

CENTER FOR HEALTH POLICY RESEARCH

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HEALTH & MEDICINE LETTER



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• HEALTH INSURANCE •

PARITY COVERAGE FOR MENTAL ILLNESS



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Why Mental Health Parity?

In a perfect world, HEALTH insurance would cover medical, dental and mental health services seamlessly. A person suffering a disorder in any of those three categories are without "health" as much as anyone else.

This is not a perfect world. Disparities exist. When inappropriate disparity is found, the most rational approach is to restore "parity." This is the case with certain severe mental health conditions.

Mental Health Insurance Parity is where modern science collides with outmoded notions about mental illness and how best to insure against the risk. Few people ... insurers, elected officials, physicians, behavioral scientists, employers, employees, and others ... will deny that much of "severe mental illness" is biologically based in exactly the same manner as Downs Syndrome and Parkinson's Disease. It is difficult to rationally distinguish between the "insurance worthiness" of Downs Syndrome and schizophrenia. The stumbling block does not appear to be the science, but rather the policy and politics of implementing equity adjustments.

The Mental Health Insurance Parity debate typically includes three groups: (1) mental health advocates seeking insurance coverage for some or all mental and behavioral disorders (2) insurers/business leaders seeking strict status quo spending and (3) those seeking compromise.

Every discussion of mental health "parity" must begin with an understanding of why "disparity" exists. Differences in insurance coverages between physical and mental health problems are historical responses to risk assessments made many years before the organic/biological nature of mental illnesses was known.

Recent advances in neuroscience and psychopharmacology have led to effective treatments of many serious mental disorders.

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• WE CONCLUDE •

... there is compelling reason, and minimal associated risk, to enact state mental health parity legislation similar to Senate Bill 1059. We recommend that insurers and advocates use Fall 1998 to jointly craft an improved bill, and that both responsibly engage Oklahoma businesses and Chambers of Commerce ...

• DID YOU KNOW •

Oklahoma 1997

10 Most Frequently Prescribed Drugs & Their Purpose

Source: An Oklahoma Insurance Company (see right)

Drug(s)	Primary Purpose	Pct *
Prozac/Zoloft/Paxil	Depression/Anxiety	29%
Prilosec/Prevacid	Esophageal reflux/indigestion	28%
Claritin	Allergies	16%
Zocor/Lipitor	High cholesterol	16%
Norvasc	High blood pressure	6%
Premarin	Estrogen	5%
		100%

* This is a list of the 10 most frequently prescribed drugs paid for by the insurer. The listed percent is of this list, not the percentage of all drugs prescribed. The most commonly prescribed drugs in Oklahoma are those used to treat depression and/or anxiety. Although this is the experience of this insurer, it is believed to be very representative of all insurers.

So what does society do when "conventional wisdom" is proven inaccurate? An intelligent and compassionate society uses the new knowledge to adapt and improve the quality of life.

This is the challenge that contemporary medical research offers to Oklahoma's policymakers.

Health Policy and Parity

The most responsible purpose for Mental Health Parity initiatives is to correct inequities caused by ignorance; inequities that have been exposed by contemporary medical research. Traditional wisdom has been to provide separate benefit coverages for physical and mental health conditions. That rationale is no longer defensible by any credible source.

It is now accepted that many, if not most, severe mental illnesses have a specific and identifiable biological basis. And severe mental illness is relatively uncommon. That said, the seventh leading cause of death in Oklahoma is suicide; and much of that is attributable to severe mental illness.

The severely mentally ill are a small cohort of Oklahomans. But their illnesses are no less devastating than major cases of heart disease, diabetes or cancer.

Roadblocks to Parity

There seems to be a great deal of agreement among health care professionals, mental health advocates, employers and insurers ... and elected officials ... that mental health parity for severe mental health illness is the right thing to do.

An Oklahoma Insurer

What proportion of an insurer's expense is attributable to severe mental illness (SMI)? Do insurers reimburse differently for SMI than general medical problems? An analysis of the impacts mental health parity must begin here. Then changed utilizations may be converted to assumed impacts upon outlays and premiums.

