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DOES THE SUNSET OF MENTAL HEALTH PARITY REALLY MATTER?

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ABSTRACT: The 1996 Mental Health Parity Act (MHPA), which became effective in January 1998, is scheduled to expire in September 2001. This article provides an overview of what the MHPA intended to do and what it actually has accomplished. We summarize state legislature actions through the end of 2000 and report on their effects on employer-sponsored mental health coverage using a national survey fielded in 1999–2000. We then discuss possible amendments to the MHPA and reforms beyond full parity that might be considered.

KEY WORDS: Congress; employer-sponsored health insurance; Mental Health Parity Act; regulation; state legislature.

The 1996 Mental Health Parity Act (MHPA), which became effective in January 1998, is scheduled to expire in September 2001. The 107th Congress faces a set of choices: (1) allow the sunset of mental health parity; (2) reauthorize parity in its current MHPA form; (3) mandate parity and require all group plans to provide equal coverage; or (4) mandate "full" parity if mental health coverage is *already* offered, that is, in addition to

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annual and lifetime dollar limits, require the same inpatient-day limits and outpatient-visit limits, deductibles, and out-of-pocket maximums in mental health benefits as in medical and surgical benefits; (5) end or amend the smaller employer and 1% claim increase exemption.

The 2001 Mental Health Equitable Treatment Act (S. 543), proposed by MHPA sponsors Senator Pete Domenici (R-NM) and Senator Paul Wellstone (D-MN), attempts to address the sunset and requires that group plans or insurers that *already offer* coverage cannot impose any treatment limitations or financial requirements on mental health benefits unless comparable restrictions are imposed on medical and surgical benefits. The treatment limitation prohibits restrictions on frequency of treatment, number of visits or days of coverage, or other limits on the duration or scope of treatment. The financial requirement precludes use of different deductibles, coinsurance, copayments, and other cost sharing. Mental health benefits, which incorporate a mental illness definition, refer to services for all mental health conditions listed in the *DSM-IV* (American Psychiatric Association, 1994). The small employer exemption is amended to apply to firms with 25 or fewer employees (the MHPA exempted firms with 50 or fewer employees).

The policy challenge is deciding exactly how to expand mental health coverage. This article provides an overview of parity developments in the past two years. We summarize state legislature actions through the end of 2000 and report on their effects on employer-sponsored mental health coverage using a national survey fielded in 1999–2000. We then discuss possible amendments to the MHPA and reforms beyond full parity that might be considered.

THE 1996 MHPA: WHAT WAS IT INTENDED TO DO?

In 1996, in conference committee, an amendment was added to an unrelated appropriations bill, requiring any group health plan that covered mental health benefits to provide the same dollar limits on annual and lifetime coverage as for medical and surgical benefits. The conferees substituted less restrictive requirements on plans than the original Domenici/Wellstone proposal, which had required plans that provided mental health coverage to do so without imposing treatment limitations or financial requirements if similar limitations were not imposed on coverage for services of other conditions (*Congressional Quarterly Almanac*, 1996). In a compromise worked out between Majority Leader Trent Lott (R-MS) and House Speaker Newt Gingrich (R-GA), provisions were added to exempt small employers and to clarify to employers that this was not a mental health mandate.

The 1996 amendment, which became known as the Mental Health Parity Act, took effect in January 1998. The MHPA removal of annual and lifetime dollar limits was *intended* as a major expansion in mental health coverage for the most severely mentally ill, who were most at risk of out-of-pocket costs or losing coverage entirely. Among those with private health insurance, this primarily has meant parity protection for child dependents with serious mental illness (Sturm 1997; Gresenz, Liu, & Sturm, 1998).

Although mental health advocates and policy makers had imagined the removal of unfair barriers to mental health services, the law contains several provisions that have minimized its effect. First, the MHPA does not require that employers offer coverage, only that dollar limits on mental health be equal to dollar limits on medical and surgical benefits *if* coverage is offered. Thus, plans may drop mental health coverage entirely.

Second, the MHPA does not impose any restrictions on deductibles, copayments, days, or visits, and does not require coverage for substance abuse. Thus, it allows plans to continue to limit annual days and visits and to use higher levels of cost sharing for mental health than for medical/surgical services. The conferees specifically intended that plans retain the flexibility to define the scope of benefits, to establish cost-sharing requirements, and to impose limits on hospital days and outpatient visits. Third, the law provides explicit exemptions: If parity actually increases total claims costs by more than 1%, plans can apply for exemption after 6 months. Small firms (defined as 50 or fewer employees) and products in the individual (nongroup) market are exempted from the law entirely.

