

“Parity” Politics Shows How Reform Can Be Won

BY JANE HIEBERT-WHITE

Congress, in a flurry of preelection activity, approved several health insurance reforms, including one that will regulate mental health insurance benefits. Although the mental health measure is modest and will have little or no impact on people who are currently uninsured, it is nonetheless politically significant and has policy ramifications for future insurance reform debates.

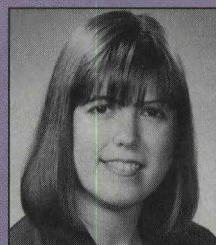
The measure, which puts coverage for mental illness on a more equal level with coverage for physiological illnesses, says that annual and lifetime limits must be the same for both. Eventually attached to an appropriations bill for the Veterans Administration and the Department of Housing and Urban Development, the measure was approved by Congress on September 24 and signed by President Bill Clinton two days later. It will take effect January 1, 1998.

Success came, however, only after a phenomenal political turnaround. During the August debate on the Kassebaum-Kennedy bill on portability for health insurance, Sen. Pete Domenici, R-NM, had lobbied vigorously for an amendment that would establish “parity” for mental health coverage with physical health coverage. Kassebaum-Kennedy evolved into the Health Insurance Portability and Accountability Act (HIPAA), which became law in late August—but without Domenici’s amendment. Then, just weeks later, both the House and the Senate approved the scaled-down version of Domenici’s amendment as part of the appropriations measure.

What happened during those end-of-session weeks to turn the tide?

THE POLITICS OF PARITY

Most analysts agree that, although the mental health parity measure is both exceedingly modest and full of loopholes sure to gratify insurers who want to evade its provisions, it does at least represent a foot in the door for an area of healthcare that has never received much coverage. More-



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over, an examination of the politics behind the measure’s passage may be useful for reform advocates. It could show them how to broaden insurance coverage through incremental steps.

Find a Strong Advocate “Without question, Sen. Domenici played a key role,” said Chris Koyanagi in a recent interview. Koyanagi, who is codirector for government relations at the Judge David L. Bazelon Center for Mental Health Law, a Washington, DC-based legal advocacy organization concerned about the rights of persons with severe mental illness, added that Domenici’s “central passion [for mental health parity] would not let this drop.”

The senator, who has a daughter with mental illness, has fought for mental health parity for a decade. His prominence as chairperson of the Senate Finance Committee and his reputation as a budget conservative have lent credibility to his work for mental health insurance reform.

“I have found that if a member [of Congress] has a personal passion—boy, does that carry weight!” said Koyanagi. Domenici was a strong champion of parity even in a Republican-led Congress that did not want to regulate insurance or create new costs for business. “Domenici was very upset” when mental health parity was dropped from the HIPAA in August, said Koyanagi. But the senator, with Sen. Paul Wellstone, D-MN, the parity amendment’s cosponsor, stuck with the measure and made sure it was finally approved a month later.

Keep the Costs Moderate A second key factor in the passage of parity legislation was the fact that its backers kept its costs down. Many of the measure’s opponents feared that forcing insurance plans to provide mental health parity would cause premium costs to skyrocket. The chief opponents were from the business community, including the National Association of Manufacturers and the Association of Private Pension and Welfare Plans (APPWP).

In February the APPWP had underwritten an analysis of Domenici’s earlier parity bill (S.298,

"The Equitable Health Care for Severe Mental Illness Act"). That study, conducted by Wilson Wyatt Worldwide, predicted that insurance premiums would increase by as much as 8.3 percent to 11.4 percent as a result of parity legislation. In April the bill's supporters countered with a study by Milliman & Robertson, Inc., which estimated that premium increases would be held to 2.5 percent to 3.9 percent.

After mental health parity was dropped from the HIPAA in August, its supporters restructured the amendment so that it would focus on parity for coverage of catastrophic costs, rather than establish parity across the board. "When we took [the new catastrophic approach] to Domenici's office, it took some time to explain why it was more in line with the way insurance operates," said Koyanagi. "But then it took off as a sensible approach. [Under it] costs could be estimated, costs were more moderate, costs could be tinkered with. And—the main advantage for Domenici—it helped people with severe mental illness without getting into the awful problems of defining what that meant."

In the catastrophic version, parity would require insurance plans to offer the same annual and lifetime limits for mental health treatment as they do for medical/surgical care. As things currently stand, a typical insurance plan may set \$50,000 as the lifetime limit for a person's mental health coverage, while capping his or her medical/surgical care at \$1 million. In the same way, annual limits are typically 30 hospital days for a person's inpatient mental healthcare—with no limit on the time he or she is hospitalized for medical/surgical care.

"Typical mental health insurance does the opposite of what insurance is supposed to do," said Richard Frank, a Harvard Medical School economist who was instrumental in pushing the catastrophic approach to mental health parity. "If you get really sick, the family gets wiped out. Insurance should protect the sickest people from financial ruin."