An experienced Oklahoma health insurer has shared their 1997 data with the Center for the purpose of forthrightly calculating service utilization for mental health disorders. The insurer calculated the number of claims, amount of charges and amount paid for all covered lives. They separated the insured groups by self-insured, commercial insurance and HMO. The patients were categorized by under 18, 18-64, and 65 and over.

The claims, charges and payments were grouped into three categories (1) severe mental illness [SMI] services (diagnoses covered by OK SB 1059); (2) "all other" mental illness and; (3) medical-surgical services.

The amount of data is comprehensive. The summaries here are simplified for discussion purposes. They pertain to groups over 50 who are self-insured and those commercially insured by the company.

Table 1
Percent of Allowed Charges Paid
Adults Only (ages 18-64)

Service	Self-Ins	Comm Ins
Severe Mental Illness	76%	53%
Other Mental Illness	78%	57%
Medical-Surgical	81%	76%
Totals	81%	76%

The self-insured and commercial plans pay slightly less for SMI and OMI claims than for medical-surgical services.

Table 2
Percent of Expense
Severe Mental Health Illness (SMI)

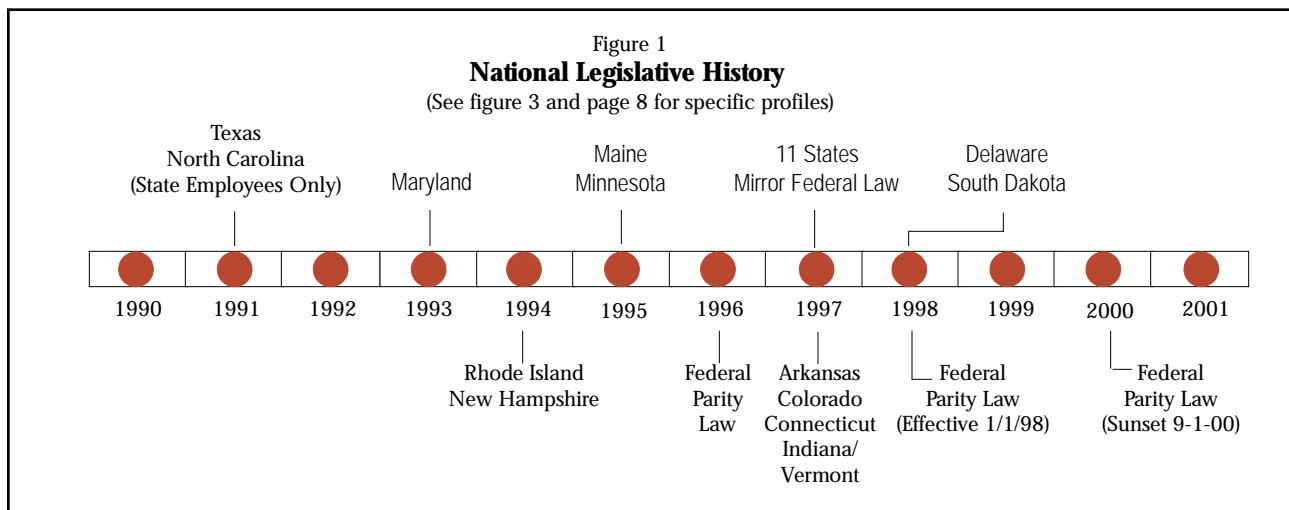
Ages	Self-Ins	Comm Ins
Children	0.1%	0.1%
Adults	0.2%	0.1%
Elderly	-	0.2%
Overall	0.2%	0.1%

All plans are at negligible risk for SMI claims.

Table 3
Percent of Expense
"Other" Mental Disorders
(including substance abuse)

Ages	Self-Ins	Comm Ins
Children	4.2%	1.6%
Adults	3.3%	1.5%
Elderly	2.3%	2.1%
Total	3.3%	1.5%

The inclusion of "other" mental illnesses, including substance abuse, into the parity equation will have significantly more impact.



Almost all will profess that this equity correction is long overdue. There are roadblocks to be understood and resolved. They include:

- There is a lack of precise clinical definition in many legislative efforts. Mental illnesses are not as easily categorized as heart attacks, broken bones or breast cancer. This can be remedied.
- The cost impact is not well understood. This leads insurance company actuaries to require conservative estimate safety buffers in premium pricing to avoid the risk of loss.
- Selected insurers and employers, who may support mental health parity, may not be able to afford any potential cost increase at this time.
- There is a minor concern that small numbers of providers will inappropriately code disorders or extend treatments, particularly in borderline mental disorders that are not easily measured.