WHAT DID THE MHPA DO?

After enactment of the MHPA, it was predicted that no overall benefit expansion would occur if employers and plans compensated for the requirements with other benefit restrictions. Frank and colleagues (1997) warned that policies aimed at mandating certain benefit design structures leave open to managed care many other ways to affect coverage. No matter how comprehensive a parity law, management techniques will be largely immune from regulation (Frank, Koyanagi, & McGuire, 1997). Sturm and Pacula (1999) predicted limited expansion of coverage if employers and plans impose other constraints to compensate for the annual and lifetime dollar limits. Insiders in the managed care industry also confirmed that restructuring, not expanding, mental health benefits would be employers' most common response.

In preparation for the 2001 sunset, Senator James Jeffords (I-VT), Chair of the Committee on Health, Education, Labor and Pensions (HELP), requested a Government Accounting Office (GAO) report examining the

implementation and effects of the MHPA. The GAO (2000) reported that most employers were complying with the MHPA, but because its scope was narrow and reductions in mental health benefits were made to offset the costs of compliance, it was having little impact on employees' access to mental health services. Most employers operating in states subject only to the federal law offered insurance that replaced dollar limits on mental health benefits with equivalent dollar limits on inpatient stays and outpatient visits. In fact, the GAO reported that 87% of plans that complied did contain at least one other design feature more restrictive for mental health benefits than for medical and surgical benefits (GAO 2000).

The GAO concluded that consumers/employees in states without more comprehensive parity laws have often seen only minor changes in their mental health benefits.

The GAO concluded that consumers/employees in states *without* more comprehensive parity laws have often seen only minor changes in their mental health benefits, resulting in little or no increase in their access to mental health services, and that the costs associated with the MHPA have been negligible for most plans. The GAO did not evaluate states with more comprehensive or full parity, but noted that such statutory regulation is more likely to have an effect on claims costs. However, the GAO warned that state laws apply only to group health plans and the federal law applies only to annual and lifetime dollar limits, and many employees were likely to remain in plans that continue to provide less coverage for mental illness than for other types of illness (Allen 2000).

WHAT HAVE STATES DONE SINCE THE MHPA?

Although the 1996 MHPA has been criticized for what it did not do, it did place parity on the agenda and enabled state legislatures to experiment with full parity. Thirty-one states now require some form of parity in employer-sponsored health insurance as of January 2001. The majority enacted provisions more comprehensive than the MHPA, but the 1974 Employee Retirement Income Security Act (ERISA) preemption provisions limit the scope of state action and exempt self-insured plans from state regulation. Such plans cover approximately one third of all employer-insured Americans (Pollitz, Tapay, Hadley, & Specht, 2000).

Table 1 provides an overview of recent state parity laws and highlights variations in the major statutory provisions. Across the states, only five early adopters initiated some form of parity before the MHPA: Maryland,

TABLE 1
Variation in State Mental Health Parity Provisions

State	*Year Enacted*	*Mandated Benefit*	*Covers All Mental Illness*	*Covers Substance Abuse*	*Prohibits Limits on Inpatient Days and Outpatient Visits*[a]	*Covers Individual and Group Plans*	*Covers Small Employers*[b]	*Covers Policies or Employers Regardless of Cost Increases*
Total		28	15	13	26	21	20	27
Alabama	2000		✔		✔			✔
Arkansas	1997	✔	✔		✔			
California	1999	✔			✔	✔	✔	✔
Colorado	1997	✔			✔		✔	✔
Connecticut	1999	✔	✔	✔	✔	✔	✔	✔
Delaware	1998	✔			✔	✔	✔	✔
Georgia	1998		✔	✔	✔[c]	✔	✔	✔
Hawaii	1999	✔			✔	✔		✔
Indiana	1999				✔	✔		
Kentucky	2000		✔	✔	✔			✔
Louisiana	1999	✔[d]	✔				✔	✔
Maine	1995	✔[e]			✔	✔		✔
Maryland	1994	✔	✔	✔		✔	✔	✔
Massachusetts	2000	✔		✔[f]	✔[g]	✔	✔[h]	✔
Minnesota	1995	✔[i]	✔	✔	✔		✔	✔
Missouri 1999			✔		✔	✔	✔	
Montana	1999	✔			✔	✔	✔	✔
Nebraska	1999	✔			✔			✔
Nevada	1999	✔				✔		

