



National Conference of State Legislatures

# POLICY MATTERS

CRITICAL ISSUES IN HEALTH CARE ACCESS

## SUBSTANCE ABUSE PARITY: STATE ACTIONS

by Greg Martin

### THE PUSH FOR PARITY

In response to growing awareness of the human and economic toll of mental illness, the Clinton administration proposed, and Congress subsequently passed, the Mental Health Parity Act of 1996. As drafted, the bill essentially required health plans that provide mental health coverage to provide those benefits at the same level as physical health coverage. As passed, however, the bill contained several provisions that allowed insurers to maintain their benefit packages at prior levels and excluded substance abuse treatment benefits. Spurred by the passage of the act, lawmakers in many states sought full parity in all health plans between mental health and physical benefits.

In writing parity laws, state legislators faced a basic question—with so many mental illness conditions, which ones should be covered? Lawmakers found the answer in two basic manuals: the *International Classification of Disease Manual* (ICD) published by the World Health Organization and the *Diagnostic and Statistical Manual* (DSM IV) published by the American Psychiatric Association. These two manuals provided lawmakers with standards—that had been drafted and agreed upon by field experts—from which to begin drafting their bills.

Complicating the debate over mental health parity has been the decision of whether to include substance abuse benefits. Underlying the discussion are two issues: 1) the stigmatization of substance abuse as a moral failing and a crime and 2) the fear of skyrocketing treatment costs and the notion that it would require taxpayers to pay for others' lifestyles. Research over the last decade, however, indicates that treatment does help reduce crime. A 1994 study, *Evaluating Recovery Services: The California Drug and Alcohol Treatment & Assessment* (CALDATA), found that treatment of substance abuse resulted in a 43.3 percent drop in criminal activity.

### ARGUMENTS SURROUNDING PARITY

Typically, several arguments against parity surface when a legislature considers mental health parity legislation. The

first contends that parity would be cost-prohibitive, because it would inflate premiums for consumers (thus pricing many people out of the market) and ultimately lead to a higher rate of uninsured. The second argument is that many professional definitions of mental illness are too broad, particularly those in the DSM IV. According to critics, the DSM IV includes even such mental maladies such as jet lag in its definition of mental illness.

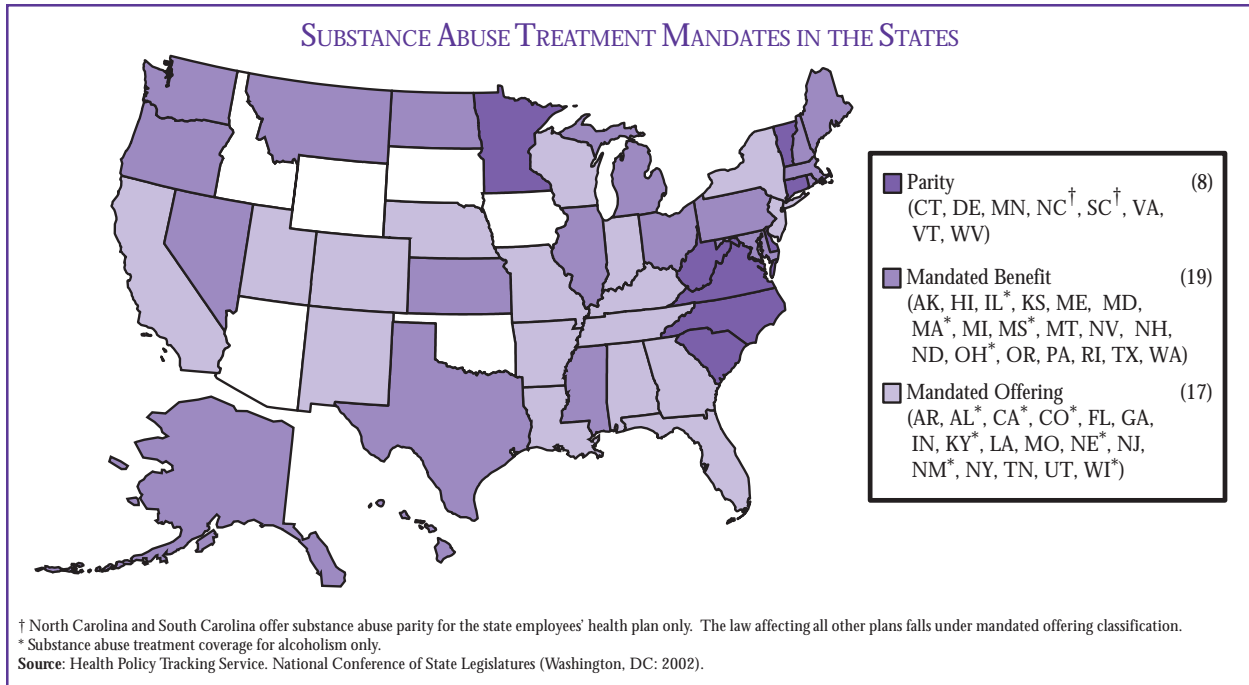
Proponents of parity offer several answers and solutions to counter these arguments. Against the first, they point to several studies indicating the cost benefits of providing parity. A 1999 report from the Substance Abuse and Mental Health Services Administration, for example, estimated that the average yearly cost increase for insurance with full parity for substance abuse treatment would be \$5 per person.<sup>1</sup> Proponents also cite CALDATA's finding that every \$1 spent on treatment saved state taxpayers \$7 in future costs (emergency health care, imprisonment, court costs, etc.).

