

ALASKA LEGISLATURE SPECIAL COMMITTEE / SUBJECT FILES 8672

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paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(iii) Example. The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) A group health plan that is subject to the requirements of this section includes a \$100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that \$1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) In this Example, the plan is not described in paragraph (b)(3) of this section because there is not one annual limit that applies to at least two-thirds of all medical/surgical benefits. Further, the plan is not described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual limit on mental health benefits, or to include an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual limit that can be applied to mental health benefits is \$640,000 ($40\% \times \$100,000 + 60\% \times \$1,000,000 = \$640,000$).

(c) Rule in the case of separate benefit packages. If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

(d) Applicability--(1) Group health plans. The requirements of this section apply to a group health plan offering both medical/surgical benefits and mental health benefits regardless of whether the mental health benefits are administered separately under the plan.

(2) Health insurance issuers. The requirements of this section apply to a health insurance issuer offering health insurance coverage for both medical/surgical benefits and mental health benefits in connection with a group health plan.

(3) Scope. This section does not—

(i) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) to provide any mental health benefits; or

(ii) Affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health benefits under the plan (or coverage) except as specifically provided in paragraph (b) of this section.

(e) Small employer exemption--(1) In general. The requirements of this section do not apply to a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. For purposes of this paragraph (e), the term small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. See section 732(a) of the Act and Sec. 2590.732(a), which provide that this section (and certain other sections) does not apply to any group health plan (and health insurance issuer offering coverage in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) Rules in determining employer size. For purposes of paragraph (e)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. 414) are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(f) Increased cost exemption--(1) In general. A group health plan (or health insurance coverage offered in connection with a group health plan) is not subject to the requirements of this section if the requirements of this paragraph (f) are satisfied. If a plan offers more than one benefit package, this paragraph (f) applies separately to each benefit package. Except as provided in paragraph (h) of this section, a plan must comply with the requirements of paragraph (b)(1)(i) of this section for the first plan year beginning on or after January 1, 1998, and must continue to comply with the requirements of paragraph (b)(1)(i) of this section until the plan satisfies the requirements in this paragraph (f). In no event is the exemption of this paragraph (f) effective until 30 days after the notice requirements in paragraph (f)(3) of this section are satisfied. If the requirements of this paragraph (f) are satisfied with respect to a plan, the exemption continues in effect (at the plan's discretion) until September 30, 2001, even if the plan subsequently purchases a different policy from the same or a different issuer and regardless of any other changes to the plan's benefit structure.

(2) Calculation of the one-percent increase--(i) Ratio. A group health plan (or group health insurance coverage) satisfies the requirements of this paragraph (f)(2) if the application of paragraph (b)(1)(i) of this section to the plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least one percent. The application of paragraph (b)(1)(i) of this section results in an increased cost of at least one percent under a group health plan (or for such coverage) only if the ratio below equals or exceeds 1.01000. The ratio is determined as follows:

(A) The incurred expenditures during the base period, divided by, (B) The incurred expenditures during the base period, reduced by—

(1) The claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section; and

(2) Administrative expenses attributable to complying with the requirements of this section.

(ii) Formula. The ratio of paragraph (f)(2)(i) of this section is expressed mathematically as follows:

(A) IE means the incurred expenditures during the base period.

(B) CE means the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section

(C) AE means administrative costs related to claims in CE and other administrative costs attributable to complying with the requirements of this section.

(iii) Incurred expenditures. Incurred expenditures means actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(iv) Base period. Base period means the period used to calculate whether the plan may claim the one-percent increased cost exemption in this paragraph (f). The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104-204, 110 Stat. 2944)).

(v) Rating pools. For plans that are combined in a pool for rating purposes, the calculation under this paragraph (f)(2) for each plan in the pool for the base period is based on the incurred expenditures of the pool, whether or not all the plans in the pool have participated in the pool for the entire base period. (However, only the plans that have complied with paragraph (b)(1)(i) of this section for at least six months as a member of the pool satisfy the requirements of this paragraph (f)(2).) Otherwise, the calculation under this paragraph (f)(2) for each plan is calculated by the plan administrator (or issuer) based on the incurred expenditures of the plan.

(vi) Examples. The rules of this paragraph (f)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan satisfies the requirements of paragraph (b)(1)(i) of this section as of January 1, 1998. On September 15, 1998, the plan determines that \$1,000,000 in claims have been incurred during the period between January 1, 1998 and June 30, 1998 and reported by August 30, 1998. The plan also determines that \$100,000 in administrative costs have been incurred for all benefits under the group health plan, including mental health benefits. Thus, the plan determines that its incurred expenditures for the base period are \$1,100,000. The plan also determines that the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section

are \$40,000 and that administrative expenses attributable to complying with the requirements of this section are \$10,000. Thus, the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$1,050,000 (\$1,100,000 - (\$40,000 + \$10,000) = \$1,050,000).

(ii) In this Example 1, the plan satisfies the requirements of this paragraph (f)(2) because the application of this section results in an increased cost of at least one percent under the terms of the plan ($\$1,100,000/\$1,050,000 = 1.04762$).

Example 2. (i) A health insurance issuer sells a group health insurance policy that is rated on a pooled basis and is sold to 30 group health plans. One of the group health plans inquires whether it qualifies for the one-percent increased cost exemption. The issuer performs the calculation for the pool as a whole and determines that the application of this section results in an increased cost of 0.500 percent (for a ratio under this paragraph (f)(2) of 1.00500) for the pool. The issuer informs the requesting plan and the other plans in the pool of the calculation.

(ii) In this Example 2, none of the plans satisfy the requirements of this paragraph

(f)(2) and a plan that purchases a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section. In addition, an issuer that issues to any of the plans in the pool a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section.

Example 3. (i) A partially insured plan is collecting the information to determine whether it qualifies for the exemption. The plan administrator determines the incurred expenses for the base period for the self-funded portion of the plan to be \$2,000,000 and the administrative expenses for the base period for the self-funded portion to be \$200,000. For the insured portion of the plan, the plan administrator requests data from the insurer. For the insured portion of the plan, the plan's own incurred expenses for the base period are \$1,000,000 and the administrative expenses for the base period are \$100,000. The plan administrator determines that under the self-funded portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$0 because the self-funded portion does not cover mental health benefits and the plan's administrative costs attributable to complying with the requirements of this section are \$1,000. The issuer determines that under the insured portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$25,000 and the administrative costs attributable to complying with the requirements of this section are \$1,000. Thus, the total incurred expenditures for the plan for the base period are \$3,300,000 ($\$2,000,000 + \$200,000 + \$1,000,000 + \$100,000 = \$3,300,000$) and the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$3,273,000 ($\$3,300,000 - (\$0 + \$1,000 + \$25,000 + \$1,000) = \$3,273,000$).

(ii) In this Example 3, the plan does not satisfy the requirements of this paragraph (f)(2) because the application of this section does not result in an increased cost of at least one percent under the terms of the plan ($\$3,300,000/\$3,273,000 = 1.00825$).

(3) Notice of exemption--(i) Participants and beneficiaries--(A) In general. A group health plan must notify participants and beneficiaries of the plan's decision to claim the one-percent increased cost exemption. The notice must include the following information:

- (1) A statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption;
- (2) The name and telephone number of the individual to contact for further information;
- (3) The plan name and plan number (PN);
- (4) The plan administrator's name, address, and telephone number;
- (5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (f)(3)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN);
- (6) The effective date of the exemption;
- (7) The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's claim of the exemption; and
- (8) The availability, upon request and free of charge, of a summary of the information required under paragraph (f)(4) of this section.

(B) Use of summary of material reductions in covered services or benefits. A plan may satisfy the requirements of paragraph (f)(3)(i)(A) of this section by providing participants and beneficiaries (in accordance with paragraph (f)(3)(i)(c) of this section) with a summary of material reductions in covered services or benefits required under Sec. 2520.104b-3(d) that also includes the information of this paragraph (f)(3)(i). However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) Delivery. The notice described in this paragraph (f)(3)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (e.g., first-class mail). If the notice is provided to the participant at the participant's last known address, then the requirements of this paragraph (f)(3)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) Example. The rules of this paragraph (f)(3)(i) are illustrated by the following example:

Example. (i) A group health plan has a plan year that is the calendar year and has an open enrollment period every November 1 through November 30. The plan determines on September 15 that it satisfies the requirements of paragraph (f)(2) of this section. As part of its open enrollment materials, the plan mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of this paragraph (f)(3)(i).

(ii) In this Example, the plan has sent the notice in a manner that complies with

this paragraph (f)(3)(i).

(ii) Federal agencies--(A) Church plans. A church plan (as defined in section 414(e) of the Internal Revenue Code) claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of the Treasury. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(B) Group health plans subject to Part 7 of Subtitle B of Title I of ERISA. A group health plan subject to Part 7 of Subtitle B of Title I of ERISA, and claiming the exemption of this paragraph (f) for any benefit package, must provide notice to the Department of Labor. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(c) Nonfederal governmental plans. A group health plan that is a nonfederal governmental plan claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of Health and Human Services (HHS). This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(4) Availability of documentation. The plan (or issuer) must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (f)(3)(i) of this section with any individually identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with paragraph (b)(1)(i) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements of this section. In no event should the summary of information include any individually identifiable information.

(g) Special rules for group health insurance coverage--(1) Sale of nonparity policies. An issuer may sell a policy without parity (as described in paragraph (b) of this section) only to a plan that meets the requirements of paragraphs (e) or (f) of this section.

(2) Duration of exemption. After a plan meets the requirements of paragraph (f) of this section, the plan may change issuers without having to meet the requirements of paragraph (f) of this section again before September 30, 2001.

(h) Effective dates--(1) In general. The requirements of this section are applicable for plan years beginning on or after January 1, 1998.

(2) Limitation on actions. (i) Except as provided in paragraph (h)(3) of this section, no enforcement action is to be taken by the Secretary against a group health plan that has sought to comply in good faith with the requirements of

section 712 of the Act, with respect to a violation that occurs before the earlier of—

(A) The first day of the first plan year beginning on or after April 1, 1998; or

(B) January 1, 1999.

(ii) Compliance with the requirements of this section is deemed to be good faith compliance with the requirements of section 712 of Part 7 of Subtitle B of Title I of ERISA.

(iii) The rules of this paragraph (h)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan complies with section 712 of Part 7 of Subtitle B of Title I of ERISA in good faith using assumptions inconsistent with paragraph (b)(6) of this section relating to weighted averages for categories of benefits.

(ii) In this Example 1, no enforcement action may be taken against the plan with respect to a violation resulting solely from those assumptions and occurring before January 1, 1999.

Example 2. (i) A group health plan has a plan year that is the calendar year. For the entire 1998 plan year, the plan applies a \$1,000,000 annual limit on medical/surgical benefits and a \$100,000 annual limit on mental health benefits.

(ii) In this Example 2, the plan has not sought to comply with the requirements of section 712 of the Act in good faith and this paragraph (h)(2) does not apply.

(3) Transition period for increased cost exemption-- (i) In general. No enforcement action will be taken against a group health plan that is subject to the requirements of this section based on a violation of this section that occurs before April 1, 1998 solely because the plan claims the increased cost exemption under section 712(c)(2) of Part 7 of Subtitle B of Title I of ERISA based on assumptions inconsistent with the rules under paragraph (f) of this section, provided that a plan amendment that complies with the requirements of paragraph (b)(1)(i) of this section is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) Notice of plan's use of transition period. (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts such notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of ERISA and the regulations thereunder (29 CFR 2520.104b-1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan, the applicable federal agency is the Department of the Treasury. For a group health plan that is subject to Part 7 of Subtitle B of Title I of ERISA, the applicable federal agency is the Department of Labor. For a group health plan that is a nonfederal governmental plan, the applicable federal agency is the Department of Health and Human Services. The notice must include—

(1) The name of the plan and the plan number (PN);

- (2) The name, address, and telephone number of the plan administrator;
 - (3) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);
 - (4) The name and telephone number of the individual to contact for further information; and
 - (5) The signature of the plan administrator and the date of the signature.
- (B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.
- (i) Sunset. This section does not apply to benefits for services furnished on or after September 30, 2001.

Signed at Washington, DC, this 16th day of December, 1997.

Olena Berg,

Assistant Secretary, Pension Welfare Benefits Administration, U.S.

Department of Labor.

Health Care Financing Administration

45 CFR Subtitle A, Subchapter B

45 CFR Part 146 is amended as follows:

PART 146--REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

1. The authority citation for Part 146 is revised to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg-3, 300gg-91, and 300gg-92).

2. A new Subpart C is added to Part 146 to read as follows:

Subpart C—Requirements Related to Benefits

Sec. 146.136 Parity in the application of certain limits to mental health benefits.

- (a) Definitions. For purposes of this section, except where the context clearly indicates otherwise, the following definitions apply:

Aggregate lifetime limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or group health insurance coverage offered in connection with such plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Annual limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan (or group health insurance coverage offered in connection with such plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Medical/surgical benefits means benefits for medical or surgical services, as defined under the terms of the plan or group health insurance coverage, but does not include mental health benefits.

Mental health benefits means benefits for mental health services, as defined under the terms of the plan or group health insurance coverage, but does not include benefits for treatment of substance abuse or chemical dependency.

(b) Requirements regarding limits on benefits--(1) In general--(i) General parity requirement. A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health benefits must comply with paragraph (b)(2), paragraph (b)(3), or paragraph (b)(6) of this section.

(ii) Exception. The rule in paragraph (b)(1)(i) of this section does not apply if a plan, or coverage, satisfies the requirements of paragraph (e) or paragraph (f) of this section.

(2) Plan with no limit or limits on less than one-third of all medical/surgical benefits. If a plan (or group health insurance coverage) does not include an aggregate lifetime or annual limit on any medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.

(3) Plan with a limit on at least two-thirds of all medical/ surgical benefits. If a plan (or group health insurance coverage) includes an aggregate lifetime or annual limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits; or

(ii) Not include an aggregate lifetime or annual limit on mental health benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(4) Examples. The rules of paragraphs (b) (2) and (3) of this section are illustrated by the following examples:

Example 1. (i) Prior to the effective date of the mental health parity provisions, a group health plan had no annual limit on medical/surgical benefits and had a \$10,000 annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual limit on mental health benefits;

(B) Replacing the plan's previous annual limit on mental health benefits with a

\$500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and

(C) Replacing the plan's previous annual limit on mental health benefits with a \$250,000 annual limit on medical/surgical benefits and a \$250,000 annual limit on mental health benefits.

(ii) In this Example 1, each of the three options being considered by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 2. (i) Prior to the effective date of the mental health parity provisions, a group health plan had a \$100,000 annual limit on medical/surgical inpatient benefits, a \$50,000 annual limit on medical/surgical outpatient benefits, and a \$100,000 annual limit on all mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Replacing the plan's previous annual limit on mental health benefits with a \$150,000 annual limit on mental health benefits; and

(B) Replacing the plan's previous annual limit on mental health benefits with a \$100,000 annual limit on mental health inpatient benefits and a \$50,000 annual limit on mental health outpatient benefits.

(ii) In this Example 2, each option under consideration by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 3. (i) A group health plan that is subject to the requirements of this section has no aggregate lifetime or annual limit for either medical/surgical benefits or mental health benefits. While the plan provides medical/surgical benefits with respect to both network and out-of-network providers, it does not provide mental health benefits with respect to out-of-network providers.

(ii) In this Example 3, the plan complies with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 4. (i) Prior to the effective date of the mental health parity provisions, a group health plan had an annual limit on medical/surgical benefits and a separate but identical annual limit on mental health benefits. The plan included benefits for treatment of substance abuse and chemical dependency in its definition of mental health benefits. Accordingly, claims paid for treatment of substance abuse and chemical dependency were counted in applying the annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Making no change in the plan so that claims paid for treatment of substance abuse and chemical dependency continue to count in applying the annual limit on mental health benefits;

(B) Amending the plan to count claims paid for treatment of substance abuse and chemical dependency in applying the annual limit on medical/surgical benefits (rather than counting those claims in applying the annual limit on mental health benefits);

(C) Amending the plan to provide a new category of benefits for treatment of chemical dependency and substance abuse that is subject to a separate, lower limit and under which claims paid for treatment of substance abuse and chemical dependency are counted only in applying the annual limit on this separate category; and

(D) Amending the plan to eliminate distinctions between medical/ surgical benefits and mental health benefits and establishing an overall limit on benefits offered under the plan under which claims paid for treatment of substance abuse and chemical dependency are counted with medical/surgical benefits and mental health benefits in applying the overall limit.