TABLE 1 (*Continued*)

State	*Year Enacted*	*Mandated Benefit*	*Covers All Mental Illness*	*Covers Substance Abuse*	*Prohibits Limits on Inpatient Days and Outpatient Visits*[a]	*Covers Individual and Group Plans*	*Covers Small Employers*[b]	*Covers Policies or Employers Regardless of Cost Increases*
New Hampshire	1994	✔			✔		✔	✔
New Jersey	1999	✔			✔	✔	✔	✔
New Mexico	2000	✔	✔		✔		✔	
North Carolina	1997	✔	✔	✔	✔	✔[j]	✔	✔
Ohio[k]	1990	✔	✔	✔	✔	✔[i]	✔	✔
Oklahoma	1999	✔			✔			
Pennsylvania	1998	✔				✔[l]		✔
Rhode Island	1994	✔			✔[m]	✔	✔	✔
South Carolina	2000	✔		✔	✔	✔[i]	✔	
South Dakota	1998	✔[n]			✔	✔	✔	✔
Tennessee	1998	✔	✔					
Texas	1997	✔						✔
Utah	2000		✔	✔				✔
Vermont	1997	✔	✔	✔	✔	✔	✔	✔
Virginia	1999	✔		✔	✔	✔		✔
Federal MHPA	1996		✔					

[a]States that are not checked in this column permit a disparity in the terms and conditions required for mental health coverage compared to other physical health conditions. For example, the parity statute may set a cap on the number of inpatient and/or outpatient days required by insurers for mental health coverage, without setting the same cap on coverage for other physical illnesses.
[b]The statute covers small employers, most commonly defined as employers with either 25 or fewer employees or those with 50 or fewer employees.
[c]Parity provision applies only to group plans.

[d]Louisiana: The statute mandates coverage of serious mental illness and requires a "mandated offering" for other mental illnesses.
[e]Maine: The statute mandates coverage for group plans and requires a "mandated offering" for individual policies.
[f]Massachusetts: The parity requirements apply to co-occurring mental illness and substance abuse disorders.
[g]Massachusetts: The statute requires equal terms and conditions for biologically based disorders as defined in the statute, rape-related mental disorders, and all mental disorders for children and adolescents that substantially interfere with or limit the functioning and social interactions of such a child or adolescent.
[h]Massachusetts: The statute exempts businesses with 1 to 50 employees and non-group health plans from compliance until 1 year after the effective date of the statute.
[i]Minnesota: The statute mandates coverage for HMOs and a "mandated, if offered" requirement for individual and group plans.
[j]Parity provisions apply only to state employees.
[k]Ohio: The state did not enact a statute. Parity is applicable to state employee mental health coverage through the collective bargaining agreement between the state and the Ohio Civil Service union. The current agreement containing the parity provision is effective 1997–2000.
[l]Parity provisions apply only to HMO groups.
[m]Rhode Island: The statute includes one limitation that may not result in setting equal terms and conditions; inpatient coverage in cases where continuous hospitalization is medically necessary is limited to 90 consecutive days.
[n]South Dakota: A 1999 amendment to the statute narrowed the definition of biologically based mental illness to schizophrenia and other psychotic disorders, bipolar disorder, major depression, and obsessive-compulsive disorder.

New Hampshire, and Rhode Island in 1994, and Maine and Minnesota in 1995. After the 1996 MHPA, 26 states enacted some form of parity. In addition, two states revisited existing parity laws in 1999: Connecticut expanded the definition of mental illness, and Missouri replaced the existing "mandated offering" provision with a "mandated, if offered" provision. Five states also offer some form of parity for state employees, and after a pilot with the state employee program, Indiana, Massachusetts, and Texas enacted statewide parity.

In general, the provisions of the state laws are more comprehensive than those of the MHPA, although there is wide variation across states in the scope of the mandate and definition of "parity" and "mental illness." State legislatures differ in how they conceptualize parity across these dimensions: the scope of the benefit mandate, the definition of mental illness, substance abuse coverage, the equality of the terms and conditions, the inclusion of individual and/or group health plans, and exemptions for cost increases and/or small employers.

