

Rollcall No. 286—Slaughter amendment—“yes.”

Rollcall No. 287—Stearns amendment—“no.”

Rollcall No. 288—Rahall—“yes.”

Rollcall No. 300—Previous question on H. Res. 246, rule on H.R. 2490, Treasury Postal—“no.”

PERSONAL EXPLANATION

HON. BILL LUTHER

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 22, 1999

Mr. LUTHER. Mr. Speaker, due to a family commitment I was unable to cast House votes 301–305 on July 15th, 1999 and House vote 306 on July 16th, 1999.

NATIONAL MENTAL HEALTH PARITY ACT OF 1999

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 22, 1999

Mr. STARK. Mr. Speaker, I am proud to join with my colleagues to introduce the National Mental Health Parity Act of 1999. The goal of this legislation is to provide parity in insurance coverage of mental illness and improve mental health services available to Medicare beneficiaries. This legislation will end the systematic discrimination against those with mental illness and reflect the many improvements in mental health treatment.

My legislation would prohibit health plans from imposing treatment limitations or financial requirements on coverage of mental illness, if they do not have similar limitations or requirements for the coverage of other health conditions. The bill also expands Medicare mental health and substance abuse benefits to include a wider array of settings in which services may be delivered. Specifically, the legislation would eliminate the current bias in the law toward delivering services in general hospitals by allowing patients to receive treatment in a variety of residential and community-based settings. This transition saves money for the simple reason that community-based services are far less expensive than hospital services. In addition, community-based providers can better meet the patient's personal needs.

Providing access to mental health treatment offers many benefits because of the significant social costs resulting from mental health and substance abuse disorders. Treatable mental and addictive disorders exact enormous social and economic costs, individual suffering, breakup of families, suicide, crime, violence, homelessness, impaired performance at work and partial or total disability. Recent estimates indicate that mental and addictive disorders cost the economy well over \$300 billion annually. This includes productivity losses of \$150 billion, health care costs of \$70 billion and other costs (e.g. criminal justice) of \$80 billion.

Two to three percent of the population experience severe mental illness disorders. As

many as 25 percent suffer from milder forms of mental illness, and approximately one out of ten Americans suffers from alcohol abuse. One out of thirty Americans suffer from drug abuse.

Alcohol and drug dependence is not the result of a weak will or a poor character. In many cases, the dependence results from chemical abnormalities in the person's brain that makes them prone to dependence. In other cases, the dependence represents a reaction to unhealthy social and environmental conditions that perpetuate abuse of alcohol and drugs. Regardless of the cause of the abuse, alcohol and drug abuse can be treated and allow the person to live a normal and productive life.

Mental health disorders are like other health disorders. With appropriate treatment, some mental health problems can be resolved. Other mental health conditions, like physical health conditions can persist for decades. Indeed, there are those who battle mental illness their entire life just as there are those who suffer from diabetes, congenital birth defects, or long-term conditions like multiple sclerosis. Whereas insurance policies cover the chronic health problems, they do not offer the same support for mental health conditions.

During the last 104th Congressional session, parity in the treatment of mental illness was a widely and hotly debated issue. Although parity legislation was finally developed, insurance carriers found gaping loopholes and created mental health insurance policies that provide less access to mental health services. Furthermore, the current parity legislation includes many exemptions in coverage requirements for small employers. If an employer has at least 2 but not more than 50 employees, they can be exempt from the coverage requirement. Finally, if a group health plan experiences an increase in costs of at least 1 percent, they can be exempted in subsequent years. We can and must do more for our constituents.

My proposed legislation addresses two fundamental problems in both public and private health care coverage of mental illness. First, despite the prevalence and cost of untreated mental illness, we still lack full parity for treatment. The availability of treatment, as well as the limits imposed, are linked to coverage for all medical and surgical benefits. Whatever limitations exist for those benefits will also apply to mental health benefits.

Let us not forget the small employers either. If a company qualifies for the small employer exemption, the insurance companies will be able to set different, lower limits on the scope and duration of care for mental illness compared to other illnesses. This means that people suffering from depression may get less care and coverage than those suffering a heart attack. This disparity is indefensible.

Access to equitable mental health treatment is essential and can be offered at a reasonable price. Recent estimates indicate that true parity for mental health services will increase insurance rates by a mere one percent, a trivial price to pay for the well being of all Americans.

Second, the diagnoses and treatment of mental illness and substance abuse has changed dramatically since the start of Medi-

care. Treatment options are no longer limited to large public psychiatric hospitals. The great majority of people receive treatment on an outpatient basis, recover quickly, and return to productive lives. Even those who once would have been banished to the back wards of large institutions can now live successfully in the community. Unfortunately, the current Medicare benefit package does not reflect the many changes that have occurred in mental health care. This bill would permit Medicare to pay for a number of intensive community-based services. These services are far less expensive than inpatient hospitalization.

For those who cannot be treated while living in their own homes, this bill would make several residential treatment alternatives available. These alternatives include residential detoxification centers, crisis residential programs, therapeutic family or group treatment homes and residential centers for substance abuse. Clinicians will no longer be limited to sending their patients to inpatient hospitals. Treatment can be provided in the specialized setting best suited to addressing the person's specific problem.

Currently there is a 190-day lifetime limit for psychiatric hospital treatment. This limit was originally established primarily in order to contain costs. In fact, CBO estimates that under modern treatment methods, only about 1.6% of Medicare enrollees hospitalized for mental disorders or substance abuse used more than 190 days of service over a five year period.

Under the provisions of this bill, beneficiaries who need inpatient hospitalization would be admitted to the type of hospital that can best provide treatment for his or her needs.

Inpatient hospitalization would be covered for up to 60 days per year. The average length of hospital stay for mental illness in 1995 for all populations was 11.5 days. Adolescents averaged 12.2 days; 14.6 for children; 16.6 days for older adolescents; 8.6 days for the aged and disabled; 9.9 days for adults. A stay of 30 days or fewer is found in 93.5% of the cases. The 60-day limit, therefore, would adequately cover inpatient hospitalization for the vast majority of Medicare beneficiaries, while still providing some modest cost containment. Restructuring the benefit in this manner will level the playing field for psychiatric and general hospitals.

In summary, my legislation is an important step toward providing comprehensive coverage for mental health. Further leveling the health care coverage playing field to include mental illness and timely treatment in appropriate settings will lessen health care costs in the long run. These provisions will also lessen the social costs of crime, welfare, and lost productivity to society. This bill will assure that the mental health needs of all Americans are no longer ignored. I urge my colleagues to join me in support of this bill.

MISS MARTHA DAVIS

HON. BOB BARR

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 22, 1999

Mr. BARR of Georgia. Mr. Speaker, if you spend much time examining popular television