(ii) In this Example 4, the group health plan is described in paragraph (b)(3) of this section. Because mental health benefits are defined in paragraph (a) of this section as excluding benefits for treatment of substance abuse and chemical dependency, the inclusion of benefits for treatment of substance abuse and chemical dependency in applying an aggregate lifetime limit or annual limit on mental health benefits under option (A) of this Example 4 would not comply with the requirements of paragraph (b)(3) of this section. However, options (B), (C), and (D) of this Example 4 would comply with the requirements of paragraph (b)(3) of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

(5) Determining one-third and two-thirds of all medical/surgical benefits. For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to a limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/ surgical benefits.

(6) Plan not described in paragraph (b)(2) or paragraph (b)(3) of this section--(i) In general. A group health plan (or group health insurance coverage) that is not described in paragraph (b)(2) or paragraph (b)(3) of this section, must either impose—

(A) No aggregate lifetime or annual limit, as appropriate, on mental health benefits; or

(B) An aggregate lifetime or annual limit on mental health benefits that is no less than an average limit for medical/surgical benefits calculated in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment, or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(6)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) **Weighting.** For purposes of this paragraph (b)(6), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(iii) **Examples.** The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) A group health plan that is subject to the requirements of this section includes a \$100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that \$1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) In this Example, the plan is not described in paragraph (b)(3) of this section because there is not one annual limit that applies to at least two-thirds of all medical/surgical benefits. Further, the plan is not described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual limit on mental health benefits, or to include an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual limit that can be applied to mental health benefits is \$640,000 ($40\% \times \$100,000 + 60\% \times \$1,000,000 = \$640,000$).

(c) **Rule in the case of separate benefit packages.** If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

(d) **Applicability--(1) Group health plans.** The requirements of this section apply to a group health plan offering both medical/surgical benefits and mental health benefits regardless of whether the mental health benefits are administered separately under the plan.

(2) **Health insurance issuers.** The requirements of this section apply to a health insurance issuer offering health insurance coverage for both medical/surgical benefits and mental health benefits in connection with a group health plan.

(3) **Scope.** This section does not—

(i) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) to provide any mental health benefits; or

(ii) Affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health benefits under the plan (or coverage) except as specifically provided in

paragraph (b) of this section.

(e) Small employer exemption--(1) In general. The requirements of this section do not apply to a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. For purposes of this paragraph (e), the term small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. See regulations at Sec. 146.145(a), which provide that this section (and certain other sections) does not apply to any group health plan (and health insurance issuer offering coverage in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) Rules in determining employer size. For purposes of paragraph (e)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. 414) are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(f) Increased cost exemption--(1) In general. A group health plan (or health insurance coverage offered in connection with a group health plan) is not subject to the requirements of this section if the requirements of this paragraph (f) are satisfied. If a plan offers more than one benefit package, this paragraph (f) applies separately to each benefit package. Except as provided in paragraph (h) of this section, a plan must comply with the requirements of paragraph (b)(1)(i) of this section for the first plan year beginning on or after January 1, 1998, and must continue to comply with the requirements of paragraph (b)(1)(i) of this section until the plan satisfies the requirements in this paragraph (f). In no event is the exemption of this paragraph (f) effective until 30 days after the notice requirements in paragraph (f)(3) of this section are satisfied. If the requirements of this paragraph (f) are satisfied with respect to a plan, the exemption continues in effect (at the plan's discretion) until September 30, 2001, even if the plan subsequently purchases a different policy from the same or a different issuer and regardless of any other changes to the plan's benefit structure.

(2) Calculation of the one-percent increase--(i) Ratio. A group health plan (or group health insurance coverage) satisfies the requirements of this paragraph (f)(2) if the application of paragraph (b)(1)(i) of this section to the plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least one percent. The application of paragraph (b)(1)(i) of this section results in an increased cost of at least one percent under a group health plan (or for such coverage) only if the ratio below equals or exceeds 1.01000. The ratio is determined as follows:

(A) The incurred expenditures during the base period, divided by,

(B) The incurred expenditures during the base period, reduced by—

(1) The claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section, and

(2) Administrative expenses attributable to complying with the requirements of this section.

(ii) Formula. The ratio of paragraph (f)(2)(i) is expressed mathematically as follows:

(A) IE means the incurred expenditures during the base period.

(B) CE means the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section.

(C) AE means administrative costs related to claims in CE and other administrative costs attributable to complying with the requirements of this section.

(iii) Incurred expenditures. Incurred expenditures means actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(iv) Base period. Base period means the period used to calculate whether the plan may claim the one-percent increased cost exemption in this paragraph (f). The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104-204, 110 Stat. 2944)).

(v) Rating pools. For plans that are combined in a pool for rating purposes, the calculation under this paragraph (f)(2) for each plan in the pool for the base period is based on the incurred expenditures of the pool, whether or not all the plans in the pool have participated in the pool for the entire base period. (However, only the plans that have complied with paragraph (b)(1)(i) of this section for at least six months as a member of the pool satisfy the requirements of this paragraph (f)(2).) Otherwise, the calculation under this paragraph (f)(2) for each plan is calculated by the plan administrator (or issuer) based on the incurred expenditures of the plan.

(vi) Examples. The rules of this paragraph (f)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan satisfies the requirements of paragraph (b)(1)(i) of this section as of January 1, 1998. On September 15, 1998, the plan determines that \$1,000,000 in claims have been incurred during the period between January 1, 1998 and June 30, 1998 and reported by August 30, 1998. The plan also determines that \$100,000 in administrative costs have been incurred for all benefits under the group health plan, including mental health benefits. Thus, the plan determines that its incurred expenditures for the base period are \$1,100,000. The plan also determines that

the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section are \$40,000 and that administrative expenses attributable to complying with the requirements of this section are \$10,000. Thus, the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$1,050,000 (\$1,100,000--

$(\$40,000 + \$10,000) = \$1,050,000$).

(ii) In this Example 1, the plan satisfies the requirements of this paragraph (f)(2) because the application of this section results in an increased cost of at least one percent under the terms of the plan ($\$1,100,000/\$1,050,000 = 1.04762$).

Example 2. (i) A health insurance issuer sells a group health insurance policy that is rated on a pooled-basis and is sold to 30 group health plans. One of the group health plans inquires whether it qualifies for the one percent increased cost exemption. The issuer performs the calculation for the pool as a whole and determines that the application of this section results in an increased cost of 0.500 percent (for a ratio under this paragraph (f)(2) of 1.00500) for the pool. The issuer informs the requesting plan and the other plans in the pool of the calculation.

(ii) In this Example 2, none of the plans satisfy the requirements of this paragraph (f)(2) and a plan that purchases a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section. In addition, an issuer that issues to any of the plans in the pool a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section.

Example 3. (i) A partially-insured plan is collecting the information to determine whether it qualifies for the exemption. The plan administrator determines the incurred expenses for the base period for the self-funded portion of the plan to be \$2,000,000 and the administrative expenses for the base period for the self-funded portion to be \$200,000. For the insured portion of the plan, the plan administrator requests data from the insurer. For the insured portion of the plan, the plan's own incurred expenses for the base period are \$1,000,000 and the administrative expenses for the base period are \$100,000. The plan administrator determines that under the self-funded portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$0 because the self-funded portion does not cover mental health benefits and the plan's administrative costs attributable to complying with the requirements of this section are \$1,000. The issuer determines that under the insured portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$25,000 and the administrative costs attributable to complying with the requirements of this section are \$1,000. Thus, the total incurred expenditures for the plan for the base period are \$3,300,000 ($\$2,000,000 + \$200,000 + \$1,000,000 + \$100,000 = \$3,300,000$) and the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$3,273,000 ($\$3,300,000 - (\$0 + \$1,000 + \$25,000 + \$1,000) = \$3,273,000$).

(ii) In this Example 3, the plan does not satisfy the requirements of this paragraph (f)(2) because the application of this section does not result in an increased cost of at least one percent under the terms of the plan ($\$3,300,000/\$3,273,000 = 1.00825$).

(3) Notice of exemption--(i) Participants and beneficiaries--(A) In general. A group health plan must notify participants and beneficiaries of the plan's decision to claim the one percent increased cost exemption. The notice must include the following information:

(1) A statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption.

(2) The name and telephone number of the individual to contact for further information.

(3) The plan name and plan number (PN).

(4) The plan administrator's name, address, and telephone number.

(5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (f)(3)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN).

(6) The effective date of such exemption.

(7) The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's election of the exemption.

(8) The availability, upon request and free of charge, of a summary of the information required under paragraph (f)(4) of this section.

(B) Use of summary of material reductions in covered services or benefits. A plan may satisfy the requirements of paragraph (f)(3)(i)(A) by providing participants and beneficiaries (in accordance with paragraph (f)(3)(i)(c)) with a summary of material reductions in covered services or benefits consistent with Department of Labor regulations at 29 CFR 2520.104b-3(d) that also includes the information of this paragraph (f)(3)(i). However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) Delivery. The notice described in this paragraph (f)(3)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (29 U.S.C. 1024(b)(1)) (e.g., first-class mail). If the notice is provided to the participant at the participant's last known address, then the requirements of this paragraph (f)(3)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) Example. The rules of this paragraph (f)(3)(i) are illustrated by the following example:

Example. (i) A group health plan has a plan year that is the calendar year and has an open enrollment period every November 1 through November 30. The plan determines on September 15 that it satisfies the requirements of paragraph (f)(2) of this section. As part of its open enrollment materials, the plan mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of this paragraph (f)(3)(i).

(ii) In this Example, the plan has sent the notice in a manner that complies with

this paragraph (f)(3)(i).

(ii) Federal agencies--(A) Church plans. A church plan (as defined in section 414(e) of the Internal Revenue Code) claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of the Treasury. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(B) Group health plans subject to Part 7 of Subtitle B of Title I of ERISA. A group health plan subject to Part 7 of Subtitle B of Title I of ERISA, and claiming the exemption of this paragraph (f) for any benefit package, must provide notice to the Department of Labor. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(C) Non-Federal governmental plans. A group health plan that is a non-Federal governmental plan claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of Health and Human Services (HHS). This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(4) Availability of documentation. The plan (or issuer) must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (f)(3)(i) of this section with any individually identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with paragraph (b)(1)(i) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements for the exemption. In no event should the summary of information include any individually identifiable information.

(g) Special rules for group health insurance coverage--(1) Sale of nonparity policies. An issuer may sell a policy without parity (as described in paragraph (b) of this section) only to a plan that meets the requirements of paragraph (e) or paragraph (f) of this section.

(2) Duration of exemption. After a plan meets the requirements of paragraph (f) of this section, the plan may change issuers without having to meet the requirements of paragraph (f) of this section again before September 30, 2001.

(h) Effective dates--(1) In general. The requirements of this section are applicable for plan years beginning on or after January 1, 1998.

(2) Limitation on actions. (i) Except as provided in paragraph (h)(3) of this section, no enforcement action is to be taken by the Secretary against a group health plan that has sought to comply in good faith with the requirements of

section 2705 of the PHS Act, with respect to a violation that occurs before the earlier of—

(A) The first day of the first plan year beginning on or after

April 1, 1998; or

(B) January 1, 1999.

(ii) Compliance with the requirements of this section is deemed to be good faith compliance with the requirements of section 2705 of the PHS Act.

(iii) The rules of this paragraph (h)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan complies with section 2705 of the PHS Act in good faith using assumptions inconsistent with paragraph (b)(6) of this section relating to weighted averages for categories of benefits.

(ii) In this Example 1, no enforcement action may be taken against the plan with respect to a violation resulting solely from those assumptions and occurring before January 1, 1999.

Example 2. (i) A group health plan has a plan year that is the calendar year. For the entire 1998 plan year, the plan applies a \$1,000,000 annual limit on medical/surgical benefits and a \$100,000 annual limit on mental health benefits.

(ii) In this Example 2, the plan has not sought to comply with the requirements of section 2705 of the PHS Act in good faith and this paragraph (h)(2) does not apply.

(3) Transition period for increased cost exemption--(i) In general. No enforcement action will be taken against a group health plan that is subject to the requirements of this section based on a violation of this section that occurs before April 1, 1998 solely because the plan claims the increased cost exemption under section 2705(c)(2) of the PHS Act based on assumptions inconsistent with the rules under paragraph (f) of this section, provided that a plan amendment that complies with the requirements of paragraph (b)(1)(i) of this section is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) Notice of plan's use of transition period. (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts the notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of ERISA and the regulations thereunder (29 CFR 2520.104b-1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan, the applicable federal agency is the Department of the Treasury.

For a group health plan that is subject to Part 7 of Subtitle B of Title I of ERISA, the applicable federal agency is the Department of Labor. For a group health plan that is a nonfederal governmental plan, the applicable federal agency is the Department of Health and Human Services. The notice must include—

- (1) The name of the plan and the plan number (PN);
 - (2) The name, address, and telephone number of the plan administrator;
 - (3) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);
 - (4) The name and telephone number of the individual to contact for further information; and
 - (5) The signature of the plan administrator and the date of the signature.
- (B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.
- (i) Sunset. This section does not apply to benefits for services furnished on or after September 30, 2001.

Dated: December 16, 1997.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: December 16, 1997.

Donna E. Shalala,

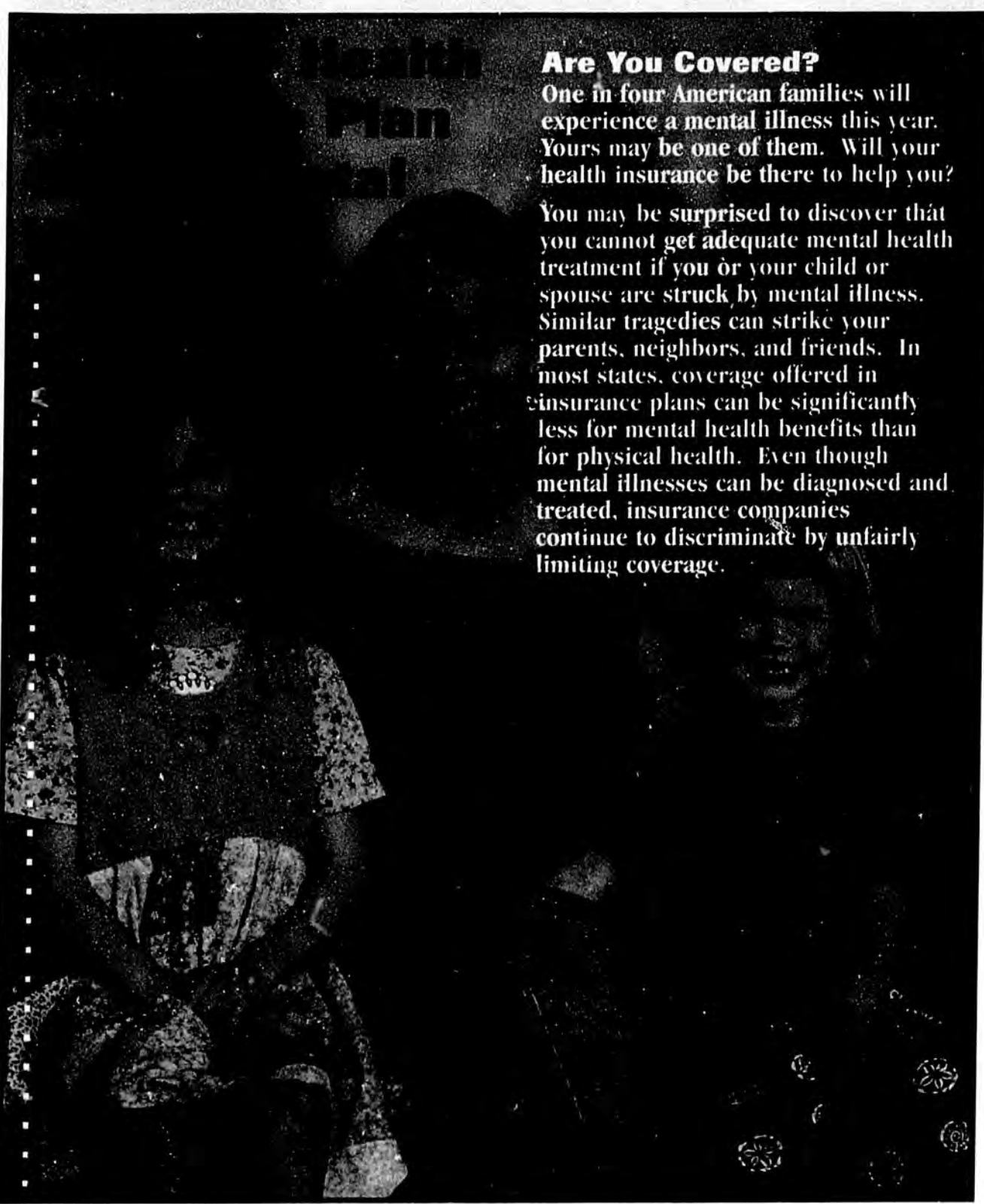
Secretary, Department of Health and Human Services.