Twenty-five states mandate parity and mental health coverage for all group health plans, whereas the MHPA requires parity only in group plans that *already offer* mental health coverage. Most states require parity for "broad-based" or, more specifically, "severe and biologically based" mental illnesses, while the MHPA allows health plans to decide which mental disorders to cover. Similarly, most states apply parity to all "terms and conditions," whereas the MHPA only applies to annual and lifetime dollar limits. About half of the states allow a small employer exemption and only seven permit employers to claim a cost exemption, while the MHPA allows both employer-size and cost exemptions (Table 1).

There is also significant variation in how state legislatures define "mental illness." Political and economic factors dominate over need-based strategies or clinical judgments in statutory definitions. The National Alliance of the Mentally Ill (NAMI) emphasizes the importance of biological factors in the etiology of a serious mental disorder, often using the terms "serious mental illness" and "biologically based mental illness" in an effort to prioritize care and coverage according to diagnosis. In contrast, the National Mental Health Association (NMHA) suggests that severe mental illness discriminates against children and adults who have serious illnesses but do not have one of the SMI diagnoses. Thus, parity in mental health is defined primarily by diagnosis—a pattern that differs significantly from the coverage of medical/surgical benefits. For example, in employer-sponsored health coverage, certain medical procedures may not be covered or the number of office visits for a specific diagnosis may be limited; rarely is a specific diagnosis excluded from coverage altogether. In contrast, a person with mental illness may be denied treatment regardless of need, solely on the basis of a diagnosis (Table 1). Thus far, most states do not

mandate parity for substance abuse. Those states that do are Arkansas (includes an opt-out for insurers), Connecticut, Georgia, Kentucky, Maryland, Massachusetts (limited to co-occurring addictive and mental illness disorders), Minnesota, Missouri, North Carolina and Ohio (state employees only), Utah, Vermont, and Virginia. In states that require parity for mental health but not for substance abuse, health plans often face coverage decisions for patients presenting with mental illness and addictive disorders. Only Massachusetts addressed the issue of co-occurring disorders (Table 1).

Twenty-three states require equal terms and conditions or full parity; that is, rates, terms, and conditions of coverage must be the same for mental health benefits as for medical and surgical benefits. For example, a state typically would prevent health plans from establishing any terms, conditions, or benefits that place a greater financial burden on an insured for access to diagnosis or treatment of mental conditions than for treatment of other physical conditions (Table 1).

There is wide variation across states in definition of "parity" and "mental illness."

Many state legislatures were influenced by and recognized the policy research conclusion that parity under managed care is affordable. In fact, in response to Sturm's (1997) finding that the MHPA removal of the typical average annual dollar limit of $25,000 would increase mental health care costs by about $1 per enrollee per year under managed care, many state legislators received a one-dollar bill from parity supporters. In several statutes, state legislatures included specific language permitting mental health benefits to be delivered under a managed care system. Twenty-one states wrote specific provisions to encourage the use of managed care or allow for use of incentives to encourage in-network rather than out-of-network care. States directly encouraged the use of managed care techniques—medical necessity determinations and/or utilization review—in the delivery of mental health services. In addition, many states included explicit language about coverage differentiation between in-network and out-of-network care.

Between 1997 and 2000, states also enacted laws to "match" the 1996 MHPA provisions. While matching a federal law may appear meaningless, state legislatures were motivated by a variety of factors. Some wanted to block any state action above the federal minimum standards, but still allow legislators strategically to support mental health parity. Others wanted to push incremental action on parity, intending to revisit the issue in future years. In fact, in a two-step process, 7 of the 15 states that matched the

MHPA later enacted more comprehensive parity. And finally, for some states, a matching statute provided the state insurance agency with oversight and enforcement authority.

In addition, former President Clinton issued an executive order to implement full parity for mental health and substance abuse coverage in the Federal Employees Health Benefit Plan (FEHBP) by 2001. Parity, as defined in the FEHBP, requires coverage for mental health, substance abuse, medical, surgical, and hospital services to be identical to that for traditional medical care in terms of deductibles, coinsurance, copayments, and day and visit limitations. An evaluation of the implementation and impact of this policy change is currently under way, enhancing further the opportunity to understand the effect of full parity on mental health and substance abuse benefit and service costs.

THE IMPACT OF PARITY ON MENTAL HEALTH BENEFITS

Despite all this action on parity in Congress and state legislatures, what really has changed in mental health coverage? Has more comprehensive or full parity improved mental health benefit design?