Mandates?

In some cases, the health care marketplace would be better served if governments did not "help" by mandating specific services be included in insurance plans. In other cases, "mandates" are the simplest and most equitable method of achieving an overwhelming social good that could not be achieved voluntarily. Good governments know the difference.

Unfortunately, the mental health parity debate often is reduced to a debate over the merits of "mandates." It is likely the Oklahoma debate will be no exception. Rather than arguing over the philosophies of mandates, it is recommended that the debate be centered upon

whether this is a "good" mandate that is reasonable ... or a "bad" mandate that is simply selfish, partisan and destructive. The recommendations of this issue brief suggest that this will likely be a "good" mandate that will do no harm, be equitable to all insurers, and will achieve a desired public good.

Federal Legislation

Regardless of the legislative vetoes of 1997 and 1998, mental health parity (in dollar coverage) is required of Oklahoma insurers and employers. The federal law was effective January 1, 1998 and will "sunset" September, 2000. It is very likely that a strengthened bill be enacted prior to the sunset date. Oklahomans currently affected are:

- Insured groups larger than 50 people
- All employer provided health plans
- All self-insured private health plans (there is no ERISA exemption for self-insured plans)

State Legislation

Pre-1998 legislative activity shows that 29 states have enacted a total of 38 laws and resolutions concerning some aspect of mental health parity.

In 1998 alone, 31 states considered 88 separate pieces of legislation. Many bills were redundant. All are listed for inclusiveness. Their disposition has been:

Introduced/No Action	23
Introduced and Failed	39
Introduced and Carried Over	2
Passed Senate	6
Passed House/Assembly	6
Passed and Vetoed	3
Passed Both Houses	1
Conference/Failed	1
<u>Passed and Enacted</u>	<u>7</u>
TOTAL	88

Cost Estimate Data

There are three kinds of estimates available to measure the cost impacts of Mental Health Parity. They are actual experience, theoretical models and planning estimates:

Those ACTUAL cost increases reported by pioneering states show that any increase is nominal or non-existent. These cost increases are:

Maryland (- 0.2%); Rhode Island (+ 0.3%); and New Hampshire (none).

The THEORETICAL models are using a host of assumptions. In almost every case, the ranges of estimates range from nominal increase to almost 5%. In every case the estimates must be read very carefully and matched to the appropriate coverages and plan construction.

Study Group	Limited Parity	Full Parity
RAND Corporation	- 0.2%	
Hay Group (for DHHS)	0.0%	3.6%
Congressional Budget Office	+ 0.4%	

INSURERS have suggested a variety of estimates. None are accompanied by data or methodology. In reality, insurers are not likely to publish theoretical cost/premium increases for practical competitive purposes.

We have been unable to identify any experience based methodology that definitively proves a required net increase in premium due to mental health parity legislation.

Conclusions Concerning Cost

Costs of mental health parity are dependent upon many different variables (see figure 2, page 5). This is a real danger in simply grabbing numbers.

- In states where mental health parity laws have been in force, studies indicate nominal, if any increases attributed to parity.
- In all studies, whether empirical or theoretical, tightly managed plans report little or no increase in overall costs.
- Most, if not all, major employers have elements of managed care and/or Employee Assistance Programs in place. This is particularly true for higher dollar cases like major mental illness.

- The higher cost estimates (3-5%) are for FULL PARITY, in unmanaged plans that included substance abuse conditions. Most proposed laws have coverages that are less than full parity.
- Oklahoma specific data shows that severe mental illnesses constitute nominal amounts of current employer/insurer expense (see page 2).

The nation has become accustomed to having big ticket items "managed" in some form or fashion. It is suggested here that any effort to manage these costs will result in no, or nominal, cost increases.

Summary and Recommendations

This analysis examined the utilization data of a large Oklahoma insurer; data from states with MHP laws; theoretical cost models; and the science suggesting the biological causes of severe mental illness.