[FR Doc. 97-33262 Filed 12-19-97; 8:45 am]

BILLING CODE 4830-01-P; 4510-29-P; 4120-01-P

SCOMM

112:7



Are You Covered?

One in four American families will experience a mental illness this year. Yours may be one of them. Will your health insurance be there to help you?

You may be surprised to discover that you cannot get adequate mental health treatment if you or your child or spouse are struck by mental illness. Similar tragedies can strike your parents, neighbors, and friends. In most states, coverage offered in insurance plans can be significantly less for mental health benefits than for physical health. Even though mental illnesses can be diagnosed and treated, insurance companies continue to discriminate by unfairly limiting coverage.



Insurance Discrimination is Common.

- In most parts of the country, health care plans cover mental disorders but have significantly more restrictions on the scope and type of services covered.
- Insurance policies typically impose higher co-payments and more restrictive day and visit limits for mental health care than they do for physical health care.

What are Mental Illnesses?

Mental illnesses are real, common and treatable disturbances in thought and/or behavior. Each year, 51 million Americans suffer from mental and emotional disorders ranging from phobias to psychoses. In comparison, 100 million Americans have a physical illness in a given year, ranging from the flu to cancer.

Doctors and mental health specialists use a recognized, standardized compendium – the Diagnostic and Statistical Manual (DSM) – to diagnose a broad range of mental illnesses. A wide variety of specialized treatments are available, ranging from behavioral therapies and modern medicines to psychotherapy and self-help activities. Sadly, due to stigma and discrimination, many people with mental illnesses do not receive the treatment that they need.

mental health parity legislation that would end practices that unfairly limit mental healthcare or deny access to needed treatment.” By enacting parity, insurance companies would be required to provide the same level of mental health coverage as is offered for physical health care needs.

How Much Will Parity Cost?

- Preventing insurance discrimination means only minimal increases in insurance premiums. Some studies estimate only a few extra pennies per month.
- Providing insurance protections to all Americans is only marginally more expensive than protecting only those with a narrow range of diagnoses.

Ending insurance discrimination is not only the right thing to do, but it is also affordable. Mental illnesses can be treated effectively and affordably if access to equitable health care coverage and appropriate services are available.



Discrimination

What Have States Done to End Insurance Discrimination?

Several states have already passed limited mental health parity laws. With the exceptions of Maryland, Minnesota, and Vermont, however, these laws cover only limited types of benefits, exclusively protect those with specific diagnoses, or have other

significant limitations. In all other states, much work remains in our efforts to eliminate discrimination in health insurance.

used to describe a specific group of mental illnesses. Unfortunately, limiting mental health parity to those with "severe mental illness" discriminates against children and adults whose illnesses can also be seriously disabling. Diagnoses typically excluded in these bills include dementia, multiple personality disorders, anorexia nervosa and bulimia, learning disorders associated with brain damage, phobias, post traumatic stress disorder, as well as serious emotional disorders (SED) affecting children – diagnoses that can be just as severe and debilitating.

Those who argue that equity in insurance coverage should only be offered to those with a limited group of diagnoses ignore the mental health needs of millions of Americans. All Americans should be protected from insurance discrimination.

Didn't the Federal Government Already Pass Mental Health Parity?

Yes, but in limited form. In 1996, the federal government took a first step by requiring group health plans that offer mental health services to provide the same lifetime and annual spending limits as they do for physical illness. The National Mental Health Association advocates that Congress pass comprehensive mental health parity for all Americans which would include equity in other benefits such as treatment limitations and co-payments. Until this happens, it is up to the states to pass parity laws that protect their residents.



Act Now! Join the Mental Health Association Movement to Pass Parity!

On both the national and state levels, the National

Mental Health Association works with broad-based coalitions to advocate for parity in coverage for mental and physical health care. These efforts have met with significant success resulting in new protections written into federal law and in a growing number of states. However, it is clear that the greatest battles are still ahead of us. Parity advocates are too often willing to accept legislation that would only protect individuals with specific diagnoses that continue to discriminate against children and adults.

Join the Mental Health Association movement in our efforts to end insurance discrimination for all Americans. To find out about mental health parity campaigns in your state, contact the National Mental Health Association's Information Center at 1-800-969-NMHA.

Stigma Watch is a powerful reminder of the harrowing treatment individuals once endured.

Now the symbol of NMHA, the Bell tolls to end misunderstanding and discrimination, and rings out hope in the fight for victory over mental illnesses.

1021 Prince Street

Alexandria, VA 22314-2971

Main (703) 684-7722

Toll-free (800) 969-6642

TTY (800) 433-5959

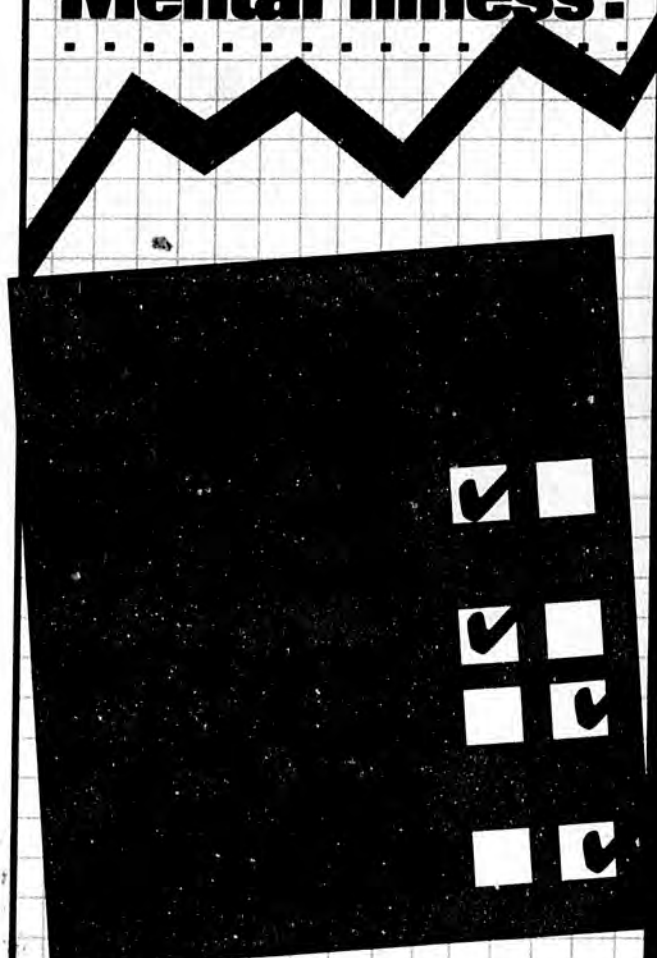
Fax (703) 684-5968

Stigma Watch (800) 969-6642

Web site - <http://www.nmha.org>



Health Insurance Discrimination: **Will Your Plan Cover Mental Illness?**



MENTAL HEALTH PARITY ISSUES AND COSTS



INFORMATION TO ASSIST STATES IN THE UNDERSTANDING AND DEVELOPMENT OF LEGISLATION

Ronald E. Bachman, F.S.A., M.A.A.A.
Principal
PricewaterhouseCoopers LLP
(404) 870-1388

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* Documents similar to these were used in an educational meeting with the Interim Insurance Availability Commission, State of Missouri

Definitions of Mental Health Parity Original Federal Language

In the case a group health plan or an individual health plan that provides both medical and surgical benefits and mental health benefits, such plan shall not impose treatment limitations or financial requirements on the coverage of mental health benefits if similar limitations or requirements are not imposed on medical and surgical benefits.

Nothing in this section shall be construed as:

(a) requiring the provision of mental health benefits where none were previously offered;

Alternative: (a) requiring a group health plan to provide any mental health benefits.

(b) requiring parity coverage between treatments for mental illness and preventive care; or

(c) prohibiting a group health from

(i) negotiating separate reimbursement rates and service delivery systems, such as but not limited to a mental health carve-out plan; or

(ii) managing the provision of benefits through common methods including but not limited to pre-admission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for mental illness only to those that are deemed medically necessary; or

(iii) limiting services to those authorized according to the health plan contract.

Definitions:

(a) the term "treatment limits" refers to limits on the number of outpatient visits and inpatient hospital days covered by a group health plan or individual health plan;

(b) the term "financial requirements" refers to copayments, deductibles, out-of-pocket contributions, fees, annual limits, and lifetime aggregate limits imposed on covered individuals;

(c) the term "group health plan" and "individual health plan" do not refer to Medicare, Medicaid, Medicare Supplement, hospital indemnity plans, cancer policies, accidental death policies, and other specific disease policies.

Definitions of Mental Health Parity Maryland Language

(1) Subject to the provisions of this section, each contract or policy of health insurance delivered or issued for delivery within this State to an employer or an individual on a group or individual basis that provides coverage for health care on an expense-incurred basis **may not discriminate** against any person with a mental illness, emotional disorder or a drug abuse or alcohol abuse disorder by failing to provide benefits for treatment and diagnosis of these illnesses under the same terms and conditions that apply under the contract or policy for treatment of physical illness.

(2) It shall not be considered to be discriminatory under section (1) if at least the following benefits are provided:

(i) With respect to inpatient benefits provided in a licensed or certified facility, which shall include hospital inpatient benefits, the total number of days for which benefits are payable shall be:

1. (for the first year after effective date of legislation) at least 60 days in any calendar year or a benefit period of not more than 12 months under the same terms and conditions that apply to benefits available under the contract or policy for physical illness; and

2. (one year after the effective date of legislation) at least equal to the same terms and conditions that apply to the benefits available under the contract or policy for physical illness;

Definitions of Mental Health Parity Minnesota Language

(a) All health plans that provide coverage for mental health or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency services must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical services must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

Definitions of Mental Health Parity Vermont Language

A health insurance plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition.

A health insurance plan shall be construed to be in compliance with this section if at least one choice for treatment of mental health conditions provided to the insured within the plan has rates, terms, and conditions that place no greater financial burden on the insured than for access to treatment of physical conditions. The commissioner may disapprove any plan that the commissioner determines to be inconsistent with the purposes of this section.

Definitions of Mental Illness

1. The term "mental illnesses" includes mental disorders defined in the **Diagnostic and Statistical Manual IV** or subsequent editions published by the American Psychiatric Association, except those codes defining substance abuse disorders (291.0 to 292.9 and 303.0 to 305.9) and the "V" codes.
2. Mental disorder diagnosis codes are limited to the diagnosis range of 290.0 to 301.9, inclusive, and 306.0 to 315.9, inclusive contained in the **ICD-9-CM**.
3. The term "mental health benefits" means benefits with respect to mental health services, as defined under the **terms of the plan** or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.
4. **SAMHSA** (Substance Abuse and Mental Health Services Administration):

Children: children with a serious emotional disturbance are persons from birth up to age 18, who currently or at any time during the past year, have had a diagnosable mental behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most recent edition of the **Diagnostic and Statistical Manual of Mental Disorders** published by the American Psychiatric Association, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Adults: adults with a serious mental illness age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria within the most recent edition of the **Diagnostic and Statistical Manual of Mental Disorders** published by the American Psychiatric Association that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

5. The term "severe mental illness" means an illness that is defined through diagnosis, disability and duration, and includes disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, bipolar disorder, dementia, autism, and other pervasive developmental disorders, as well as severe forms of other disorders such as major depression, panic disorder, obsessive compulsive disorder, multiple personality disorder, anorexia nervosa, bulimia, learning disorder associated with brain damage, phobia associated with significant functional impairment, and disruptive behavior disorders of childhood as determined by the **Insurance Commissioner**.

6. National Advisory Mental Health Council Definition of SMI: The term "severe mental illness" is defined through diagnosis, disability, and duration, and includes disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, manic depressive disorder, autism as well as severe forms of other disorders such as major depression, panic disorder, and obsessive compulsive disorder.

Definition of Eligible Expenses

1. BC/BS FEHBP: All benefits are subject to the definitions, limitations and exclusions in the policy and are payable when **determined by the Carrier to be medically necessary**. The Carrier has the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. The Plan pays all covered outpatient care (including related services and supplies, such as psychological testing) for treatment of a mental condition, including substance abuse.

What is not covered:

1. Marital, family, educational, or other counseling or training services.
2. Services rendered or billed by a school or halfway house or a member of its staff.
3. Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present.
4. Services and supplies that are not medically necessary.

2. Free State Health Plan (BC/BS) - To the extent shown below, this Plan provides the following medically necessary services for the diagnosis and treatment of mental illness, or emotional disorder, drug abuse and alcohol abuse. This Plan provides medical and hospital services such as acute detoxification for the medical non-psychiatric aspects of drug abuse and alcohol abuse, **under the same terms and conditions as for any other illness or condition**. Outpatient visits to Plan mental health providers for follow-up care are covered, as well as inpatient services necessary for diagnosis and treatment.

1. Diagnostic evaluation
2. Psychological testing
3. Psychiatric, drug abuse and alcohol abuse treatment (including individual and group therapy).
4. Hospitalization (including inpatient professional services)

What is not covered:

1. Care for psychiatric, drug abuse and alcohol abuse conditions which in the professional judgment of Plan doctors are not treatable.
2. Psychiatric, drug abuse and alcohol abuse evaluations or therapy on court order, or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
3. Psychological testing that is not medically necessary to determine the appropriate treatment of a condition.
4. Treatment which is not authorized by a Plan doctor.

3. Maryland - Eligible expenses: ...expenses arising for treatment of mental illnesses, emotional disorders, drug abuse and alcohol abuse which in the professional judgment of practitioners is medically necessary and treatable.

4. Medically Necessary Definition (typical Insurance Policy)

Medically Necessary means a service or supply that is required to diagnose or treat an Injury or Sickness. It must:

- a. be performed and/or prescribed by a Physician; and
- b. be consistent with the diagnosis and treatment of such Injury or Sickness; and
- c. be in accordance with generally accepted standards of medical practice; and
- d. not be solely for the convenience of the Insured Person or Insured Dependent or any other person who provides care for the Insured Person or Insured Dependent.

Mental Health Parity

A Framework for Discussing the Continuum of Options

I. Introduction and Background

This paper proposes a framework for discussing legislative options for mental health parity legislation. To better understand many of the issues, a continuum of progressive and related options are presented. These are not the only options that can be considered, but should form a basis of common understanding before more complex options are presented.

The federal legislation, the Mental Health Parity Act of 1996 (MHPA), forced states to pass comparable legislation or have regulatory oversight on the issue default to the federal government. As a consequence, the historical tension between federal and state regulation of insurance was heightened and, in general, most states passed or are in the process of passing appropriate mental health legislation to retain state oversight.