In refocusing parity on catastrophic limits rather than insisting on equal coverage for mental and physiological illnesses, reform advocates dodged the sticky issue of *which* mental illnesses could be considered "on par" with physiological illnesses—where, that is, does one draw the line between severe mental illness and symptoms shown by the "worried well"? The catastrophic approach also lowered the projected costs of the measure considerably. The Congressional Budget Office estimated that the measure would increase

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premiums by only 0.4 percent.

The low cost reflects the fact that, as it was eventually approved, the parity legislation carries a number of loopholes for insurers. For one thing, health plans are not required to include mental health coverage in the first place; only when it *is* offered must plans make its annual and lifetime limits equal to those for medical/surgical coverage. In addition, there are no restrictions on copayments. For example, as Frank noted in an interview, a patient whose coverage set no limits on length of hospital stay might find, after 30 days, that he or she must pay 75 percent of the bill for it. The legislation "doesn't cost business that much," Frank said. "Insurers can still change cost sharing a lot. And managed care can control many things that limits [on the amount of coverage] used to control." Other loopholes exempt from the legislation companies with 50 or fewer employees and group plans whose premiums increase 1 percent or more as a result of the new law.

Push Reform at Election Time Good timing was the third key factor in the approval of the parity measure. "If you had held a conference seven months ago on mental health coverage, we would have said it will never happen," Douglas Besharov, a resident scholar at the American Enterprise Institute, told an early October gathering at Columbia University in New York City. But, as the fall congressional elections came nearer, he said, "Republicans got a little frightened of saying no."

Koyanagi agreed. By late September, she said, there had occurred "a general shift on the Hill. [Members of Congress] were conscious of their reputation as hatchet men, and this amendment came along at just the right time—as they were trying to get out of town" to campaign for reelection. Koyanagi said she doubted that most members of Congress had actually come to favor mental health parity. "The polls just scared them to death."

Package Reform with a Popular Cause A fourth key factor was last summer's controversy over the "drive-through" delivery of babies. By the time Congress came to vote on it, the parity measure had been packaged with one requiring health plans (including self-insured employer plans) to allow women to stay in maternity wards at least 48 hours for normal deliveries and at least 96 hours for cesarean births. The maternity stay amendment was so popular that simply being associated with it improved the parity measure's

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chances, noted Koyanagi. "The House did not want to go on record as being against all these measures," she said.

Build a Broad Supporting Coalition Broad support by the mental health field was the fifth key factor in the passage of parity. The field comprises a wide range of groups—including practitioners, consumer advocates, managed behavioral healthcare firms, and specialized facilities—each of which has its own interests. For example, some groups favor managed care and others oppose it. Some argue that insurance should focus on care of the severely ill, whereas others think it should target prevention of mental illness in the population at large.

Despite this diversity of interests, all groups favored the parity measure. Consumer groups saw it as a step toward ending healthcare discrimination against the mentally ill. Managed behavioral healthcare firms saw it as another incentive for health plans to employ managed care to help control costs. The entire field came together to form the Coalition for Fairness in Mental Illness Coverage, which strongly backed the parity measure. "This was one of those occasions where we stuck together in the mental health field," Koyanagi said.

USING THESE FACTORS TO EXPAND COVERAGE

The three recent healthcare reforms—the HIPAA, the maternity-stay amendment, and the parity measure—primarily help middle-class Americans protect themselves from financial risk. None does much to expand coverage to the uninsured.

A report the Lewin Group has recently prepared for the American Hospital Association underscores the growing problem represented by those

who have no health insurance coverage (John Sheils and Lisa Alexih, "Recent Trends in Employer Health Insurance Coverage and Benefits," September 3, 1996). The report's authors estimate that, if current trends continue, the number of uninsured Americans, 39.6 million (15.1 percent of the population) in 1995, will grow to 45.6 million (16.2 percent) by 2002. The authors do not expect the new reforms to make much difference in this respect. "Recent legislation guaranteeing portability of coverage is not likely to have a significant effect either, since 45 states already have enacted similar legislation that is already reflected in these data," they write.

On the other hand, the political progress the reforms represent is perhaps more important than the actual coverage benefits contained in them. All three demonstrate that reform advocates can compete successfully with such powerful lobbies as those representing small-business and insurance groups. And, as the parity measure shows, when reform advocates focus on five key legislative factors—a strong advocate, low costs, good timing and packaging, and broad support—they can prevail.

Groups concerned about obtaining coverage for the uninsured should therefore ask themselves certain questions:

- Who might serve as a strong political proponent for the uninsured (or perhaps a segment of the uninsured, such as children)?
- How can the costs of arranging coverage for such persons be minimized?
- When will the next window of opportunity open?
- And will reform advocates be ready for it? □



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