- There appears to be minimal risk of premium increases.
- Patients would be redirected toward more appropriate treatment sources and professionals.
- Oklahoma would begin correcting scientifically unsupportable disparities in insurance coverages.
- Oklahoma would determine local priorities rather than relying upon federal legislation and mandates.
- Empirical and theoretical estimates of cost increases show minimal increases in any plans that are managed.

The disparity of benefits tends to drive patients away from mental health professionals and toward medical practitioners. We are likely paying the same amounts, or more, for care. But our policies encourage patients away from those professionals seemingly best qualified to counsel, treat and modify their behavior.

We conclude there is compelling reason, and minimal associated risk, to enact state mental health parity legislation similar to Senate Bill 1059.

We recommend that insurers and advocates use Fall 1998 period to jointly craft and agree upon an improved bill; and that both responsibly engage Oklahoma businesses and Chambers of Commerce to support the mental health parity legislative effort. Statewide efforts currently underway need to be "information-oriented" and discuss and negotiate in good faith. Limited mental health parity legislation is likely to be a "win-win" for all concerned.

**Figure 2
Costs of Mental Health Parity**

The ultimate costs, if any, of any mental health parity initiative depends upon a host of variables that have unknown and complex impacts upon utilization. Some of these variables are listed below:

INSURANCE PLAN ELEMENTS?

- Annual/Lifetime Limits
- Co-Payments
- Annual Deductibles
- Outpatient Visits
- Hospitalizations

INSURANCE PLAN TYPE?

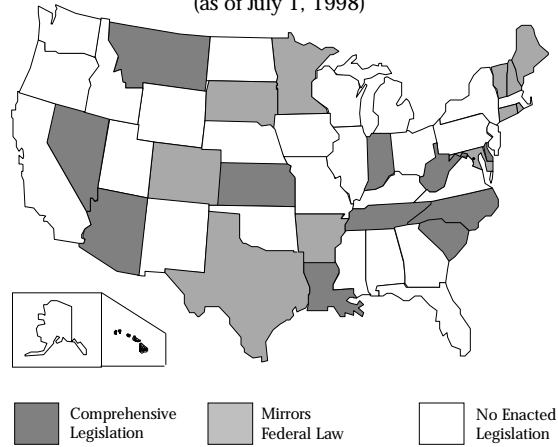
- Fee for Service (FFS)
- Point of Service (POS)
- "Carve Outs" Mental Health Benefits
- Preferred Provider Organization (PPO)
- Health Maintenance Organization (HMO)

COVERED SERVICES?

- Selected Mental Disorders
- All Mental Disorders
- All Alcohol Abuse
- All Drug Abuse
- All Substance Abuse

**Mental Health Parity Legislation ...
and Resulting Utilization/Cost Impacts**

**Figure 3
State Mental Health Parity Legislation
(as of July 1, 1998)**



**Table 4
Average Premium Increase Across Plan Types**

Assumes insurance distribution of HMO, 30%; FFS, 20%; PPO, 30%, POS, 20%

Illnesses/Conditions	Parity	Parity	Full
	Cost Sharing	Service Limit	Parity
Mental Health/Subs Abuse	0.4%	1.2%	3.6%
Mental Health Only	0.3%	1.1%	3.4%
Substance Abuse Only	0.1%	0.03%	0.2%

Source: USDHHS, "The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits", Apr1998. Actuarial models by The Hay Group. Estimates for HMO managed care plans only, indicated an overall increase of 0.6% for full parity.

**Table 5
Estimated Adult Oklahomans, by Diagnosis**

(Based upon population of 1.9 million adult Oklahomans)

Schizophrenia	2.2%	42,000
Bipolar Disorder	1.2%	23,000
Major Depression	5.0%	95,000
Panic Disorder	1.3%	25,000
Obsessive-Compulsive Disorder	2.1%	40,000
Schizoaffective Disorder	NL	NL

These are the estimated numbers of adult Oklahomans with these illnesses within any single year. Source: "Use of Services by Persons with Mental & Addictive Disorders: Findings from the National Institute of Mental Health Epidemiologic Catchment Area Program", Narrow et. al., Arch Gen Psychiatry, pp 95-107, Volume 50, February 1993.