In terms of coverage and cost, the MHPA is fairly minimal. A recent Rand corporation study estimated the cost impact of MHPA to be \$1 per member per year (\$.08 per month). The requirement of the Act is that any plan offering mental health benefits must not impose any annual or lifetime dollar limits on mental health care than is not imposed on other medical and surgical benefits. The Act provides a "minimum standard" of coverage whenever the benefit is offered. However, mental health benefits are not a required coverage, and other internal limits (other than dollar limits) can act as proxies to create a limited plan of mental health benefits.

Following passage of the federal legislation in 1996, there was and continues to be a flurry of activity at the state level to pass broader more comprehensive mental health parity that would extend the federal legislation. Mental health parity legislation is currently being discussed and debated in nearly every state on the Union. Thirty seven states have introduced 86 bills attempting to address the issue of limited mental health coverage. While at least 10 states have enacted parity legislation, most states are still struggling with the issue. State laws can only affect insured plans. They can not affect large self-insured ERISA plans that fall under federal control. Additional federal legislation is more likely if and when state actions indicate a movement to parity at the state level.

As can be expected, states are the laboratories for new ideas and the diversity of opinions. No two states seem to be alike in their approach to mental health parity. Various compromises and political realities of each state form any final legislation and regulatory language. To facilitate the discussion in Missouri, C&L has developed a series of alternatives along a continuum of steps that provide for incremental analysis of mental health parity.

II. Parity Options

Option #1 (MHPA of 1996) is the Mental Health Parity Act of 1996 (MHPA). The MHPA is a federal law that became effective January 1, 1998. The federal act is a partial parity law that prevents differing lifetime or annual dollar limitations between mental health and non-mental health insurance coverage. Most states are passing parallel legislation to prevent the automatic federal oversight that occurs in the absence of state legislation. The MHPA is not a mandate. It does not require or mandate that mental health coverage be provided under any plan. However, if mental health coverage is provided, the plan can not impose annual or lifetime dollar limitations on mental health coverage that are not imposed on other coverages. The C&L cost estimate for this legislation is 0.13% of total plan costs.

Option #2 (Limited Parity) extends the MHPA to outpatient day and inpatient visit limits. Following the approach of MHPA, there is no mandated coverage. That is, while no mental health coverage is required, if mental health coverage is provided, the plan can not impose day or visit limits on mental health coverage that are not imposed on other coverages.

The C&L estimate of cost is 0.7% of total plan costs. However, this does not include potential adjustments to the mental health deductible, coinsurance/copayments, maximum out-of-pocket, movement to managed care, competitive bidding of the plan, etc. that could be made to offset the impact of this option. The C&L estimate after offsets affecting only the mental health coverages is a 0.3% or lower cost increase.

Option #3 (Catastrophic Parity) includes the features of limited parity (option #2) and adds a maximum out-of-pocket (OOP) limit. Maximum OOP limits are common features for non-mental health coverages provided by many insurance plans (particularly indemnity plans). This feature protects an individual or family from the financial ravages of a catastrophic cost where even the traditional 20% coinsurance paid by the patient can accumulate to an amount that threatens a family's financial resources.

The maximum OOP limit is the total amount of eligible expense cost sharing for which a covered member is responsible. The maximum OOP can be separate and distinct from any non-mental health maximum OOP. Again, following the MHPA approach, there is no mandated coverage. However, if mental health coverage is provided, the plan can not impose a maximum out-of-pocket limit on mental health greater than any imposed on other coverages. By including a maximum out-of-pocket limit, option #3 provides catastrophic protection.

The C&L estimate of increased cost for option #3 is 1.1% of total plan costs. However, this does not include adjustments to mental health deductibles, coinsurance/copayments, movement to managed care, competitive bidding of plan, etc. that could be made to offset the impact of this option. The C&L estimate after offsets affecting only the mental health coverages is a 0.44% or lower cost increase (less than one-half of one percent).

Option #4 (Significant Parity) includes parity provisions of Options 1-3 and extends the parity provisions to the coinsurance/copayment features of an insurance plan design. This partial parity design could be implemented on a no mandate basis for employers with more than 50 employees. However, if legislation is to include groups of 5 or more employees, a state-wide requirement is arguably needed to create a level playing field for all insurers and to allow for appropriate spreading of risks across a large population.

It is at this point of the parity continuum that optional mental health parity (especially for small employers) begins to breakdown and becomes potentially self-defeating. That is, anti-selection begins to play a part of the cost estimate. More small employers are likely to opt for no mental health rather than accept the cost of significant parity. However, as a statewide requirement, where a broad pooling of risk can occur without the anti-selection, the increased cost estimate is only 1.6% of current total plan costs. With cost offsetting actions, the net cost increase is estimated at 0.64%.

Option #5 (Financial Parity) represents financial parity where all plan reimbursement features for existing plan eligible expenses are made on the same basis as non-mental health eligible expenses. Under this option (especially for groups of 5 or more employees) a state-wide requirement would be needed to keep the cost increase impact at the estimated 2.4%. Only a state-wide requirement would allow for a spreading of the risks and a structure to avoid anti-selection.

Employers will respond to any potential increase in benefit costs in a variety of ways including competitively bidding the plan to obtain lower premiums, intensely negotiating lower provider costs, cutting plan administrative costs, increasing plan costsharing by members, increasing premium contributions by members, reducing other benefits, and in the extreme, dropping plan coverages and reducing wages (or wage increases). C&L estimates the net cost to employers for option #5 is 0.96% of total plan costs.

Option #6 (Comprehensive Parity) is comprehensive mental health parity that includes financial parity, expanded access, and coverages not necessarily provided under all plans in the market today. Option #6 may include a "horizontal" expansion of mental health coverage to include new eligible expenses and/or provider services. There are number of concerns that mental health advocates voice regarding overly restrictive managed care rules that interfere with appropriate treatment protocols, exclusions for necessary care, burdensome paper work, and seemingly arbitrary applications of medical necessity. These issues would fall under option #6.

C&L has not priced option #6.

III. Summary

There is general recognition and acceptance that legitimate medically necessary mental health care costs are not now being covered by most policies (due to inside plan limitations that are unique to mental health coverage) and that families need insurance protection against at least the cost of catastrophic costs. There is less agreement (between providers, carriers, HMOs, and employers) on the importance of increased access, broader coverage, early intervention, preventive care, efficacy of some treatments, and medical offsets through proper mental health care.

The document for discussion can assist in the development of what to cover, who to cover, and what other considerations of coverage, access and cost should apply when mental health benefits are provided.

Grid of Mental Health Parity Options

Parity Feature:	Mental Health Parity Option #					
	1	2	3	4	5	6
	MHPA of 1996	Limited Parity	Catastrophic Parity	Significant Parity	Financial Parity	Comprehensive Parity
Lifetime \$	Y	Y	Y	Y	Y	Y
Annual \$	Y	Y	Y	Y	Y	Y
Day & Visits	N	Y	Y	Y	Y	Y
Maximum Out-of-Pocket	N	N	Y	Y	Y	Y
Coinsurance/Copays	N	N	N	Y	Y	Y
Deductible	N	N	N	N	Y	Y
New Benefits	N	N	N	N	N	Y

Applied to:						
Individuals	N/A	N/A	N/A	N/A	N/A	N/A
1-4 Employees	N/A	N/A	N/A	N/A	N/A	N/A
5-50 Employees	N/A	Y	Y	Y	Y	Y
50+ Employees	Y	Y	Y	Y	Y	Y

Mandate *	N	N	N	Y	Y	Y
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Cost Est. ** (Gross)	0.13%	0.70%	1.10%	1.60%	2.40%	Not Avail
(Net)	0.05%	0.30%	0.44%	0.64%	0.96%	Not Avail

Grid of Mental Health Parity Options

	Mental Health Parity Option #					
	1	2	3	4	5	6
Parity Feature:	MHPA of 1996	Limited Parity	Catastrophic Parity	Significant Parity	Financial Parity	Comprehensive Parity
Lifetime \$	Y	Y	Y	Y	Y	Y
Annual \$	Y	Y	Y	Y	Y	Y
Day & Visits	N	Y	Y	Y	Y	Y
Maximum Out-of-Pocket	N	N	Y	Y	Y	Y
Coinsurance/Copays	N	N	N	Y	Y	Y
Deductible	N	N	N	N	Y	Y
New Benefits	N	N	N	N	N	Y

Applied to:						
Individuals	N/A	N/A	N/A	N/A	N/A	N/A
1-4 Employees	N/A	N/A	N/A	N/A	N/A	N/A
5-50 Employees	N/A	Y	Y	Y	Y	Y
50+ Employees	Y	Y	Y	Y	Y	Y

Mandate *	N	N	N	Y	Y	Y
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Cost Est. ** (Gross)	0.13%	0.70%	1.10%	1.60%	2.40%	Not Avail
(Net)	0.05%	0.30%	0.44%	0.64%	0.96%	Not Avail

* MH coverage is not required. Like the Mental Health Parity Act of 1996 (MHPA), if Mental Health (MH) is covered the parity legislation standards must be met.

** Average Cost Estimates are provided by Coopers & Lybrand (includes indemnity, PPOs, and HMOs) as a composite percentage of current total plan costs. Net costs are after employer changes to offset gross costs.

- Option #1 is the Mental Health Parity Act of 1996 which is current law (passed by federal Congress) that goes into effect January 1, 1998.
- Option #2 extends the MHPA to groups of 5 or more and includes parity for day and visit limits.
- Option #3 extends the MHPA to groups of 5 or more, includes parity for day and visit limits, and establishes a separate MH maximum out-of-pocket limit of no more than \$1000 per person per calendar year. This is the most inclusive option to provide catastrophic mental health parity without requiring a benefit mandate.
- Option #4 includes the partial parity provisions of Options 1-3 and extends partial to include equal coinsurance and/or copayments.
- Option #5 represents financial parity where all plan reimbursement features for existing plan eligible expenses are made on the same basis as non-mental health eligible expenses.
- Option #6 is comprehensive mental health parity that includes financial parity and expanded access and coverages not necessarily provided under all plans in the market today.

Mental Health Parity Cost Estimates in Other States

Similar analysis performed in other states resulted in the following cost estimates:

I. C&L Cost Estimates by State

Arkansas - H.B. 1525 Cost of Mental Health Parity

<u>Type of Delivery System</u>	<u>#</u>	<u>Distribution</u>	<u>Percentage Increase in Base Medical Plan for Change to Type of Parity</u>			
			<u>Partial</u>	<u>SMI</u>	<u>Full</u>	<u>Comprehensive</u>
Fee-for-Service	1	40%	1.2%	2.3%	2.8%	3.1%
Managed Indemnity	2	30%	0.9	1.7	2.2	2.8
PPO & POS	3	20%	0.3	1.6	2.0	2.5
HMO & Gatekeeper	4	15%	0.4	0.8	1.0	1.2
Composite Market Analysis			0.8%	1.8%	2.3%	2.7%
Composite PMPM			\$.91	\$2.04	\$2.61	\$3.07

Delaware - H.B. 156 Cost of Mental Health Parity

<u>Type of Delivery System</u>	<u>#</u>	<u>Distribution</u>	<u>Percentage Increase in Base Medical Plan for Change to Type of Parity</u>			
			<u>Partial</u>	<u>SMI</u>	<u>Full</u>	<u>Comprehensive</u>
Fee-for-Service	1	25%	1.2%	2.6%	3.3%	4.2%
Managed Indemnity	2	30%	0.9	2.0	2.5	3.4
PPO & POS	3	20%	0.5	1.8	2.3	2.8
HMO & Gatekeeper	4	25%	0.4	0.8	1.0	1.3
Composite Market Analysis			0.8%	1.8%	2.3%	2.9%
Composite PMPM			\$1.05	\$2.44	\$3.05	\$3.92

North Carolina - H.B. 563
Cost of Mental Health Parity

<u>Type of Delivery System</u>	<u>#</u>	<u>Distribution</u>	Percentage Increase in Base Medical Plan for Change to Type of Parity			
			<u>Partial</u>	<u>SMI</u>	<u>Full</u>	<u>Comprehensive</u>
Fee-for-Service	1	35%	0.9%	2.0%	2.5%	2.7%
Managed Indemnity	2	25%	0.7	1.6	2.0	2.2
PPO & POS	3	25%	0.5	1.6	2.0	2.3
HMO & Gatekeeper	4	15%	0.5	0.8	1.0	1.1
Composite Market Analysis			0.7%	1.6%	2.0%	2.2%
Composite PMPM			\$0.76	\$1.77	\$2.22	\$2.46

Pennsylvania - H.B. 1286
Cost of Mental Health Parity

<u>Type of Delivery System</u>	<u>#</u>	<u>Distribution</u>	Percentage Increase in Base Medical Plan for Change to Type of Parity			
			<u>Partial</u>	<u>SMI</u>	<u>Full</u>	<u>Comprehensive</u>
Fee-for-Service	1	30%	1.1%	2.8%	3.5%	4.2%
Managed Indemnity	2	35%	0.8	2.1	2.7	3.4
PPO & POS	3	15%	0.6	2.0	2.5	2.8
HMO & Gatekeeper	4	20%	0.5	0.9	1.2	1.3
Composite Market Analysis			0.8%	2.1%	2.6%	3.1%
Composite PMPM			\$1.12	\$2.83	\$3.53	\$4.26

Vermont - H.B. 57
Cost of Mental Health & Substance Abuse Parity

<u>Type of Delivery System</u>	<u>#</u>	<u>Distribution</u>	Percentage Increase in Base Medical Plan for Change to Type of Parity			
			<u>Partial</u>	<u>SMI</u>	<u>Full</u>	<u>Comprehensive</u>
Fee-for-Service	1	30%	1.3%	3.5%	4.3%	4.9%
Managed Indemnity	2	25%	0.9	2.5	3.1	3.6
PPO & POS	3	10%	0.6	2.3	2.9	3.8
HMO & Gatekeeper	4	35%	0.6	1.0	1.3	1.8
Composite Market Analysis			0.9%	2.3%	2.8%	3.4%
Composite PMPM			\$0.91	\$2.33	\$2.84	\$3.45

II. Interim Report to Congress by the National Advisory Mental Health Council

A report entitled "Parity in Coverage of Mental Health Services in an Era of Managed Care" is a product of the Department of Health and Human Services, the National Institutes of Health and the National Institute of Mental Health. This report is an interim report to Congress by the National Advisory Mental Health Council. The study's major findings are:

- "1. Based upon empirical studies and economic simulations across diverse populations, managed care approaches, and parity structures suggest that the introduction of parity in combination with managed care results in lowered costs and lowered premiums (or, at most, very modest cost increases) within the first year of parity implementation.**
- 2. These findings do not support earlier concern about potentially high financial costs caused by parity. Prior estimates were based on fee-for-service (FFS) models that are no longer valid for a market dominated by managed care and likely to become even more so."**

A. Texas

On September 1, 1992, the State of Texas implemented legislation requiring parity in mental health insurance coverage for State and local government employees. Parity was also required for the treatment of chemical dependency. Experience for 170,000 members in managed FFS/PPO/POS (non-HMO) coverage for the years 1992 through 1995 shows a 47.9% decrease in the cost of care for mental health and chemical dependency.

B. Maryland

On July 1, 1995, the State of Maryland implemented parity legislation that applied to all insurers. The legislation applied to those mental health and addictive disorders determined to be medically necessary and treatable. After parity was instituted, a small increase was observed in the number of inpatient admissions per 1000; that increase was more than offset by a more significant decrease in the average length of inpatient stays. Outpatient visits decreased as much as 9%, although isolated instances of increased outpatient utilization were seen.

For one insurer, the proportion of the total medical premium attributable to the mental health benefit actually decreased by 0.2 percent after the implementation of full parity. A second managed care company with extensive experience in Maryland subsequently confirmed that their average that their average expense per member per month increase by less than 1.0 percent during the first 7 months after full implementation of parity.

C. Rhode Island

On January 1, 1995, the State of Rhode Island implemented limited parity legislation. After parity was instituted in Rhode Island, there was a moderate increase in the number of inpatient admissions per 1000 members, and a moderate reduction in the average length of inpatient stays, with an overall increase in days per 1000 members. The average overall mental health cost increases resulted in an increase of total plan costs of less than 1 percent (specifically 0.33 percent of total benefit).