Weighing each of these arguments against each other, state legislators have sought greater balance and equity between mental health and physical benefits through three modes parity, minimum mandated benefits and mandated offerings. Because there is no firm, commonly accepted definition of parity, the Health Policy Tracking Service (HPTS) at the National Conference of State Legislatures uses these three terms to categorize state approaches in order to paint a clearer picture of what states are requiring of health plans.

### PARITY

HPTS qualifies a state's law as parity only when it requires equality between mental health services and physical care services across five categories: scope of inpatient treatment; scope of outpatient treatment; scope of partial or residential treatment; co-payments and co-insurance; and lifetime and annual dollar limits. To date, under HPTS standards, only six states—**Connecticut, Delaware, Minnesota, Vermont, Virginia and West Virginia**—have full parity laws for mental health and substance abuse. Two states—**North Carolina and South**





**Carolina**—offer substance abuse parity, but in the state employees' health plan only. Some states, such as **California**, offer parity for mental health benefits but exclude substance abuse from the legal definition of mental illness.

**MINIMUM MANDATED BENEFITS**

Minimum mandated benefit is the classification assigned to state laws that mandate coverage for mental health services, but do so at levels that are less than equal to physical care services across the five categories mentioned previously. Under these requirements, a state law may require parity across as many as four of the five categories and still be a minimum mandated benefit because benefits are unequal in the remaining category. Laws in 15 states fall under the minimum mandated benefit category for comprehensive substance abuse treatment: **Alaska, Hawaii, Kansas, Maine, Maryland, Michigan, Montana, Nevada, New Hampshire, North Dakota, Oregon, Pennsylvania, Rhode Island, Texas and Washington**. Another four states—**Illinois, Massachusetts, Mississippi and Ohio**—fall under this classification but only for treatment of alcohol dependency.

**MANDATED OFFERING**

Several state actions took the form of a mandated offering (**Arkansas, Florida, Georgia, Louisiana, Missouri, New Jersey, New York, North Carolina, Ohio, South Carolina, Tennessee and Utah**). HPTS standards define a law as a mandated offering if it either, “1) requires the insurer to offer the option of a policy with coverage, that the insured can choose to accept or reject (usually for a an additional or higher premium); 2) requires that if benefits are offered, they must be equal to the benefits provided for physical illnesses; or 3)

requires that if benefits are offered, they must provide the minimum level of benefits specified in the law.”<sup>2</sup> As with minimum mandated benefits, several additional states have a mandated offering only for alcohol dependency (**Alabama, California, Colorado, Kentucky, Nebraska, New Mexico and Wisconsin**). □

**NOTES**

- 1 Substance Abuse and Mental Health Services Administration. *The Cost and Effects of Parity for Substance Abuse Insurance Benefits* (Washington, D.C.: SAMHSA, US DHHS, 1998) <http://www.samhsa.gov>.
- 2 Tracey Delaney and Crean, Eileen, “*Mental Health and Substance Abuse Parity*” (Washington, D.C.: HPTS, NCSL, 2002) <http://www.hpts.org>.

**RESOURCES**

- Tracey Delaney and Crean, Eileen, “*Minimum Mandated Benefits and Mandated Offerings for Mental Health and Substance Abuse*” Washington, D.C.: HPTS, NCSL, 2002; <http://www.hpts.org>.
- Gerstein, Dean, et al. National Opinion Research Center. *Evaluating Recovery Services: The California Drug and Alcohol Treatment & Assessment*. Sacramento, Calif.: California Department of Alcohol and Drug Programs, 1994; <http://www.adp.cahwnet.gov/RC/pdf/caldata.pdf>.

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