**Table 6
Percent of Patients in U.S. by Source of Care**

Disorder	MH (1)	Phys (2)	Other (3)
Schizophrenia	70%	46%	33%
Bipolar Disorder	52%	56%	33%
Major Depression	50%	47%	53%
Panic Disorder	56%	51%	44%
Obsessive-Compulsive	54%	41%	48%
Schizoaffective Disorder	NL	NL	NL

(1) Mental health professionals (2) Licensed physicians excluding psychiatrists (3) Clergy, family friends and other support systems

Visit totals equal 100%; Patient totals are greater than 100% as people seek multiple sources of care. Source: "Use of Services by Persons with Mental & Addictive Disorders: Findings from the National Institute of Mental Health Epidemiologic Catchment Area Program", Narrow et. al., Arch Gen Psychiatry, pp 95-107, Volume 50, February 1993.

**Table 7
Percent of Visits in U.S. by Source of Care**

Disorder	MH (1)	Phys (2)	Other (3)
Schizophrenia	58%	11%	31%
Bipolar Disorder	49%	20%	31%
Major Depression	53%	12%	36%
Panic Disorder	48%	18%	34%
Obsessive-Compulsive	48%	9%	43%
Schizoaffective Disorder	NL	NL	NL

Senate Bill 1059
Oklahoma Mental Health Parity Act of 1998

ENROLLED SENATE By: Monson of the Senate And Seikel, Glover, Collins, Davis and Gilbert of the House

An Act relating to insurance; requiring group health insurance and health benefit plans to include coverage for severe mental illness; allowing managed care systems to provide benefits; requiring equality of benefits; making certain exceptions; providing for procedures; clarifying application of requirement to agreement, contract or policy provisions; defining term; limiting provisions of this act; providing for codification; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.10 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. Any group health insurance or health-benefit-plan agreement, contract or policy, including the State and Education Employees Group Insurance Board and any indemnity plan, not-for-profit hospital or medical service or indemnity contract, prepaid or managed care plan or provider arrangement, and Multiple Employer Welfare Arrangement (MEWA) or employer self-insured plan, except as exempt under federal ERISA provisions, that is offered, issued, or renewed on or after the effective date of this act shall provide benefits for treatment of adults, adolescents and children with severe mental illness. Such benefits may be provided through a managed care system.

2. Such benefits shall be equal to benefits for treatment of and shall be subject to the same preauthorization and utilization review mechanisms and other terms and conditions as all other physical diseases and disorders.

3. This requirement shall not apply to agreements, contracts or policies that provide coverage for a specified disease or other limited benefit coverage or groups with fifty (50) or fewer employees.

B. 1. The nondiscrimination requirement set forth in subsection A of this section shall pertain to all aspects of any health insurance or health benefit plan agreement, contract or policy that is offered, issued, or renewed in this state including, but not limited to:

- a. coverage of inpatient hospital services for at least twenty-six (26) days,
- b. coverage of outpatient services,
- c. coverage of medication,
- d. maximum lifetime benefits,
- e. copayments,
- f. coverage of home health visits,
- g. individual and family deductibles, and
- h. coinsurance.

2. For purposes of this section, "severe mental illness" means:

- a. schizophrenia,
- b. bipolar disorder (manic-depressive illness),
- c. major depression,
- d. panic disorder,
- e. obsessive-compulsive disorder, and
- f. schizoaffective disorder.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.11 of Title 36, unless there is created a duplication in numbering, reads as follows:

The provisions of this law shall not apply to any agreement, contract, or policy which will have increased premium's cost of over three percent (3%) by the implementation of these provisions.

SECTION 3. This act shall become effective November 1, 1998.