III. Other Studies on the Impact of Mental Health Parity

A. Minnesota

Minnesota passed full parity effective August 1, 1995. Language to accomplish full parity is included in the Minnesota's insurance statutes. The statute is similar to the following wording with separate sections to independently describe inpatient and outpatient parity. To date, there has been no recognized cost concerns or exodus of insured plans to ERISA status in order to avoid the Minnesota parity mandate.

According to John Gross, Director of Health Care Policy - Insurance Federation, "No one has cited rising mental health costs as reasons for premium increases." The Minnesota Department of Commerce, the state agency that regulates indemnity insurance, estimated costs of 1% of total premium dollars for mental health parity. Medica, an independent consulting organization, estimated Minnesota costs for mental health parity is \$.26 per member per month.

Minnesota legislation includes the following:

All health plans that provide coverage for mental health or chemical dependency services, must comply with the following:

Cost-sharing requirements and benefit or service limitations for mental health and outpatient chemical dependency services must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for medical services.

B. North Carolina

The North Carolina State Employee Health Plan includes mental health benefits with full comprehensive parity of coverage. The background on the state benefits include:

1. Full coverage parity with medical conditions since 1992,
2. No separate additional deductible for mental health services,
3. Full freedom of choice of mental health providers,
4. Moderate management of benefits compared to many managed behavioral mental health programs,
5. Broad demographic mix of 400,000 covered lives.

Since 1992 when parity was established and a single deductible was implemented, mental health payments as a portion of total health payments decreased from 6.4% to 3.7% of total health care costs for the fiscal year ending June 30, 1995.

C. New Hampshire

A Lewin Group study of the impact of mental health parity in New Hampshire showed "no increase in overall costs were reported as a result of a state law requiring equal health insurance coverage for severe mental illness. Lewin surveyed 11 insurers accounting for the majority of lives in the state. According to the study, "increases in premiums ranged from non-existent to small or moderate." Respondents indicated that the legislation "was not a major factor of discussion or concern among those at the employer group level."

IV. Comparison to Congressional Budget Office Calculations

In a letter to Senator Nancy Kassebaum (R-KS) dated April 23, 1996, the Congressional Budget Office (CBO) estimated the cost impact of the mental health and substance abuse parity proposal by Senators Domenici (R-NM) and Wellstone (D-MN) at 4.0%. The mental health portion of the Domenici-Wellstone proposal is similar to the Comprehensive Parity options presented in this paper. However, in most states (except Vermont) substance abuse is excluded. Without substance abuse, the CBO cost impact would likely be in the 3.0-3.5% range,

With substance abuse included, the CBO cost estimate is 5.3% for Fee-for-Service plans and 4.0% for the market composite that includes managed care plans. As written in the CBO letter, "Because employers would be better able to control costs for mental health services, CBO assumed that the average premium increase initially would be 4 percent."

Impact of MH Parity on Employer with Five Employees

North Carolina

**Cost Increase for Five (5) Employee Group
Mental Health Only**

Gross Cost Per Person/Month	
x Plan Offsets/Adjustments	(1)
Net Cost Per Person/Month	
x Employers Portion of Cost Increase	(2)
Net Employer Cost Per Person/Month	
#Persons (5 Ees + 10 Dependents)	
Total Monthly Cost Increase for Employer	

TYPE OF PLAN					
Indemnity	Managed Indemnity	PPO/POS	HMO or Gatekeeper	Composite Average	
\$3.09	\$2.51	\$2.43	\$1.11	\$2.46	
0.4	0.4	0.4	0.4	0.4	
\$1.24	\$1.00	\$0.97	\$0.44	\$0.98	
0.5	0.5	0.5	0.5	0.5	
\$0.62	\$0.50	\$0.49	\$0.22	\$0.49	
15	15	15	15	15	
\$9.27	\$7.53	\$7.29	\$3.33	\$7.38	

(1) Plan Offsets occur as employers adjust plan designs to mitigate the impact of any rate increase. Actions include: competitive bidding of plan to other carriers, increasing plan deductibles for all coverages, moving more towards managed care, negotiating provider reimbursements, lowering wage increases, reducing other ancillary benefits,

(2) The employer portion of the cost is approximately 50% of any premium due for the benefit plan. Employees pay the remaining 50% of costs. Some employers pay the employee premium with employees paying the dependent premium.

NC COMPREHENSIVE MAJOR MEDICAL PLAN FOR TEACHERS AND STATE EMPLOYEES

Mental Health Costs

Fiscal Year Ending

	June-97	June-96	June-95	June-94	June-93 (Full MH Mgmt)	June-92 (No Outpatient Cap or MH Mgmt)	June-91	June-90
TOTAL: Actives & Dependents	292,572	305,924	322,827	322,900	322,088	330,613	351,189	341,098
TOTAL: Covered Lives	393,985	404,210	415,225	412,529	409,302	415,302	433,069	420,184
Total Mental Health Payments	\$19,008,825	\$19,936,678	\$20,424,916	\$23,138,778	\$25,612,004	\$32,361,152	\$30,830,831	\$27,914,870
— Total Payments PMPY*	\$48.25	\$49.32	\$49.19	\$56.09	\$62.57	\$77.92	\$71.19	\$66.43
— Total Payments PMPM*	\$4.02	\$4.11	\$4.10	\$4.67	\$5.21	\$6.49	\$5.93	\$5.54
— % of Total of all Medical Claims Paid	3.3%	3.4%	3.7%	4.5%	5.2%	6.4%	6.1%	6.6%
Total Administrative Payments	\$2,452,923	\$2,493,405	\$2,476,755	\$2,404,000	\$2,273,862			
— Total Payments PMPY	\$6.23	\$6.23	\$5.96	\$5.72	\$5.56			
— Total Payments PMPM	\$0.52	\$0.52	\$0.50	\$0.48	\$0.46			
Breakdown of Cost Per Member Per Month								
— Mental Health PMPM	\$4.02	\$4.11	\$4.10	\$4.67	\$5.21			
— Administrative PMPM	\$0.52	\$0.52	\$0.50	\$0.48	\$0.46			
Total Cost Per Member Per Month	\$4.54	\$4.61	\$4.60	\$5.15	\$5.67	\$6.49	\$5.93	\$5.54

*Note: PMPY and PMPM - Is actually per covered life per year or per month

Prepared by NC Psychological Association from data supplied by the NC State Health Plan Office

5/98

NC COMPREHENSIVE MAJOR MEDICAL PLAN FOR TEACHERS AND STATE EMPLOYEES

Mental Health Experience (Excluding Substance Abuse) Inpatient/Outpatient Data

Fiscal Year Ending

	FY 6/97	FY 6/96	FY 6/95	FY 6/94	FY 6/93	FY 6/92	FY 6/91	FY 6/90
<u>Inpatient (Actives & Dependents Only)</u>								
# of Admissions	781	876	971	1,092	1,142	1,276	1,403	1,367
Adm/10,000	28.7	28.6	30.3	34.1	35.5	38.2	39.5	39.8
Days/10,000	269.8	308.5	318.9	391.6	484.9	807.1	859.6	917.9
ALOS	10.1	10.8	10.5	11.5	13.7	21.1	21.7	23.1
ALOS (outliers greater than 50 days excluded)	(10.1)	(8.3)	(9.2)	(10.8)	(12.2)			
<u>Outpatient (Actives & Dependents Only)</u>								
# Patients	20,113	20,519	20,562	19,674	19,659	20,520	21,092	18,913
Patients as %	6.8%	6.7%	6.4%	6.1%	6.1%	6.1%	6.0%	5.6%
# Visits	160,666	170,225	172,664	185,866	193,601	217,944	212,612	192,488
# Visits/1000 members	549	551	539	557	602	653	609	567
# Visits/Patient								
— Median	4.0	4.0	4.0	4.0	4.0	5.0	5.0	5.0
— 75th Percentile	11.0	11.0	12.0	13.0	13.0	13.0	14.0	14.0
— Mean	8.0	8.3	8.5	9.2	9.8	10.6	10.1	10.2
Utilization > 26 Visits								
— # of patients	1,203	1,216	1,508	1,642	1,842	2,482	2,499	2,173
— % of patients	6.0%	5.9%	7.3%	8.3%	9.4%	12.1%	11.8%	11.5%
— % of covered lives	0.41%	0.40%	0.47%	0.51%	0.57%	0.75%	0.71%	0.64%

Analysis of Catastrophic MH Parity Cost Impact on Small & Large Employers

* Based on 1996 Foster Higgins National Survey of Employer-sponsored Health Plans

Premium Increase Estimates are before any Plan or Other Changes that Might Mitigate Increases

	Small Employers		
	Indemnity	PPO	HMO
Monthly Cost per Employee*	\$260	\$237	\$218
C&L Cost Estimates: % Cost of Option #3 Catastrophic MH Parity	1.28%	1.10%	0.60%
Monthly Cost Per Employee	\$3.34	\$2.61	\$1.30

	Large Employers		
	Indemnity	PPO	HMO
	\$296	\$260	\$264
	1.28%	1.10%	0.60%
	\$3.80	\$2.86	\$1.57

# Employees	Current Total Monthly Premium		
	Indemnity	PPO	HMO
250	\$65,087	\$59,290	\$54,539
200	\$52,070	\$47,432	\$43,631
150	\$39,052	\$35,574	\$32,723
100	\$26,035	\$23,716	\$21,816
75	\$19,526	\$17,787	\$16,362
50	\$13,017	\$11,858	\$10,908
40	\$10,414	\$9,486	\$8,726
30	\$7,810	\$7,115	\$6,545
20	\$5,207	\$4,743	\$4,363
10	\$2,603	\$2,372	\$2,182
5	\$1,302	\$1,186	\$1,091

# Employees	Current Total Monthly Premium		
	Indemnity	PPO	HMO
250	\$73,998	\$65,111	\$65,935
200	\$59,198	\$52,089	\$52,748
150	\$44,399	\$39,067	\$39,561
100	\$29,599	\$26,044	\$26,374
75	\$22,199	\$19,533	\$19,781
50	\$14,800	\$13,022	\$13,187
40	\$11,840	\$10,418	\$10,550
30	\$8,880	\$7,813	\$7,912
20	\$5,920	\$5,209	\$5,275
10	\$2,960	\$2,604	\$2,637
5	\$1,480	\$1,302	\$1,319

# Employees	Total Monthly Premium Increase Before Plan Design Offsets		
	Indemnity	PPO	HMO
250	\$835	\$652	\$325
200	\$668	\$522	\$260
150	\$501	\$391	\$195
100	\$334	\$261	\$130
75	\$251	\$196	\$97
50	\$167	\$130	\$65
40	\$134	\$104	\$52
30	\$100	\$78	\$39
20	\$67	\$52	\$26
10	\$33	\$26	\$13
5	\$17	\$13	\$6

# Employees	Total Monthly Premium Increase Before Plan Design Offsets		
	Indemnity	PPO	HMO
250	\$950	\$716	\$393
200	\$760	\$573	\$314
150	\$570	\$430	\$236
100	\$380	\$286	\$157
75	\$285	\$215	\$118
50	\$190	\$143	\$79
40	\$152	\$115	\$63
30	\$114	\$86	\$47
20	\$76	\$57	\$31
10	\$38	\$29	\$16
5	\$19	\$14	\$8

# Employees	Total Monthly Premium Increase After Plan Design Offsets (60%)		
	Indemnity	PPO	HMO
250	\$334	\$261	\$130
200	\$267	\$209	\$104
150	\$200	\$157	\$78
100	\$134	\$104	\$52
75	\$100	\$78	\$39
50	\$67	\$52	\$26
40	\$53	\$42	\$21
30	\$40	\$31	\$16
20	\$27	\$21	\$10
10	\$13	\$10	\$5
5	\$7	\$5	\$3

# Employees	Total Monthly Premium Increase After Plan Design Offsets (60%)		
	Indemnity	PPO	HMO
250	\$380	\$286	\$157
200	\$304	\$229	\$126
150	\$228	\$172	\$94
100	\$152	\$115	\$63
75	\$114	\$86	\$47
50	\$76	\$57	\$31
40	\$61	\$46	\$25
30	\$46	\$34	\$19
20	\$30	\$23	\$13
10	\$15	\$11	\$6
5	\$8	\$6	\$3

Analysis of Catastrophic MH Parity Cost Impact on Small & Large Employers

* Based on 1996 Foster Higgins National Survey of Employer-sponsored Health Plans
Premium Increase Estimates are before any Plan or Other Changes that Might Mitigate Increases

	Small Employers		
	Indemnity	PPO	HMO
Monthly Cost per Employee*	\$260	\$237	\$218
GAHMO Cost Survey: % Cost of Option #3 Catastrophic MH Parity	5.90%	5.90%	2.80%
Monthly Cost Per Employee	\$15.36	\$13.99	\$6.11

	Large Employers		
	Indemnity	PPO	HMO
	\$296	\$260	\$264
	5.25%	5.25%	1.60%
	\$15.54	\$13.67	\$4.22

# Employees	Current Total Monthly Premium		
	Indemnity	PPO	HMO
250	\$65,087	\$59,290	\$54,539
200	\$52,070	\$47,432	\$43,631
150	\$39,052	\$35,574	\$32,723
100	\$26,035	\$23,716	\$21,816
75	\$19,526	\$17,787	\$16,362
50	\$13,017	\$11,858	\$10,908
40	\$10,414	\$9,486	\$8,726
30	\$7,810	\$7,115	\$6,545
20	\$5,207	\$4,743	\$4,363
10	\$2,603	\$2,372	\$2,182
5	\$1,302	\$1,186	\$1,091

	Current Total Monthly Premium		
	Indemnity	PPO	HMO
	\$73,998	\$65,111	\$65,935
	\$59,198	\$52,089	\$52,748
	\$44,399	\$39,067	\$39,561
	\$29,599	\$26,044	\$26,374
	\$22,199	\$19,533	\$19,781
	\$14,800	\$13,022	\$13,187
	\$11,840	\$10,418	\$10,550
	\$8,880	\$7,813	\$7,912
	\$5,920	\$5,209	\$5,275
	\$2,960	\$2,604	\$2,637
	\$1,480	\$1,302	\$1,319

# Employees	Total Monthly Premium Increase Before Plan Design Offsets		
	Indemnity	PPO	HMO
250	\$3,840	\$3,498	\$1,527
200	\$3,072	\$2,798	\$1,222
150	\$2,304	\$2,099	\$916
100	\$1,536	\$1,399	\$611
75	\$1,152	\$1,049	\$458
50	\$768	\$700	\$305
40	\$614	\$560	\$244
30	\$461	\$420	\$183
20	\$307	\$280	\$122
10	\$154	\$140	\$61
5	\$77	\$70	\$31

	Total Monthly Premium Increase Before Plan Design Offsets		
	Indemnity	PPO	HMO
	\$3,885	\$3,418	\$1,055
	\$3,108	\$2,735	\$844
	\$2,331	\$2,051	\$633
	\$1,554	\$1,367	\$422
	\$1,165	\$1,025	\$316
	\$777	\$684	\$211
	\$622	\$547	\$169
	\$466	\$410	\$127
	\$311	\$273	\$84
	\$155	\$137	\$42
	\$78	\$68	\$21

# Employees	Total Monthly Premium Increase After Plan Design Offsets (60%)		
	Indemnity	PPO	HMO
250	\$1,536	\$1,399	\$611
200	\$1,229	\$1,119	\$489
150	\$922	\$840	\$367
100	\$614	\$560	\$244
75	\$461	\$420	\$183
50	\$307	\$280	\$122
40	\$246	\$224	\$98
30	\$184	\$168	\$73
20	\$123	\$112	\$49
10	\$61	\$56	\$24
5	\$31	\$28	\$12

	Total Monthly Premium Increase After Plan Design Offsets (60%)		
	Indemnity	PPO	HMO
	\$1,554	\$1,367	\$422
	\$1,243	\$1,094	\$338
	\$932	\$820	\$253
	\$622	\$547	\$169
	\$466	\$410	\$127
	\$311	\$273	\$84
	\$249	\$219	\$68
	\$186	\$164	\$51
	\$124	\$109	\$34
	\$62	\$55	\$17
	\$31	\$27	\$8

Public's attitude about mental illness shifting

By Andy Miller
STAFF WRITER

Nine of ten Georgians believe mental illness can be treated successfully — and that insurance policies should cover it on an equal basis with general physical illnesses, a new survey finds.