In 1999–2000, the Healthcare for Communities Employer Survey contacted employers that had been identified by individuals in the prior survey as providing coverage to them or someone in their household. Individuals with coverage through self-employment, government, or unions, or who reported working for a firm with six or fewer employees, were not matched to an employer. Because of these exclusions, incomplete information, and the fact that in some cases two or more HCC respondents specified the same employer, about 2,300 employers were identified. Phone interviews were completed with 689 (30.3% response rate) by July 2000. Although this response rate is relatively low, it is not unusual for employer benefit surveys. The benchmark for employer surveys is the Bureau of Labor Statistics' Employee Benefit Survey (EBS), which had a response rate of 53% in 1997, the last year in which the EBS was fielded for medium/large employers.

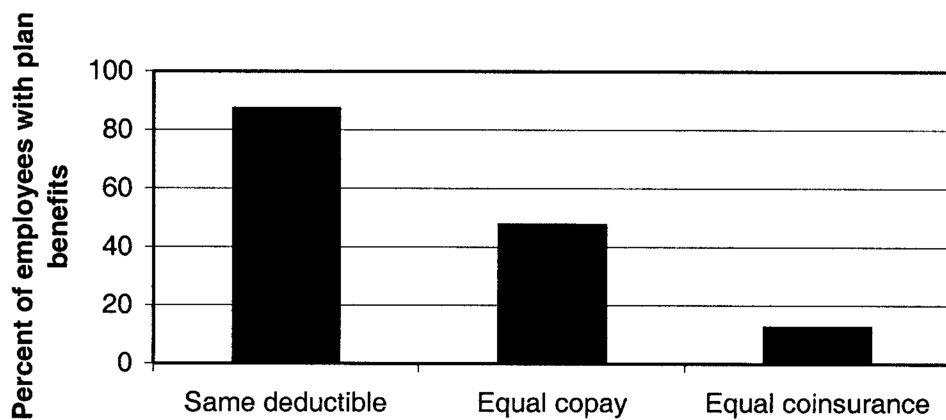
The statistics are weighted at the individual level and should be interpreted as describing employer/plan characteristics for the average adult in the United States with employer-sponsored insurance, not as describing the average plan or average employer (which would underrepresent large plans/employers relative to the enrollee-weighted numbers shown here).

Has more comprehensive or full parity improved mental health benefit design?

Evidence from the Healthcare for Communities (HCC) Employer Survey is mixed. Although 87.3% of respondents are in plans that have the same deductibles for medical care and mental health care, only 47.6% of the enrollees in plans with copayments for outpatient services have parity in copayments for mental health. Parity in coinsurance rates is even lower, with only 12.5% of respondents in plans with equal coinsurance for outpatient mental health. Day and visit limits are still quite common; 88% of enrollees report some type of day limit on inpatient mental health (Figure 1); and 90% report some type of visit limits on outpatient mental health (data not shown).

Examining cost-sharing arrangements by plan type shows pronounced differences in the generosity of benefits. Figure 1 shows cost-sharing arrangements for enrollees in HMOs, Preferred Provider Organizations or Point of Service (PPO/POS) plans, and in traditional plans. Plans that are more "managed" appear to be far more equitable in coverage of mental and physical health services. HMOs and PPO/POSs are much more likely to have the same deductibles and copayments than traditional plans. These managed plans are much less likely to have equal coinsurance rates, but coinsurance for outpatient services is far less common in managed care. Although the vast majority of plans impose inpatient-day or outpatient-visit limits, there are some differences among them. For example, in our data, inpatient day limits are significantly less common in HMOs than in traditional indemnity plans. However, for outpatient visits, there were no significant differences in limits.

FIGURE 1
Cost-Sharing Arrangements in 1999–2000



Note. Source is the Healthcare for Communities (HCC) Employer Survey.