1998 Veto Statement

This is to advise you that on this date, pursuant to the authority vested in my Section 11 of Article VI of the Oklahoma Constitution to approve or object to legislation presented to me, I have VETOED Senate Bill 1059 because almost 20% of Oklahomans currently do not have health insurance and the additional health benefits mandated in this bill will increase the cost of medical insurance to the average Oklahoma citizen. Clearly, the Legislature contemplated that there would be cost increases because they inserted a limit on the amount of the cost increase that would be allowed. For a typical medical plan, Senate Bill 1059 would drive up the cost of medical insurance for a family of four by more than one hundred and fifty dollars per year, assuming an increase of 2 1/2 %. In a recent meeting 15 insurance professionals estimated the mandated coverage would result in a 1 1/2% to 4% cost increase. In 1997, legislation similar to Senate Bill 1059 was presented to me. I vetoed that legislation because of my continuing concern that we have not yet reached my goal of reducing the number of uninsured Oklahomans to the national average of 14%. Oklahoma is still a chronically underinsured state. Increasing costs and mandating benefits will not increase the number of Oklahomans with health insurance.

H.R. 3666
Mental Health Parity Act of 1996

Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1997 (Enrolled Bill Sent to President)

TITLE VII

PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS

SEC. 701

SHORT TITLE

This title may be cited as the 'Mental Health Parity Act of 1996'.

SEC. 702

AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974- (a) IN GENERAL- Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by section 603(a)) is amended by adding at the end the following new section:

SEC. 712.

PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.

(a) IN GENERAL-

(1) AGGREGATE LIFETIME LIMITS- In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits--

(A) NO LIFETIME LIMIT- If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

(B) LIFETIME LIMIT- If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable lifetime limit'), the plan or coverage shall either--

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

(C) RULE IN CASE OF DIFFERENT LIMITS- In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) ANNUAL LIMITS- In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits--

(A) NO ANNUAL LIMIT- If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

(B) ANNUAL LIMIT- If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable annual limit'), the plan or coverage shall either--

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

(C) RULE IN CASE OF DIFFERENT LIMITS- In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

Mental Health Parity

Definitions of Selected Mental Illnesses or Conditions Included in OK Senate Bill 1059

Sources: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), 1994 American Psychiatric Association
Synopsis of Psychiatry, Eighth Edition, Harold Kaplan, MD and Benjamin Sadock, MD

Schizophrenia

Schizophrenia has a lifetime prevalence range of 1 to 1.5 percent. About 0.025 to 0.05 percent of the total population is treated for schizophrenia in any single year. Although two thirds of treated patients require hospitalization, only about half of all patients with schizophrenia obtain treatment, in spite of the severity of the disorder.

Suicide is a common cause of death among patients with schizophrenia. About 50 percent of all patients with schizophrenia attempt suicide at least once in their lifetimes, and 10 to 15 percent die by suicide.

Diagnosis of Schizophrenia - For an individual to be diagnosed with schizophrenia they must have two or more of the following symptoms: delusions; hallucinations; disorganized speech; grossly disorganized or catatonic behavior; negative symptoms such as affective flattening, alogia, or avolition. Also during the active phase the individual must show a markedly below level achieved prior to the onset for one or more major areas of function, such as work; interpersonal relations; self-care. The signs of the disturbance must persist for at least 6 months which would include at least 1 month of symptoms. Schizoaffective disorder and mood disorder with psychotic features must have been ruled out, the disturbance must not be due to the direct physiological effects of a substance or a general medical condition, and if there is a history of autistic disorder or another pervasive developmental disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month.

Prognosis of Schizophrenia - Over the 5-10 year period after the first psychiatric hospitalization for schizophrenia, only about 10-20% of patients can be described as having a good outcome. More than 50 percent of patients can be described as having a poor outcome with repeated hospitalizations, exacerbations of symptoms, episodes of major mood disorders, and suicide attempts. Recovery rates range from 10 - 60 percent and 20-30 percent of all schizophrenic patients are able to lead somewhat normal lives.

Treatment - Antipsychotic medications (neuroleptics) are the mainstay of the treatment for schizophrenia, however, research has found that psychosocial interventions can augment the clinical improvement. Most patients benefit from the combined use of antipsychotic drugs and psychosocial treatment. Hospitalization is indicated primarily for diagnostic purposes, for stabilization of medications, for patients' safety because of suicidal or homicidal ideation, and for grossly disorganized or inappropriate behavior. Short stays of 4 - 6 weeks have been found as effective as long-term hospitalization.