But lack of insurance or ability to pay, along with lingering stigma about mental illness, remain barriers to people getting treatment, according to the survey released Friday.

And about half of Georgians surveyed said they would not want their employer to know they were being treated for a mental illness.

The results of the September survey of 404 Georgia households, conducted by the University of Georgia, were released at the Rosalynn Carter Georgia Mental Health Forum.

The survey showed great advances in the public's understanding of mental illness, said Carter. Almost 95 percent of Georgians believe people with mental illness can be helped through treatment, she noted.

"That is a huge step forward," Carter said. "It was not very long ago that people thought of mental illness as a weakness."

More than 80 percent said they would support a political candidate who had been treated for mental illness if the person were the best for the job. That shows great progress from 1972, when Sen. Thomas Eagleton withdrew from the Democratic ticket over concerns about a past treatment for mental illness, Carter said.

In other survey findings, 40 percent know someone who had been diagnosed with a mental illness, which the survey listed as major depression, schizophrenia

or obsessive-compulsive disorder, among others.

And 88 percent said they would knowingly employ or recommend someone for a job who had received mental health treatment. Still, almost 50 percent said they would not want their employer to know if they were seeking treatment for mental illness.

"It's an ongoing fear of people losing their job and insurance coverage," said Darrell Kirch, dean of the School of Medicine at the Medical College of Georgia. People seeking treatment, he said, may fear they will be seen as not competent to do a job.

Doug Bachtel of the University of Georgia added many people work for small firms, "where you don't necessarily have all the safeguards as you would if you were working for state government or a large corporation."

Ron Finch of consulting firm

Coopers & Lybrand said although the stigma still exists, the employer issue may involve the right to privacy.

"There's so much paranoia over downsizing," Finch said. "Many employees don't want their employer to know anything about their health," including conditions such as heart disease and hypertension.

Carter noted that Congress recently passed a bill requiring that annual or lifetime caps on mental health benefits be on par with those for physical illnesses.

"It's a real victory," though broader benefits parity is needed, she said.

Added Cynthia Wainscott of the Mental Health Association of Georgia: "We need to have employers understand they can save money by treating depression."

289.59 Other

Lien migrans

Perisplenitis

Splenitis:

abscess

atrophy

cyst

EXCLUDES

Splenitis:

fibrosis

infarction

rupture, nontraumatic

Splenitis

Wandering spleen

bilateral splenic fibrosis (120.0-120.9)

hepatosplenic fibrosis (571.5)

splenomegaly NOS (789.2)

289.6 Familial polycythemia

Familial:

benign polycythemia

Familial:

erythrocytosis

289.7 Methemoglobinemia

Congenital NADH [DPNH]-methemoglobin-reductase deficiency

Hemoglobin M [Hb-M] disease

Methemoglobinemia:

NOS

acquired (with sulfhemoglobinemia)

hereditary

toxic

Stokvis' disease

Sulfhemoglobinemia

Use additional E code to identify cause

289.8 Other specified diseases of blood and blood-forming organs

Hypergammaglobulinemia

Myelofibrosis

Pseudocholinesterase deficiency

289.9 Unspecified diseases of blood and blood-forming organs

Blood dyscrasia NOS

Erythroid hyperplasia

5. MENTAL DISORDERS (290-319)

In the *International Classification of Diseases, 9th Revision (ICD-9)*, the corresponding Chapter V, "Mental Disorders," includes a glossary which defines the contents of each category. The introduction to Chapter V in ICD-9 indicates that the glossary is intended so that psychiatrists can make the diagnosis based on the descriptions provided rather than from the category titles. Lay coders are instructed to code whatever diagnosis the physician records.

Chapter 5, "Mental Disorders," in ICD-9-CM uses the standard classification format with inclusion and exclusion terms, omitting the glossary as part of the main text.

The mental disorders section of ICD-9-CM has been expanded to incorporate additional psychiatric disorders not listed in ICD-9. The glossary from ICD-9 does not contain all these terms. It now appears in Appendix B, which also contains descriptions and definitions for the terms added in ICD-9-CM. Some of these were provided by the American Psychiatric Association's Task Force on Nomenclature and Statistics who are preparing the *Diagnostic and Statistical Manual, Third Edition (DSM-III)*, and others from *A Psychiatric Glossary*.

The American Psychiatric Association provided invaluable assistance in modifying Chapter 5 of ICD-9-CM to incorporate detail useful to American clinicians and gave permission to use material from the aforementioned sources.

1. *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, 9th Revision*. World Health Organization. Geneva, Switzerland, 1975.

2. American Psychiatric Association. Task Force on Nomenclature and Statistics. Robert L. Spitzer, M.D., Chairman.

3. *A Psychiatric Glossary*. Fourth Edition. American Psychiatric Association, Washington, D.C., 1975.

PSYCHOSES (290-299)

EXCLUDES

mental retardation (317-319)

ORGANIC PSYCHOTIC CONDITIONS (290-299)

INCLUDES

psychotic organic brain syndrome

EXCLUDES

nonpsychotic syndromes of organic etiology (310.9)

psychoses classifiable to 295-298 and without impairment of orientation, comprehension, calculation, learning capacity, and judgment but associated with physical disease or condition affecting the brain (e.g., following childbirth) (295.0-298.8)

290 Senile and presenile organic psychotic conditions

Use additional code to identify the associated neurological condition

EXCLUDES

dementia not classified as senile, presenile, or arteriosclerotic (294.1)

psychoses classifiable to 295-298 occurring in the senium without dementia or delirium (295.0-298.8)

senility with mental changes of nonpsychotic etiology (310.1)

transient organic psychotic conditions (293.0-293.8)

290.0 Senile dementia, uncomplicated

Senile dementia:

NOS

simple type

EXCLUDES

mild memory disturbances, not amounting to dementia, associated with senile brain disease (310.1)

senile dementia with:

delirium or confusion (290.3)

delusional (paranoid) features (290.3)

depressive features (290.21)

290.1 Presenile dementia

Brain syndrome with presenile brain disease

EXCLUDES

arteriosclerotic dementia (290.40-290.43)
dementia associated with other cerebral conditions (294.1)

290.10 Presenile dementia, uncomplicated

Presenile dementia: Presenile dementia:

NOS

simple type

290.11 Presenile dementia with delirium

Presenile dementia with acute confusional state

290.12 Presenile dementia with delusional features

Presenile dementia, paranoid type

290.13 Presenile dementia with depressive features

Presenile dementia, depressed type

290.2 Senile dementia with delusional or depressive features

EXCLUDES

senile dementia:

NOS (290.0)

with delirium and/or confusion (290.3)

290.20 Senile dementia with delusional features

Senile dementia, paranoid type

Senile psychosis NOS

290.21 Senile dementia with depressive features

290.3 Senile dementia with delirium

Senile dementia with acute confusional state

EXCLUDES

senile:

dementia NOS (290.0)

psychosis NOS (290.20)

290.4 Arteriosclerotic dementia

Multi-infarct dementia or psychosis

Use additional code to identify cerebral atherosclerosis (437.0)

EXCLUDES

suspected cases with no clear evidence of arteriosclerosis (290.9)

290.40 Arteriosclerotic dementia, uncomplicated

Arteriosclerotic dementia:

NOS

simple type

290.41 Arteriosclerotic dementia with delirium

Arteriosclerotic dementia with acute

confusional state

290.42 Arteriosclerotic dementia with delusional features

Arteriosclerotic dementia, paranoid type

290.43 Arteriosclerotic dementia with depressive features

Arteriosclerotic dementia, depressed type

◆ **290.8 Other specified senile psychotic conditions**
Presbyophrenic psychosis

◆ **290.9 Unspecified senile psychotic condition**

● **291 Alcoholic psychoses**

EXCLUDES alcoholism without psychosis (303.0-303.9)

291.0 Alcohol withdrawal delirium

Alcoholic delirium Delirium tremens

EXCLUDES alcohol withdrawal (291.81)

291.1 Alcohol amnesic syndrome

Alcoholic polyneuritic psychosis

Korsakoff's psychosis, alcoholic

Wernicke-Korsakoff syndrome (alcoholic)

◆ **291.2 Other alcoholic dementia**

Alcoholic dementia NOS

Alcoholism associated with dementia NOS

Chronic alcoholic brain syndrome

291.3 Alcohol withdrawal hallucinosis

Alcoholic:

hallucinosis (acute)

Alcoholic:

psychosis with hallucinosis

EXCLUDES alcohol withdrawal with delirium (291.0)

schizophrenia (295.0-295.9) and paranoid

states (297.0-297.9) taking the form of

chronic hallucinosis with clear

consciousness in an alcoholic

291.4 Idiosyncratic alcohol intoxication

Pathologic:

alcohol intoxication

Pathologic:

drunkenness

EXCLUDES acute alcohol intoxication (305.0)

in alcoholism (303.0)

simple drunkenness (305.0)

291.5 Alcoholic jealousy

Alcoholic:

paranoia

Alcoholic:

psychosis, paranoid type

EXCLUDES nonalcoholic paranoid states (297.0-297.9)

schizophrenia, paranoid type (295.3)

● **291.8 Other specified alcoholic psychosis**

291.81 Alcohol withdrawal

Alcohol:

withdrawal syndrome or symptoms

abstinence syndrome or symptoms

EXCLUDES alcohol withdrawal:

delirium (291.0)

hallucinosis (291.3)

delirium tremens (291.0)

◆ **291.89 Other**

◆ **291.9 Unspecified alcoholic psychosis**

Alcoholic:

mania NOS

psychosis NOS

Alcoholism (chronic) with psychosis

● **292 Drug psychoses**

INCLUDES drug-induced mental disorders

organic brain syndrome associated with

consumption of drugs

Use additional code for any associated drug dependence (304.0-304.9)

Use additional E code to identify drug

292.0 Drug withdrawal syndrome

Drug:

abstinence syndrome or symptoms

withdrawal syndrome or symptoms

● **292.1 Paranoid and/or hallucinatory states induced by drugs**

292.11 Drug-induced organic delusional syndrome

Paranoid state induced by drugs

292.12 Drug-induced hallucinosis

Hallucinatory state induced by drugs

EXCLUDES states following LSD or other hallucinogens, lasting only a few days or less ("bad trips") (305.3)

292.2 Pathological drug intoxication

Drug reaction:

NOS

idiosyncratic

pathologic

resulting in brief
psychotic
states

EXCLUDES expected brief psychotic reactions to hallucinogens ("bad trips") (305.3)
physiological side-effects of drugs (e.g., dystonias)

● **292.8 Other specified drug-induced mental disorders**

292.81 Drug-induced delirium

292.82 Drug-induced dementia

292.83 Drug-induced amnesic syndrome

292.84 Drug-induced organic affective syndrome

Depressive state induced by drugs

292.89 Other

Drug-induced organic personality syndrome

292.9 Unspecified drug-induced mental disorder

Organic psychosis NOS due to or associated with drugs

● **293 Transient organic psychotic conditions**

INCLUDES transient organic mental disorders not associated with alcohol or drugs

Code first the associated physical or neurological condition

EXCLUDES confusional state or delirium superimposed on senile dementia (290.3)

dementia due to:

alcohol (291.0-291.9)

arteriosclerosis (290.40-290.43)

drugs (292.82)

senility (290.0)

293.0 Acute delirium

Acute:

confusional state

infective psychosis

organic reaction

posttraumatic organic psychosis

psycho-organic syndrome

Acute psychosis associated with endocrine, metabolic, or cerebrovascular disorder

Epileptic:

confusional state

twilight state

293.1 Subacute delirium

Subacute:

confusional state

infective psychosis

organic reaction

posttraumatic organic psychosis

psycho-organic syndrome

psychosis associated with endocrine or metabolic disorder

● **293.8 Other specified transient organic mental disorders**

293.81 Organic delusional syndrome

Transient organic psychotic condition, paranoid type

293.82 Organic hallucinosis syndrome

Transient organic psychotic condition, hallucinatory type

293.83 Organic affective syndrome

Transient organic psychotic condition, depressive type

293.84 Organic anxiety syndrome

293.89 Other

293.9 Unspecified transient organic mental disorder

Organic psychosis:

infective NOS

posttraumatic NOS

Organic psychosis:

transient NOS

Psycho-organic syndrome

● **294 Other organic psychotic conditions (chronic)**

INCLUDES organic psychotic brain syndromes (chronic), not elsewhere classified

294.0 Amnesic syndrome

Korsakoff's psychosis or syndrome (nonalcoholic)

EXCLUDES alcoholic:

amnesic syndrome (291.1)

Korsakoff's psychosis (291.1)

294.1 Dementia in conditions classified elsewhere
Code first any underlying physical condition, as:
dementia in:

Alzheimer's disease (331.0) ▲
cerebral lipidoses (330.1)
epilepsy (345.0-345.9)
general paresis [syphilis] (094.1)
hepatolenticular degeneration (275.1)
Huntington's chorea (333.4)
Jakob-Creutzfeldt disease (046.1) ◆
multiple sclerosis (340)
Pick's disease of the brain (331.1) ◆
polyarteritis nodosa (446.0)
syphilis (094.1)

EXCLUDES dementia:

arteriosclerotic (290.40-290.43)
presenile (290.10-290.13)
senile (290.0)
epileptic psychosis NOS (294.8)

294.8 Other specified organic brain syndromes (chronic)
Epileptic psychosis NOS
Mixed paranoid and affective organic psychotic states
Use additional code for associated epilepsy (345.0-345.9)

EXCLUDES mild memory disturbances, not amounting to dementia (310.1)

294.9 Unspecified organic brain syndrome (chronic)
Organic psychosis (chronic)

OTHER PSYCHOSES (295-299)

Use additional code to identify any associated physical disease, injury, or condition affecting the brain with psychoses classifiable to 295-298

295 Schizophrenic disorders

INCLUDES schizophrenia of the types described in 295.0-295.9 occurring in children

EXCLUDES childhood type schizophrenia (299.9)
infantile autism (299.0)

The following fifth-digit subclassification is for use with category 295:

- 0 unspecified
- 1 subchronic
- 2 chronic
- 3 subchronic with acute exacerbation
- 4 chronic with acute exacerbation
- 5 in remission

295.0 Simple type

Schizophrenia simplex

EXCLUDES latent schizophrenia (295.5)

295.1 Disorganized type

Hebephrenia

Hebephrenic type schizophrenia

295.2 Catatonic type

Catatonic (schizophrenia):	Schizophrenic:
agitation	cataplexy
excitation	catatonia
excited type	flexibilitas cerea
stupor	
withdrawn type	

295.3 Paranoid type

Paraphrenic schizophrenia

EXCLUDES involutional paranoid state (297.2)
paranoia (297.1)
paraphrenia (297.2)

295.4 Acute schizophrenic episode

Onetizophrenia
Schizophreniform:
attack

Schizophreniform:
disorder
psychosis, confusional type

EXCLUDES acute forms of schizophrenia of:
catatonic type (295.2)
hebephrenic type (295.1)
paranoid type (295.3)
simple type (295.0)
undifferentiated type (295.8)

295.5 Latent schizophrenia

Latent schizophrenic reaction
Schizophrenia:
borderline
incipient
prepsychotic

Schizophrenia:
prodromal
pseudoneurotic
pseudopsychopathic

EXCLUDES schizoid personality (301.20-301.22)

295.6 Residual schizophrenia

Chronic undifferentiated schizophrenia
Restzustand (schizophrenic)
Schizophrenic residual state

295.7 Schizo-affective type

Cyclic schizophrenia
Mixed schizophrenic and affective psychosis
Schizo-affective psychosis
Schizophreniform psychosis, affective type