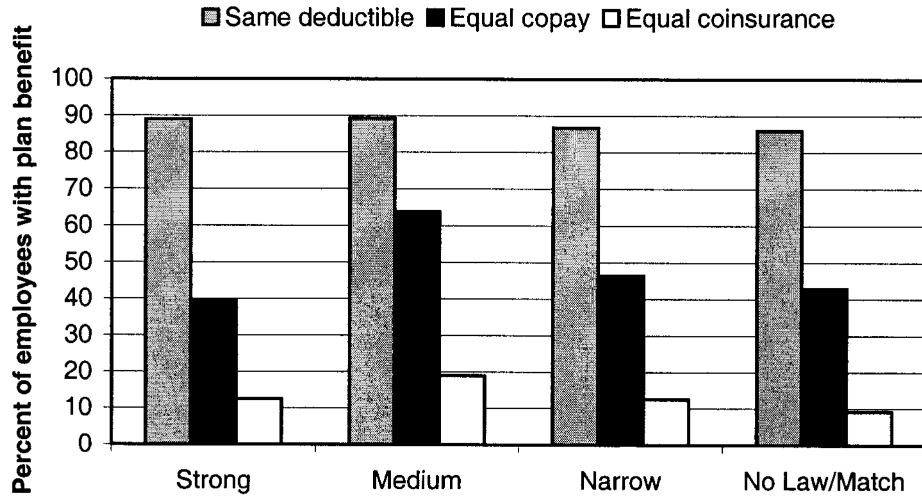
These findings suggest that *all* plan types fall short of providing comprehensive parity in mental health benefits; however, they also suggest that managed plans are providing more equitable benefits for mental and physical health services than traditional plans, on average. One explanation for the generosity of benefits in managed care is the availability of other management techniques that restrict mental health service utilization (Frank & McGuire, 1998).

An examination of mental health benefits across states with varying provisions enables us to consider the *marginal impact* of more comprehensive mental health parity. This offers some insight into the possible effects of a transition from partial to full parity coverage under pending amendments to the 1996 MHPA. We assign each state to one of four categories:

- *Strong Parity:* States that require full parity and equality in all cost-sharing dimensions and do not allow any exemptions, even if the statute limits coverage to “serious” or “biological” mental illness: California, Colorado, Connecticut, Delaware, Maryland, Minnesota, Montana, New Hampshire, New Jersey, Rhode Island, South Dakota, and Vermont.
- *Medium Parity:* States that enacted full parity, but allow some exemptions (e.g., small employer, claim cost, or “if offered” provisions): Arkansas, Hawaii, Maine, Indiana, Kentucky, Louisiana, Missouri, Nebraska, Nevada, Oklahoma, Pennsylvania, Tennessee, Texas, and Virginia.
- *Narrow Parity:* States that passed full parity as a mandated offering, not a mandated benefit: Georgia and Utah.
- *No State Law/Match Parity:* All remaining states that either have no parity law or passed a statute matching the MHPA provisions. Since all states are subject to the federal requirements, those with no state-specific parity are identical to matching states in terms of the minimum benefit and partial parity requirements.

Figure 2 shows the prevalence of same deductibles, equality in copayments and in coinsurance among respondents with employer-sponsored coverage by the scope of parity mandate. There is no significant difference in the prevalence of same deductibles or equal coinsurance rates among respondents across states. Respondents in states that have enacted medium parity, however, are significantly more likely to have equality in copayments than their counterparts in other states. Although respondents in narrow-parity states and states with only federal parity standards seem more likely to report equality in copayments, these differences are not statistically significant. Figure 3 shows the prevalence of inpatient-day and outpatient-visit limits by scope of parity mandate. Respondents in strong-

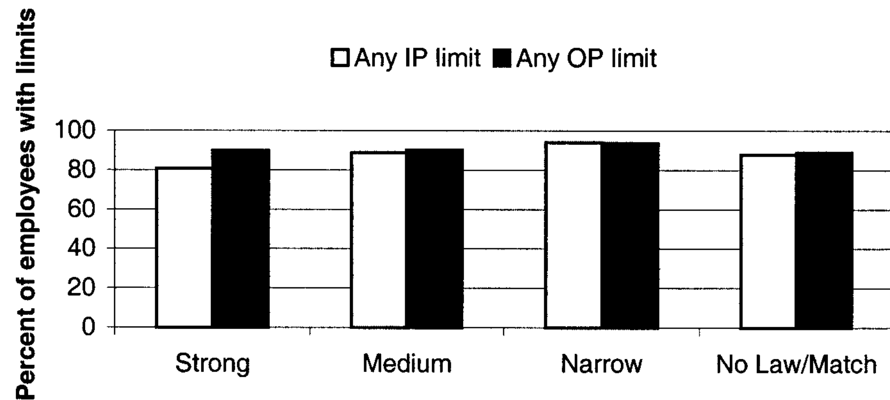
FIGURE 2
Cost Sharing by Strength of Parity Legislation



parity states are less likely to report limits on inpatient days for mental health; however, there are no statistical differences in the prevalence of outpatient visit limits for mental health.