Major Depressive Disorder

Major depressive disorder is associated with high mortality. Up to 15% of individuals with severe Major Depressive Disorder die by suicide. Epidemiological evidence also suggests that there is a fourfold increase in death rates in individuals with Major Depressive Disorder who are over age 55 years. Individuals with Major Depressive Disorder admitted to nursing homes may have a markedly increased likelihood of death in the first year. Among individuals seen in general medical settings, those with Major Depressive Disorder have more pain and physical illness and decreased physical, social, and role functioning.

Up to 20-25% of individuals with certain general medical conditions (e.g., diabetes, myocardial infarction, carcinomas, stroke) will develop Major Depressive Disorder during the course of their general medical condition. The management of the general medical condition is more complex and the prognosis is less favorable if Major Depressive Disorder is present.

The lifetime risk for Major Depressive Disorder in community samples has varied from 10% to 25% for women and from 5% to 12% for men.

Schizoaffective Disorder

The lifetime prevalence of schizoaffective disorder is less than 1 percent, possibly in the range of 0.5 to 0.8 percent. Information on the gender differences is limited. The cause of this disorder is unknown but it may be either a type of schizophrenia or a type of mood disorder.

According to the primary diagnostic criterion for schizoaffective disorder in the fourth edition of DSM-IV, the patient must meet the diagnostic criteria for a major depressive episode or a manic episode concurrently with meeting the diagnostic criteria for the active phase of schizophrenia. The patient must have had delusions or hallucinations for at least 2 weeks in the absence of prominent mood disorder symptoms. The mood disorder symptoms must also be present for a substantial part of the active and residual psychotic periods. The patient may be categorized as schizoaffective disorder, bipolar type, or schizoaffective disorder, depressive type.

Patients with schizoaffective disorder have a much worse prognosis than do patients with depressive disorders and patients with bipolar disorders and they have better prognosis than do patients with schizophrenia.

Panic Disorder

The essential feature of Panic Disorder is the presence of recurrent, unexpected Panic Attacks followed by at least 1 month of persistent concern about having another Panic Attack, worry about the possible implications or consequences of the Panic Attacks, or a significant behavioral change related to the attacks. The Panic Attacks are not due to the direct physiological effects of a substance or a general medical condition and they are not accounted for by any other mental disorder.

An unexpected Panic Attack is defined as one that is not associated with a situation trigger. At least two unexpected Panic Attacks are required for the diagnosis, but most individuals have considerably more. The frequency and the severity of the Panic Attacks vary widely.

The two most effective treatments are pharmacotherapy and cognitive-behavioral therapy. Even when pharmacotherapy is effective in eliminating the primary symptoms of panic disorder, psychotherapy may be needed to treat secondary symptoms.

Panic disorder, in general, is a chronic disorder, although its course is variable both among patients and within a single patient. About 30 to 40 percent of patients seem to be symptom free at long-term followup; about 50 percent have symptoms that are mild enough not to affect their lives significantly; and about 10 to 20 percent continue to have significant symptoms.

Obsessive Compulsive Disorder

Is described as recurring obsessions or compulsions "severe enough to be time consuming...or cause marked distress or significant impairment". People with this disorder recognize that their reactions are irrational or disproportionate.

The lifetime prevalence of obsessive-compulsive disorder in the general population is estimated at 2 to 3 percent. Some researchers have estimated that the disorder is found in as many as 10 percent of outpatients in psychiatric clinics. The mean age of onset is about 20 years. People with obsessive-compulsive disorder are commonly affected by other mental disorders.

Drug trials conducted support the hypothesis that a dysregulation of serotonin is involved in the symptom formation of Obsessive-Compulsive Disorder (OCD).

Patients with OCD often go to physicians other than psychiatrists. More than half the patients with OCD have a sudden onset of symptoms which occurs after a stressful event for about 50 - 70 percent of patients. Many people can manage their symptoms causing a 5-10 year delay before they seek treatment. About one-third of OCD patients have major depressive disorder and suicide is a risk for all patients with OCD.

Pharmacotherapy, behavior therapy, or a combination of both is effective in significantly reducing the symptoms of patients with OCD.