295.8 Other specified types of schizophrenia

Acute (undifferentiated) schizophrenia
Atypical schizophrenia
Cenesthopathic schizophrenia

EXCLUDES infantile autism (299.0)

295.9 Unspecified schizophrenia

Schizophrenia:
NOS
mixed NOS
undifferentiated NOS
Schizophrenic reaction NOS
Schizophreniform psychosis NOS

296 Affective psychoses

INCLUDES episodic affective disorders

EXCLUDES neurotic depression (300.4)
reactive depressive psychosis (298.0)
reactive excitation (298.1)

The following fifth-digit subclassification is for use with categories 296.0-296.6:

- 0 unspecified
- 1 mild
- 2 moderate
- 3 severe, without mention of psychotic behavior
- 4 severe, specified as with psychotic behavior
- 5 in partial or unspecified remission
- 6 in full remission

296.0 Manic disorder, single episode

Hypomania (mild) NOS
Hypomanic psychosis
Mania (monopolar) NOS
Manic-depressive psychosis or reaction:
hypomanic
manic

} single episode or unspecified

EXCLUDES circular type, if there was a previous attack of depression (296.4)

296.1 Manic disorder, recurrent episode

Any condition classifiable to 296.0, stated to be recurrent

EXCLUDES circular type, if there was a previous attack of depression (296.4)

296.2 Major depressive disorder, single episode

Depressive psychosis
Endogenous depression
Involutional melancholia
Manic-depressive psychosis or reaction, depressed type
Monopolar depression
Psychotic depression

} single episode or unspecified

EXCLUDES circular type, if previous attack was of manic type (296.5)

depression NOS (311)
reactive depression (neurotic) (300.4)
psychotic (298.0)

296.3 Major depressive disorder, recurrent episode

Any condition classifiable to 296.2, stated to be recurrent

EXCLUDES circular type, if previous attack was of manic type (296.5)
depression NOS (311)
reactive depression (neurotic) (300.4)
psychotic (298.0)

296.4 Bipolar affective disorder, manic

Bipolar disorder, now manic
Manic-depressive psychosis, circular type but currently manic

EXCLUDES brief compensatory or rebound mood swings (296.99)

- 296.5 Bipolar affective disorder, depressed
Bipolar disorder, now depressed
Manic-depressive psychosis, circular type but currently depressed
EXCLUDES brief compensatory or rebound mood swings (296.99)

- 296.6 Bipolar affective disorder, mixed
Manic-depressive psychosis, circular type, mixed

- ◆ 296.7 Bipolar affective disorder, unspecified
Atypical bipolar affective disorder NOS
Manic-depressive psychosis, circular type, current condition not specified as either manic or depressive

- 296.8 Manic-depressive psychosis, other and unspecified
296.80 Manic-depressive psychosis, unspecified
Manic-depressive:
reaction NOS
syndrome NOS

- 296.81 Atypical manic disorder
- 296.82 Atypical depressive disorder
- 296.89 Other

Manic-depressive psychosis, mixed type

- 296.9 Other and unspecified affective psychoses
EXCLUDES psychogenic affective psychoses (298.0-298.9)

- ◆ 296.90 Unspecified affective psychosis
Affective psychosis NOS
Melancholia NOS

- ◆ 296.99 Other specified affective psychoses
Mood swings: Mood swings:
brief compensatory: rebound

297 Paranoid states

INCLUDES paranoid disorders

EXCLUDES acute paranoid reaction (298.3)
alcoholic jealousy or paranoid state (291.5)
paranoid schizophrenia (295.3)

297.0 Paranoid state, simple

297.1 Paranoia

Chronic paranoid psychosis
Sander's disease
Systematized delusions

EXCLUDES paranoid personality disorder (301.0)

297.2 Paraphrenia

Involitional paranoid state Paraphrenia (involitional)
Late paraphrenia

297.3 Shared paranoid disorder

Folie à deux
Induced psychosis or paranoid disorder

- ◆ 297.4 Other specified paranoid states
Paranoia querulans Sensitiver Beziehungswahn
EXCLUDES acute paranoid reaction or state (298.3)
senile paranoid state (290.20)

- ◆ 297.9 Unspecified paranoid state
Paranoid: Paranoid:
disorder NOS reaction NOS
psychosis NOS state NOS

Other nonorganic psychoses

INCLUDES psychotic conditions due to or provoked by:
emotional stress
environmental factors as major part of etiology

298.0 Depressive type psychosis

Psychogenic depressive psychosis
Psychotic reactive depression
Reactive depressive psychosis

EXCLUDES manic-depressive psychosis, depressed type (296.2-296.3)
neurotic depression (300.4)
reactive depression NOS (300.4)

298.1 Excitatory type psychosis

Acute hysterical psychosis Reactiv. excitation
Psychogenic excitation

EXCLUDES manic-depressive psychosis, manic type (296.0-296.1)

298.2 Reactive confusion

Psychogenic confusion Psychogenic twilight state
EXCLUDES acute confusional state (293.0)

298.3 Acute paranoid reaction

Acute psychogenic paranoid psychosis
Bouffée délirante

EXCLUDES paranoid states (297.0-297.9)

298.4 Psychogenic paranoid psychosis

Protracted reactive paranoid psychosis

298.8 Other and unspecified reactive psychosis

Brief reactive psychosis NOS
Hysterical psychosis
Psychogenic psychosis NOS
Psychogenic stupor

EXCLUDES acute hysterical psychosis (298.1)

298.9 Unspecified psychosis

Atypical psychosis
Psychosis NOS

● 299 Psychoses with origin specific to childhood

INCLUDES pervasive developmental disorders

EXCLUDES adult type psychoses occurring in childhood, as:
affective disorders (296.0-296.9)
manic-depressive disorders (296.0-296.9)
schizophrenia (295.0-295.9)

The following fifth-digit subclassification is for use with category 299:

0 current or active state

1 residual state

● 299.0 Infantile autism

Childhood autism Kanner's syndrome
Infantile psychosis

EXCLUDES disintegrative psychosis (299.1)
Heller's syndrome (299.1)
schizophrenic syndrome of childhood (299.9)

● 299.1 Disintegrative psychosis

Heller's syndrome
Use additional code to identify any associated neurological disorder

EXCLUDES infantile autism (299.0)
schizophrenic syndrome of childhood (299.9)

● 299.8 Other specified early childhood psychoses

Atypical childhood psychosis
Borderline psychosis of childhood
EXCLUDES simple stereotypes without psychotic disturbance (307.3)

● 299.9 Unspecified

Child psychosis NOS
Schizophrenia, childhood type NOS
Schizophrenic syndrome of childhood NOS
EXCLUDES schizophrenia of adult type occurring in childhood (295.0-295.9)

NEUROTIC DISORDERS, PERSONALITY DISORDERS, AND OTHER NONPSYCHOTIC MENTAL DISORDERS (300-316)

● 300 Neurotic disorders

● 300.0 Anxiety states

EXCLUDES anxiety in:
acute stress reaction (308.0)
transient adjustment reaction (309.24)
neurasthenia (300.5)
psychophysiological disorders (306.0-306.9)
separation anxiety (309.21)

300.00 Anxiety state, unspecified

Anxiety: Anxiety:
neurosis reaction state (neurotic)
Atypical anxiety disorder

300.01 Panic disorder

Panic: Panic:
attack state

300.02 Generalized anxiety disorder

300.09 Other

● 300.1 Hysteria

EXCLUDES adjustment reaction (309.0-309.9)
anorexia nervosa (307.1)
gross stress reaction (308.0-308.9)
hysterical personality (301.50-301.59)
psychophysiological disorders (306.0-306.9)

◆ 300.10 Hysteria, unspecified

- 300.11 Conversion disorder**
 Atasia-abasia, hysterical
 Conversion hysteria or reaction
 Hysterical
 blindness
 deafness
 paralysis
- 300.12 Psychogenic amnesia**
 Hysterical amnesia
- 300.13 Psychogenic fugue**
 Hysterical fugue
- 300.14 Multiple personality**
 Dissociative identity disorder
- ◆ **300.15 Dissociative disorder or reaction, unspecified**
- 300.16 Factitious illness with psychological symptoms**
 Compensation neurosis
 Ganser's syndrome, hysterical
- ◆ **300.19 Other and unspecified factitious illness**
 Factitious illness (with physical symptoms)
 NOS
EXCLUDES multiple operations or hospital
 addiction syndrome (301.51)
- **300.2 Phobic disorders**
EXCLUDES anxiety state not associated with a specific
 situation or object (300.00-300.09)
 obsessional phobias (300.3)
- ◆ **300.20 Phobia, unspecified**
 Anxiety-hysteria NOS
 Phobia NOS
- 300.21 Agoraphobia with panic attacks**
 Fear of:
 open spaces
 streets
 travel } with panic attacks
- 300.22 Agoraphobia without mention of panic attacks**
 Any condition classifiable to 300.21 without
 mention of panic attacks
- 300.23 Social phobia**
 Fear of: Fear of:
 eating in public washing in public
 public speaking
- ◆ **300.29 Other isolated or simple phobias**
 Acrophobia Claustrophobia
 Animal phobias Fear of crowds
- 300.3 Obsessive-compulsive disorders**
 Anancastic neurosis Obsessional phobia [any]
 Compulsive neurosis
EXCLUDES obsessive-compulsive symptoms occurring in:
 endogenous depression (296.2-296.3)
 organic states (eg., encephalitis)
 schizophrenia (295.0-295.9)
- 300.4 Neurotic depression**
 Anxiety depression Dysthymic disorder
 Depression with anxiety Neurotic depressive state
 Depressive reaction Reactive depression
EXCLUDES adjustment reaction with depressive
 symptoms (309.0-309.1)
 depression NOS (311)
 manic-depressive psychosis, depressed type
 (296.2-296.3)
 reactive depressive psychosis (298.0)
- 300.5 Neurasthenia**
 Fatigue neurosis
 Nervous debility
 Psychogenic:
 asthenia
 general fatigue
 Use additional code to identify any associated physical
 disorder
EXCLUDES anxiety state (300.00-300.09)
 neurotic depression (300.4)
 psychophysiological disorders (306.0-306.9)
 specific nonpsychotic mental disorders
 following organic brain damage (310.0-
 310.9)

- 300.6 Depersonalization syndrome**
 Depersonalization disorder
 Derealization (neurotic)
 Neurotic state with depersonalization episode
EXCLUDES depersonalization associated with
 anxiety (300.00-300.09)
 depression (300.4)
 manic-depressive disorder or psychosis
 (296.0-296.9)
 schizophrenia (295.0-295.9)
- 300.7 Hypochondriasis**
 Body dysmorphic disorder
EXCLUDES hypochondriasis in:
 hysteria (300.10-300.19)
 manic-depressive psychosis, depressed
 type (296.2-296.3)
 neurasthenia (300.5)
 obsessional disorder (300.3)
 schizophrenia (295.0-295.9)
- **300.8 Other neurotic disorders**
- 300.81 Somatization disorder**
 Briquet's disorder
 Severe somatoform disorder
- 300.82 Undifferentiated somatoform disorder**
 Atypical somatoform disorder
 Somatoform disorder NOS
- ◆ **300.89 Other**
 Occupational neurosis, including writer's
 cramp
 Psychasthenia
 Psychasthenic neurosis
- ◆ **300.9 Unspecified neurotic disorder**
 Neurosis NOS Psychoneurosis NOS
- **301 Personality disorders**
INCLUDES character neurosis
 Use additional code to identify any associated neurosis or
 psychosis, or physical condition
EXCLUDES nonpsychotic personality disorder associated with
 organic brain syndromes (310.0-310.9)
- 301.0 Paranoid personality disorder**
 Fanatic personality
 Paranoid personality (disorder)
 Paranoid traits
EXCLUDES acute paranoid reaction (298.3)
 alcoholic paranoia (291.5)
 paranoid schizophrenia (295.3)
 paranoid states (297.0-297.9)
- **301.1 Affective personality disorder**
EXCLUDES affective psychotic disorders (296.0-296.9)
 neurasthenia (300.5)
 neurotic depression (300.4)
- ◆ **301.10 Affective personality disorder, unspecified**
- 301.11 Chronic hypomanic personality disorder**
 Chronic hypomanic disorder
 Hypomanic personality
- 301.12 Chronic depressive personality disorder**
 Chronic depressive disorder
 Depressive character or personality
- 301.13 Cyclothymic disorder**
 Cycloid personality Cyclothymic
 Cyclothymia personality
- **301.2 Schizoid personality disorder**
EXCLUDES schizophrenia (295.0-295.9)
- ◆ **301.20 Schizoid personality disorder, unspecified**
- 301.21 Introverted personality**
- 301.22 Schizotypal personality**
- 301.3 Explosive personality disorder**
 Aggressive: Emotional instability
 personality (excessive)
 reaction Pathological emotionality
 Aggressiveness Quarrelsomeness
EXCLUDES dyssocial personality (301.7)
 hysterical neurosis (300.10-300.19)

301.4 Compulsive personality disorder

Anancastic personality

Obsessional personality

EXCLUDES obsessive-compulsive disorder (300.3)
phobic state (300.20-300.29)**301.5 Histrionic personality disorder****EXCLUDES** hysterical neurosis (300.10-300.19)**301.50 Histrionic personality disorder, unspecified**
Hysterical personality NOS**301.51 Chronic factitious illness with physical symptoms**

Hospital addiction syndrome

Multiple operations syndrome

Munchausen syndrome

301.59 Other histrionic personality disorderPersonality: Personality:
emotionally unstable psychoinfantile
labile**301.6 Dependent personality disorder**

Asthenic personality Passive personality

Inadequate personality

EXCLUDES neurasthenia (300.5)
passive-aggressive personality (301.84)**301.7 Antisocial personality disorder**

Amoral personality

Asocial personality

Dyssocial personality

Personality disorder with predominantly sociopathic or
asocial manifestation**EXCLUDES** disturbance of conduct without specifiable
personality disorder (312.0-312.9)
explosive personality (301.3)**301.8 Other personality disorders****301.81 Narcissistic personality****301.82 Avoidant personality****301.83 Borderline personality****301.84 Passive-aggressive personality****301.89 Other**Personality: Personality:
eccentric masochistic
"histrionic" type psychoneurotic
immature**EXCLUDES** psychoinfantile personality
(301.59)**301.9 Unspecified personality disorder**

Pathological personality NOS

Personality disorder NOS

Psychopathic:

constitutional state

personality (disorder)

302 Sexual deviations and disorders**EXCLUDES** sexual disorder manifest in:
organic brain syndrome (290.0-294.9, 310.0-310.9)
psychosis (295.0-298.9)**302.0 Ego-dystonic homosexuality**

Ego-dystonic lesbianism

Homosexual conflict disorder

EXCLUDES homosexual pedophilia (302.2)**302.1 Zoophilia**

Bestiality

302.2 Pedophilia**302.3 Transvestism****EXCLUDES** trans-sexualism (302.5)**302.4 Exhibitionism****302.5 Trans-sexualism****EXCLUDES** transvestism (302.3)**302.50 With unspecified sexual history****302.51 With asexual history****302.52 With homosexual history****302.53 With heterosexual history****302.6 Disorders of psychosexual identity**

Feminism in boys

Gender identity disorder of childhood

EXCLUDES gender identity disorder in adult (302.85)
homosexuality (302.0)
trans-sexualism (302.50-302.53)
transvestism (302.3)**302.7 Psychosexual dysfunction****EXCLUDES** impotence of organic origin (607.84)
normal transient symptoms from ruptured
hymen
transient or occasional failures of erection
due to fatigue, anxiety, alcohol, or
drugs**302.70 Psychosexual dysfunction, unspecified****302.71 With inhibited sexual desire****302.72 With inhibited sexual excitement**

Frigidity Impotence

302.73 With inhibited female orgasm**302.74 With inhibited male orgasm****302.75 With premature ejaculation****302.76 With functional dyspareunia**

Dyspareunia, psychogenic

**302.79 With other specified psychosexual
dysfunctions****302.8 Other specified psychosexual disorders****302.81 Fetishism****302.82 Voyeurism****302.83 Sexual masochism****302.84 Sexual sadism****302.85 Gender identity disorder of adolescent or adult
life****302.89 Other**