The lack of a consistent finding with respect to benefit design by scope of parity statute is not too surprising. Simple descriptive statistics do not control for differences in participation in managed care plans or plan of-

FIGURE 3
Prevalence of Inpatient and Outpatient Visit Limits by Strength of Parity



ferings across states. Figure 4 shows that respondents in strong-parity states are much *more* likely to participate in an HMO than employees in medium, narrow, and no law/match states. They are also *less* likely to participate in PPO/POS plans and traditional indemnity plans. This may relate to the respondents' share of the cost of coverage, as is indicated by the relatively low cost-sharing arrangements. It also may relate to employers' willingness to offer other types of plans.

To account for these differences across states, we calculated the predicted likelihood of specific cost-sharing arrangements and limitations by parity status using logistic regression analysis. Figures 5 and 6 show that even after we control for firm and plan characteristics, we do not see a consistent finding in terms of the marginal effect of parity on cost-sharing arrangements or visitation limits. Respondents in medium-parity states are the only ones significantly more likely to report the same deductible than those in no law/match states. They are also significantly more likely to report equality in copayment arrangements. None of the other differences in cost sharing or visit limits are statistically significant.

These findings suggest that, at best, there is a very small effect of more comprehensive parity on benefit plans, but there seems to be a point beyond which more comprehensive laws (strong parity) are ineffective. Because these predicted probabilities control for differences in plan participation, we know that the lack of a difference in benefit design between strong and weak parity states cannot be attributed to managed care. If not managed care, then what?

One possible alternative explanation is that the enactment of a parity mandate is endogenous and is the result of a political process with strong interest groups on both sides. In an analysis of early adopters of state