Bipolar I Disorder

Bipolar I disorder has a lifetime prevalence from 0.4% to 1.6%. It is a recurrent disorder more than 90% of individuals who have a single Manic Episode go on to have future episode. Roughly 60-70% of Manic Episodes occur immediately before or after a Major Depressive Episode. Approximately 5%-15% of individuals with Bipolar I Disorder have multiple (four or more) mood episodes (Major Depressive, Manic, Mixed, or Hypomanic) that occur within a given year.

Although the majority of individuals with Bipolar I Disorder return to a fully functional level between episodes, some (20%-30%) continue to display mood lability and interpersonal or occupational difficulties.

Bipolar II Disorder

The essential feature of Bipolar II Disorder is a clinical course that is characterized by the occurrence of one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode. Individuals with Bipolar II Disorder may not view the Hypomanic Episodes as pathological, although others may be troubled by the individuals' erratic behavior. Often individuals, particularly when in the midst of a Major Depressive Episode, do not recall periods of hypomania without reminders from close friends or relatives. Completed suicide (usually during Major Depressive Episodes) is a significant risk, occurring in 10%-15% of persons with Bipolar II Disorder. School truancy, school failure, occupational failure, or divorce may be associated with Bipolar II Disorder. Community studies suggest a lifetime prevalence of Bipolar II Disorder of approximately 0.5%.

State Mental Health Parity Legislation

Early Adopters	Enacted State	MH Parity	Pending Activity	No Activity	Covers All	Severe	Covers	Study of	Mirrors 1996	Limited to
	MH Parity Law	Law(s) Failed			MH Disorders	MH Disorders	Substance Abuse	Parity	Federal Law Only	State Employees
North Carolina	1991				Enacted		Enacted		Enacted	Enacted
Texas	1991				Enacted					Enacted
Maine	1992					Enacted				
Maryland	1993				Enacted		Enacted			
New Hampshire	1994					Enacted				
North Dakota	1994							Enacted		
Rhode Island	1994					Enacted			Pending	
Minnesota	1995	1998			Enacted		Enacted			

Federal Mental Health Parity Act Passed in 1996

Passed Legislation

State	Year	Year	Category 1	Category 2	Category 3	Category 4	Category 5	Category 6
Arizona	1997	1998						Enacted
Arkansas	1997		Enacted					
Colorado	1997		Enacted					
Connecticut	1997	1998	Enacted					
Indiana	1997		Enacted					
Kansas	1997							Enacted
Louisiana	1997	1998						Enacted
Montana	1997							Enacted
Nevada	1997							Enacted
South Carolina	1997		Pending		Pending			Enacted
Vermont	1997		Enacted		Enacted			
West Virginia	1997	1998						Enacted
Alaska	1998	1998					Enacted	
Delaware	1998							
South Dakota	1998				Enacted			
Tennessee	1998		Failed		Enacted			Enacted

1998 Bills Defeated

State	Year	Year	Category 1	Category 2	Category 3	Category 4	Category 5	Category 6
Alabama		1998	Failed					
Florida		1998		Failed	Failed			
Georgia		1998	Failed					
Hawaii		1998	Failed		Failed	Failed		
Idaho		1998		Failed				
Iowa		1998	Failed	Failed				Failed
Nebraska		1998	Failed	Failed	Failed			
New Mexico		1998		Passed/Vetoed			Failed	Failed
Oklahoma		1997 & 1998		Passed/Vetoed				
Utah		1998		Failed				
Virginia		1998	Failed					
Washington		1998	Failed	Failed		Enacted		

1998 Bill Carried Over/Pending

State	Year	Year	Category 1	Category 2	Category 3	Category 4	Category 5	Category 6
California		1999		Failed				
Illinois		1999	Failed	Failed	Failed			Failed
Massachusetts		1999	Failed	Failed				
Michigan		1999	Failed		Failed			
New Jersey		1999	Failed	Failed				
New York		1999	Failed	Failed				
Ohio		1999	Failed	Failed	Failed	Failed	Failed	
Pennsylvania		1999	Failed				Failed	

No Legislative Activity

D.C.	None
Kentucky	None
Mississippi	None
Missouri	None
Oregon	None
Wisconsin	None
Wyoming	None

Source: National Conference of State Legislatures, Health Policy Tracking Service, Sarah Perez and Lee Dixon. July 1, 1998