesses – and not on the people who suffer from these illnesses. This is why some of the same states that support forcibly medicating the mentally ill will not support mental health parity.

A close review of mental health parity leaves no other rationale for opposing it other than the stigma against mental illnesses and those effected. Economically, policy-wise, and human-rights-wise, mental health parity makes a lot of sense. However, we use our “common sense” which tells us that mental health issues are just different instead of analyzing the issue objectively.

When mental health parity bills are proposed, legislatures couch their opposition in the language of insurance mandates, rather than examining the underlying policy issues or the hypocritical nature of supporting involuntary treatment while not providing for voluntary treatment. A close look, however, shows that mental health parity may sound like an insurance mandate, but the arguments against mandates do not apply to parity.

The main arguments against mandates are that: they are too expensive; employers would demand coverage for the condition if that was the economically rational thing to do – since they do not, it does not need to be covered; and there is no strong policy justification for requiring coverage of one particular disease over another – breast cancer patients are not inherently more important than those impacted by autism, for example.

The arguments for mandates generally include truly heart-breaking stories of people who have insurance and thought they were being economically responsible going bankrupt when coverage for a condition with costly treatment was denied. Also, some will argue that insurance companies have high profit margins and should not be able to provide insufficient coverage with no consequences.

In a policy that provides mental health parity, mental health conditions would be covered to the same or similar extent that physical conditions are covered. People may still not have complete coverage for any treatment for any mental health condition, but they would not have to go through extra hoops or have more obstacles to receive reimbursement for care for a mental illness than they would for any other acute and/or
chronic condition. The Mental Health Parity Act of 1996 ensured that annual or lifetime limits for mental healthcare could not be lower than any limits on physical health care,\(^1\) which brought the country closer to overall mental health parity but not all the way.

The question becomes whether mental health parity is just another insurance mandate and should be treated as such or whether there is something different going on here, which requires a look at whether the economic arguments against mandates discussed above argue against mental health parity as well.

The first argument was that insurance mandates are too expensive. Statistics show that: one in five children receive mental health services each year;\(^2\) 15 percent of college students have clinical depression;\(^3\) and that 30 percent of the US population has a mental health or substance abuse issue each year, although not all require professional treatment.\(^4\) These numbers do not reflect undiagnosed mental illnesses or the illnesses other than clinical depression that impact college students. Providing coverage for that level of treatment would be unduly expensive, say those making this argument, and the numbers do show that such coverage would be expensive. Estimates of the cost of mental health parity mandates vary widely,\(^5\) which makes it difficult to truly determine the cost that would be incurred. However, the Congressional Budget Office (CBO), a largely impartial agency, reviewed this issue in 2001.

The CBO was estimating the cost of a bill that would have prohibited group plans that offered physical and mental health benefits from imposing any treatment limitations or financial requirements for coverage of mental health benefits that differed from their limitations on physical health treatment and coverage.\(^6\) The CBO estimated the following costs for 2002: $230 million cost to the federal government; $150 million in lost governmental receipts; $150 million to state, local, and tribal governments; and $3.1 billion to the private section. The overall 2002 cost as estimated by the CBO would have been $3.63 billion.

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\(^5\) Merrile Sing and Steven C. Hill, The Cost of Parity Mandates for Mental Health and Substance Abuse Insurance Benefits, 52 PSYCHIATRIC SERVICES 437 (April 2001)
\(^8\) According to the CBO report, this reflects the amount of lost revenue that would be subject to pay-as-you-go procedures under the Balanced Budget and Emergency Deficit Control Act.
Four billion dollars is a lot of money. No one can argue otherwise. The question here is not whether mental health parity would be expensive; it is whether mental health parity would be unduly expensive when balanced against the costs of untreated mental illnesses. The New Freedom Commission’s estimate of the annual cost of lost work productivity from mental illness is $63 billion. This does not include expenses incurred when the state forcibly commits or medicates someone. So, mental health parity would be expensive, but it would not be unduly expensive. We would be paying approximately $4 billion to get more than $60 billion worth of services, assuming treatments would be effective. Even if treatment only reduces lost productivity by 10 percent, we would still be ahead.

That leads into the free market argument, which states that employers act in an economically rational fashion and therefore would demand mental health parity from insurers if mental health issues were truly impacting their bottom line. To support this argument, you have to say that the numbers from the New Freedom Commission and CBO are nowhere near accurate. For such conditions as migraines, the flu, and other preventable physical health complaints, the free market theory is logical and may be in fact how insurance policies become more comprehensive. The free market will not, however, deal with mental health parity on its own, since employers can only take the economically rational approach if they have information on the impact of mental illness in their workplace.

Employers do not have this information because their employees are afraid to provide it. People will call in to work sick, saying they have a migraine or have any side effects from chemotherapy treatment. They will not call in and tell their boss that their schizophrenia is acting up, they are in a manic phase, or their depression has too firm a grip on them that day. However, studies show that 37 percent of all health life-years lost through disease are from mental disorders and, as discussed above, lost productivity from mental illness is over $60 billion. If people were completely open about their mental health problems and employers calculated the business impact of not having coverage, we would already have mental health parity or at least something close to it. The numbers show that the free market is not working effectively in this area.

This leaves the policy argument regarding placing one disease or condition above another. Again, this argument does not tie in nicely with mental health parity. If there was one mental illness in the world, then this argument would work. There really would be no insurance-based policy justification – ignoring for the moment the economic issues reviewed above – to cover mental illness and not some other disease. However, that is not the case. According to a psychiatrist at the Mayo Clinic, there are seven distinct classes of mental illnesses, not including the catch-all “other disorders” category. The main physical health condition that appears somewhat similar is cancer, since cancer is

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9 The same argument can be made in the individual insurance market, but it is less convincing as individuals do not have the same negotiating power with insurance companies as large employers.  
10 Bridget M. Kuehn, Health Agencies Update: Mental Health Care Lacking, 298 JAMA 1858 (October 24-31, 2007); New Freedom Commission, supra note 7.  
not really one disease. There are 13 common types of cancer, not including more rare forms. The public and legislatures would be in an uproar if health insurance policies – be they basic, comprehensive, or even catastrophic – limited cancer coverage to 3 visits a year for any type of provider (primary care, oncologist, and/or chemotherapy provider) and required 30 percent co-pays for cancer care but not other treatment, yet this happens with respect to mental health coverage on a regular basis.

If we look at mental health parity as an economic issue, we should have it. If we look at mental health parity as an insurance issue, examining it as we would any other proposed “mandate,” we should have it. If we recognized the impact on the person with a mental illness and the healthcare providers involved in using restraints, forcing medication, and committing someone, we would have it. But we do not, because mental health is just different and mentally ill people are an “other,” not to be treated like “normal” people. Sadly, we live in a society that allows that type of thinking and does not see that the only true difference is that we allow ourselves to discriminate against the mentally ill openly. Perhaps someday soon the stigma and discrimination will wash away and we will do the right thing – economically and policy-wise, and have national mental health parity.

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