FIGURE 4
Participation in Managed Care Plans by Strength of Parity

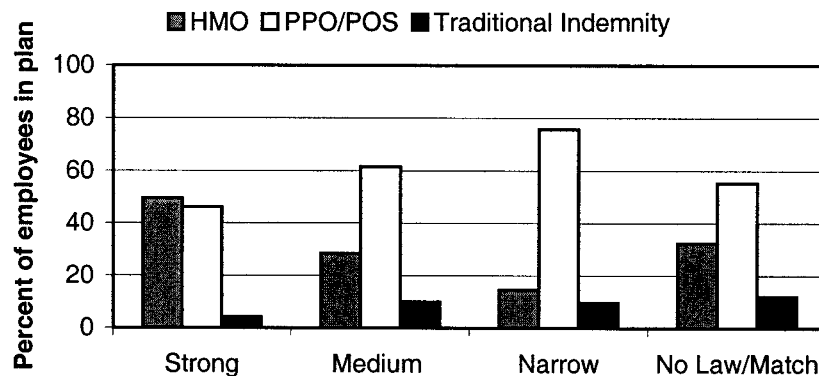


FIGURE 5
Predicted Cost Sharing by Strength of Parity Legislation

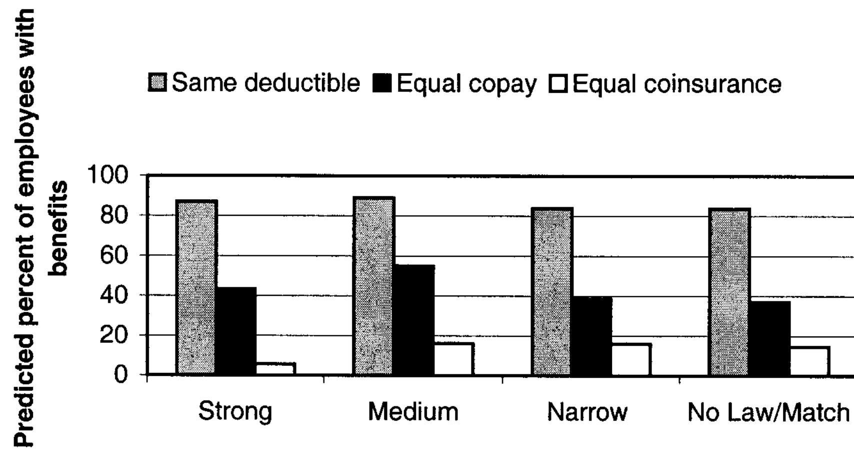
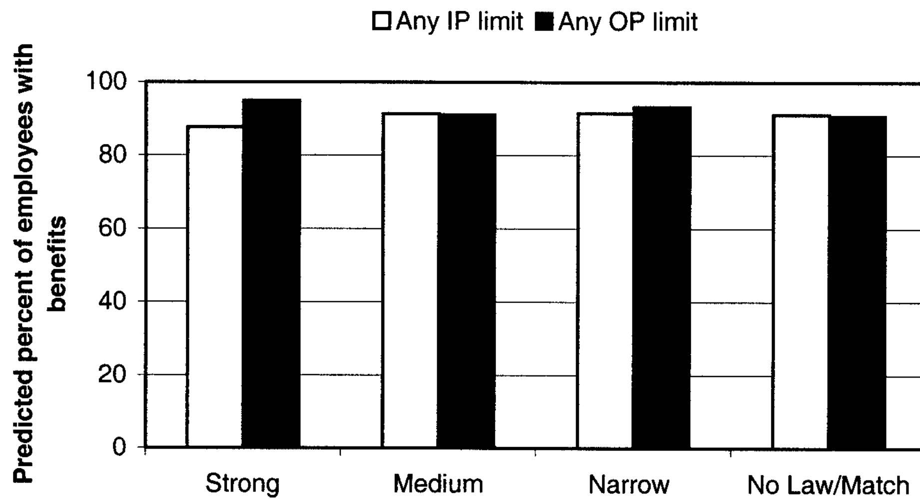


FIGURE 6
Predicted Likelihood of Any Inpatient and Outpatient Visit Limits by Strength of Parity



parity laws, Sturm and Pacula (1999) reported that these states had fewer people accessing mental health care services, which was not related to differences in population characteristics or prevalence of illness. If policy making is purposeful action, responsive to political and economic factors within a state, then estimating the impact of policy requires identifying and controlling for the forces that lead to policy changes (Gitterman, Scheffler, Schwalm, Peck, Gruttadaro, & Ciemens, 2000).

Although the data from the HCC Employer Survey suggests that full parity may not improve mental health benefit design, the reader is reminded of several limitations of the data that also may be influencing the results. First, the survey is not nationally representative of either employers or employees, but rather the average adult with employer-sponsored coverage. The sample therefore suffers from some selectivity bias in that we do not control for the likelihood that the individual chooses employer-sponsored insurance over other forms of insurance, nor do we account for the probability that a particular employer-sponsored plan is selected. Second, and perhaps more importantly, these data do not contain information as to whether the employer chose to self-insure, which will influence the firm's willingness to offer plans that comply with state mandates. The predicted probabilities reported in Figures 5 and 6 do control for differences in firm size, which may be a proxy for the decision to self-insure, but certainly it is not definitive. Additional work is needed to determine if and how parity laws influence plan offerings made by an employer as well as the choice among plans made by consumers.

REVISITING THE MHPA AND BEYOND FULL PARITY

In the U.S. system of regulatory federalism and health and mental health coverage, there is now a multi-tier system of parity regulation, and the actual legal status of mental health benefits in health plans varies from state to state. The exact nature of mental health coverage also varies significantly across different groups. If Congress *does not* act before September 30, 2001, and permits the MHPA sunset, then the states that have not passed their own parity laws may revert to pre-parity inequities in the provision of mental health care services. If Congress *does* act, then the nation would have uniform and full mental health parity standards.

In addition to revisiting the 1996 MHPA, Congress might consider other incremental next steps. Congress' action on patient bill of rights (choice of providers, access to emergency services, and a fair and efficient process for resolving disputes with health plans and providers) also could have implications for consumers in managed behavioral health care. In fact, 15 mental health professional organizations are also pushing a mental health

patient bill of rights, which sets forth fundamental principles necessary to ensure quality mental health care and protect the rights of those seeking mental health and substance abuse treatment (American Psychological Association web site). A final step is vast improvement in measuring the quality of mental health services and the performance of managed behavioral health care plans.

CONCLUSION

With or without full parity, consumers face real hurdles to accessing appropriate care in managed care environments. By confronting the MPHA sunset, Congress is likely to take one incremental step toward more comprehensive mental health parity; to encourage further innovation and experimentation in state legislatures; and to foster further policy research on the impact of full parity on costs, quality, and access to mental health care.

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