Nymphomania Satyriasis

302.9 Unspecified psychosexual disorder

Pathologic sexuality NOS Sexual deviation NOS

303 Alcohol dependence syndrome

Use additional code to identify any associated condition, as:

alcoholic psychoses (291.0-291.9)

drug dependence (304.0-304.9)

physical complications of alcohol, such as:

cerebral degeneration (331.7)

cirrhosis of liver (571.2)

epilepsy (345.0-345.9)

gastritis (535.3)

hepatitis (571.1)

liver damage NOS (571.3)

EXCLUDES drunkenness NOS (305.0)

The following fifth-digit subclassification is for use with category 303:

0 unspecified**1 continuous****2 episodic****3 in remission****303.0 Acute alcoholic intoxication**

Acute drunkenness in alcoholism

303.9 Other and unspecified alcohol dependence

Chronic alcoholism

Dipsomania

304 Drug dependence**EXCLUDES** nondependent abuse of drugs (305.1-305.9)

The following fifth-digit subclassification is for use with category 304:

0 unspecified**1 continuous****2 episodic****3 in remission****304.0 Opioid type dependence**

Heroin

Meperidine

Methadone

Morphine

Opium

Opium alkaloids and their
derivatives
Synthetics with morphine-like
effects**304.1 Barbiturate and similarly acting sedative or hypnotic
dependence**

Barbiturates

Nonbarbiturate sedatives and tranquilizers with a similar
effect:

chlordiazepoxide

diazepam

glutethimide

meprobamate
methaqualone

307.1 Anorexia nervosa

EXCLUDES eating disturbance NOS (307.50)
feeding problem (783.3)
of nonorganic origin (307.59)
loss of appetite (783.0)
of nonorganic origin (307.59)

307.2 Tics

EXCLUDES nail-biting or thumb-sucking (307.9)
stereotypes occurring in isolation (307.3)
tics of organic origin (333.3)

- 307.20 Tic disorder, unspecified
- 307.21 Transient tic disorder of childhood
- 307.22 Chronic motor tic disorder
- 307.23 Gilles de la Tourette's disorder
Motor-verbal tic disorder

307.3 Stereotyped repetitive movements

Body-rocking Spasmus nutans
Head banging Stereotypes NOS
EXCLUDES tics (307.20-307.23)

of organic origin (333.3)

307.4 Specific disorders of sleep of nonorganic origin

EXCLUDES narcolepsy (347)
those of unspecified cause (780.50-780.59)

- 307.40 Nonorganic sleep disorder, unspecified
- 307.41 Transient disorder of initiating or maintaining sleep

Hyposomnia	associated with intermittent emotional reactions or conflicts
Insomnia	
Sleeplessness	

- 307.42 Persistent disorder of initiating or maintaining sleep

Hyposomnia, insomnia, or sleeplessness associated with:
anxiety
conditioned arousal
depression (major) (minor)
psychosis

- 307.43 Transient disorder of initiating or maintaining wakefulness

Hypersomnia associated with acute or intermittent emotional reactions or conflicts

- 307.44 Persistent disorder of initiating or maintaining wakefulness

Hypersomnia associated with depression (major) (minor)

- 307.45 Phase-shift disruption of 24-hour sleep-wake cycle

Irregular sleep-wake rhythm, nonorganic origin
Jet lag syndrome
Rapid time-zone change
Shifting sleep-work schedule

- 307.46 Somnambulism or night terrors

- 307.47 Other dysfunctions of sleep stages or arousal from sleep

Nightmares:	Sleep drunkenness
NOS	
REM-sleep type	

- 307.48 Repetitive intrusions of sleep
Repetitive intrusion of sleep with:
atypical polysomnographic features
environmental disturbances
repeated REM-sleep interruptions

- 307.49 Other

"Short-sleeper"
Subjective insomnia complaint

307.5 Other and unspecified disorders of eating

EXCLUDES anorexia:
nervosa (307.1)
of unspecified cause (783.0)
overeating, of unspecified cause (783.6)
vomiting:
NOS (787.0)
cyclical (536.2)
psychogenic (306.4)

- 307.50 Eating disorder, unspecified

307.51 Bulimia

Overeating of nonorganic origin

307.52 Pica

Perverted appetite of nonorganic origin

307.53 Psychogenic rumination

Regurgitation, of nonorganic origin, of food with reswallowing

EXCLUDES obsessional rumination (300.3)

307.54 Psychogenic vomiting

307.59 Other

Infantile feeding disturbances	of nonorganic origin
Loss of appetite	

307.6 Enuresis

Enuresis (primary) (secondary) of nonorganic origin

EXCLUDES enuresis of unspecified cause (788.3)

307.7 Encopresis

Encopresis (continuous) (discontinuous) of nonorganic origin

EXCLUDES encopresis of unspecified cause (787.6)

307.8 Psychalgia

- 307.80 Psychogenic pain, site unspecified
- 307.81 Tension headache

EXCLUDES headache:
NOS (784.0)
migraine (346.0-346.9)

- 307.89 Other

Psychogenic backache

EXCLUDES pains not specifically attributable to a psychological cause (in):

back (724.5)
joint (719.4)
limb (729.5)
lumbago (724.2)
rheumatic (729.0)

- 307.9 Other and unspecified special symptoms or syndromes, not elsewhere classified

Hair plucking	Masturbation
Lalling	Nail-biting
Lisping	Thumb-sucking

308 Acute reaction to stress

INCLUDES catastrophic stress
combat fatigue
gross stress reaction (acute)
transient disorders in response to exceptional physical or mental stress which usually subside within hours or days

EXCLUDES adjustment reaction or disorder (309.0-309.9)
chronic stress reaction (309.1-309.9)

308.0 Predominant disturbance of emotions

Anxiety	as acute reaction to exceptional [gross] stress
Emotional crisis	
Panic state	

308.1 Predominant disturbance of consciousness

Fugues as acute reaction to exceptional [gross] stress

308.2 Predominant psychomotor disturbance

Agitation states	as acute reaction to exceptional [gross] stress
Stupor	

- 308.3 Other acute reactions to stress

Acute situational disturbance
Brief or acute posttraumatic stress disorder
EXCLUDES prolonged posttraumatic emotional disturbance (309.81)

308.4 Mixed disorders as reaction to stress

- 308.9 Unspecified acute reaction to stress

309 Adjustment reaction

INCLUDES adjustment disorders
reaction (adjustment) to chronic stress

EXCLUDES acute reaction to major stress (308.0-308.9)
neurotic disorders (300.0-300.9)

- 309.0 Brief depressive reaction**
Adjustment disorder with depressed mood
Grief reaction
EXCLUDES affective psychoses (296.0-296.9)
neurotic depression (300.4)
prolonged depressive reaction (309.1)
psychogenic depressive psychosis (298.0)
- 309.1 Prolonged depressive reaction**
EXCLUDES affective psychoses (296.0-296.9)
brief depressive reaction (309.0)
neurotic depression (300.4)
psychogenic depressive psychosis (298.0)
- **309.2 With predominant disturbance of other emotions**
309.21 Separation anxiety disorder
309.22 Emancipation disorder of adolescence and early adult life
309.23 Specific academic or work inhibition
309.24 Adjustment reaction with anxious mood
309.28 Adjustment reaction with mixed emotional features
Adjustment reaction with anxiety and depression
- ◄ **309.29 Other**
Culture shock
- 309.3 With predominant disturbance of conduct**
Conduct disturbance | as adjustment reaction
Destructiveness
EXCLUDES destructiveness in child (312.9)
disturbance of conduct NOS (312.9)
dysocial behavior without manifest psychiatric disorder (V71.01-V71.02)
personality disorder with predominantly sociopathic or asocial manifestations (301.7)
- 309.4 With mixed disturbance of emotions and conduct**
- **309.8 Other specified adjustment reactions**
309.81 Prolonged posttraumatic stress disorder
Chronic posttraumatic stress disorder
Concentration camp syndrome
EXCLUDES posttraumatic brain syndrome: nonpsychotic (310.2)
psychotic (293.0-293.9)
- 309.82 Adjustment reaction with physical symptoms**
309.83 Adjustment reaction with withdrawal
Elective mutism as adjustment reaction
Hospitalism (in children) NOS
- ◄ **309.89 Other**
- ◄ **309.9 Unspecified adjustment reaction**
Adaptation reaction NOS
Adjustment reaction NOS
- **310 Specific nonpsychotic mental disorders due to organic brain damage**
EXCLUDES neuroses, personality disorders, or other nonpsychotic conditions occurring in a form similar to that seen with functional disorders but in association with a physical condition (300.0-300.9, 301.0-301.9)
- 310.0 Frontal lobe syndrome**
Lobotomy syndrome
Postleucotomy syndrome [state]
EXCLUDES postcontusion syndrome (310.2)
- 310.1 Organic personality syndrome**
Cognitive or personality change of other type, of nonpsychotic severity
Mild memory disturbance
Organic psychosyndrome of nonpsychotic severity
Presbyophrenia NOS
Senility with mental changes of nonpsychotic severity
- 310.2 Postconcussion syndrome**
Postcontusion syndrome or encephalopathy
Posttraumatic brain syndrome, nonpsychotic
Status postcommotio cerebri
EXCLUDES frontal lobe syndrome (310.0)
postencephalitic syndrome (310.8)
any organic psychotic conditions following head injury (293.0-294.0)
- ◄ **310.8 Other specified nonpsychotic mental disorders due to organic brain damage**
Postencephalitic syndrome
Other focal (partial) organic psychosyndrome
- ◄ **310.9 Unspecified nonpsychotic mental disorder due to organic brain damage**
- 311 Depressive disorder, not elsewhere classified**
Depressive disorder NOS
Depressive state NOS
EXCLUDES acute reaction to major stress with depressive symptoms (308.0)
affective personality disorder (301.10-301.19)
affective psychoses (296.0-296.9)
brief depressive reaction (309.0)
depressive states associated with stressful events (309.0-309.1)
disturbance of emotions specific to childhood and adolescence, with misery and unhappiness (313.1)
mixed adjustment reaction with depressive symptoms (309.4)
neurotic depression (300.4)
prolonged depressive adjustment reaction (309.1)
psychogenic depressive psychosis (298.0)
- **312 Disturbance of conduct, not elsewhere classified**
EXCLUDES adjustment reaction with disturbance of conduct (309.3)
drug dependence (304.0-304.9)
dysocial behavior without manifest psychiatric disorder (V71.01-V71.02)
personality disorder with predominantly sociopathic or asocial manifestations (301.7)
sexual deviations (302.0-302.9)
- The following fifth-digit subclassification is for use with category 312.0-312.2:
- ◄ 0 unspecified
1 mild
2 moderate
3 severe
- **312.0 Undersocialized conduct disorder, aggressive type**
Aggressive outburst
Anger reaction
Unsocialized aggressive disorder
- **312.1 Undersocialized conduct disorder, unaggressive type**
Childhood truancy, unsocialized
Solitary stealing
Tantrums
- **312.2 Socialized conduct disorder**
Childhood truancy, socialized
Group delinquency
EXCLUDES gang activity without manifest psychiatric disorder (V71.01)
- **312.3 Disorders of impulse control, not elsewhere classified**
◄ **312.30 Impulse control disorder, unspecified**
312.31 Pathological gambling
312.32 Kleptomania
312.33 Pyromania
312.34 Intermittent explosive disorder
312.35 Isolated explosive disorder
◄ **312.39 Other**
- 312.4 Mixed disturbance of conduct and emotions**
Neurotic delinquency
EXCLUDES compulsive conduct disorder (312.3)
- **312.8 Other specified disturbances of conduct, not elsewhere classified**
312.81 Conduct disorder, childhood onset type
312.82 Conduct disorder, adolescent onset type
◄ **312.89 Other conduct disorder**
- ◄ **312.9 Unspecified disturbance of conduct**
Delinquency (juvenile)
- **313 Disturbance of emotions specific to childhood and adolescence**
EXCLUDES adjustment reaction (309.0-309.9)
emotional disorder of neurotic type (300.0-300.9)
masturbation, nail-biting, thumb-sucking, and other isolated symptoms (307.0-307.9)

- 313.0 Overanxious disorder**
Anxiety and fearfulness of childhood and adolescence
EXCLUDES abnormal separation anxiety (309.21)
anxiety states (300.00-300.09)
hospitalism in children (309.83)
phobic state (300.20-300.29)
- 313.1 Misery and unhappiness disorder**
EXCLUDES depressive neurosis (300.4)
- 313.2 Sensitivity, shyness, and social withdrawal disorder**
EXCLUDES infantile autism (299.0)
schizoid personality (301.20-301.22)
schizophrenia (295.0-295.9)
- 313.21 Shyness disorder of childhood**
Sensitivity reaction of childhood or adolescence
- 313.22 Introverted disorder of childhood**
Social withdrawal
Withdrawal reaction of childhood or adolescence
- 313.23 Elective mutism**
EXCLUDES elective mutism as adjustment reaction (309.83)
- 313.3 Relationship problems**
Sibling jealousy
EXCLUDES relationship problems associated with aggression, destruction, or other forms of conduct disturbance (312.0-312.9)
- 313.8 Other or mixed emotional disturbances of childhood or adolescence**
313.81 Oppositional disorder
313.82 Identity disorder
313.83 Academic underachievement disorder
313.89 Other
- 313.9 Unspecified emotional disturbance of childhood or adolescence**
- 314 Hyperkinetic syndrome of childhood**
EXCLUDES hyperkinesia as symptom of underlying disorder—code the underlying disorder
- 314.0 Attention deficit disorder**
314.00 Without mention of hyperactivity
Predominantly inattentive type
314.01 With hyperactivity
Combined type
Overactivity NOS
Predominantly hyperactive/impulsive type
Simple disturbance of attention with overactivity
- 314.1 Hyperkinesia with developmental delay**
Developmental disorder of hyperkinesia
Use additional code to identify any associated neurological disorder
- 314.2 Hyperkinetic conduct disorder**
Hyperkinetic conduct disorder without developmental delay
EXCLUDES hyperkinesia with significant delays in specific skills (314.1)
- 314.8 Other specified manifestations of hyperkinetic syndrome**
- 314.9 Unspecified hyperkinetic syndrome**
Hyperkinetic reaction of childhood or adolescence NOS
Hyperkinetic syndrome NOS
- 315 Specific delays in development**
EXCLUDES that due to a neurological disorder (320.0-369.9)
- 315.0 Specific reading disorder**
315.00 Reading disorder, unspecified
315.01 Alexia
315.02 Developmental dyslexia
315.09 Other
Specific spelling difficulty
- 315.1 Specific arithmetical disorder**
Dyscalculia
- 315.2 Other specific learning difficulties**
EXCLUDES specific arithmetical disorder (315.1)
specific reading disorder (315.00-315.09)
- 315.3 Developmental speech or language disorder**

- 315.31 Developmental language disorder**
Developmental aphasia
Expressive language disorder
Word deafness
EXCLUDES acquired aphasia (784.3)
elective mutism (309.83, 313.0, 313.23)
- 315.32 Receptive language disorder (mixed)**
Receptive expressive language disorder
- 315.39 Other**
Developmental articulation disorder
Dyslalia
EXCLUDES lisping and lalling (307.9)
stammering and stuttering (307.0)
- 315.4 Coordination disorder**
Clumsiness syndrome Specific motor development disorder
Dyspraxia syndrome
- 315.5 Mixed development disorder**
- 315.8 Other specified delays in development**
- 315.9 Unspecified delay in development**
Developmental disorder NOS
- 316 Psychic factors associated with diseases classified elsewhere**
Psychologic factors in physical conditions classified elsewhere
Use additional code to identify the associated physical condition, as:
psychogenic:
asthma (493.9)
dermatitis (692.9)
duodenal ulcer (532.0-532.9)
eczema (691.8, 692.9)
gastric ulcer (531.0-531.9)
mucous colitis (564.1)
paroxysmal tachycardia (427.2)
ulcerative colitis (556)
urticaria (708.0-708.9)
psychosocial dwarfism (259.4)
EXCLUDES physical symptoms and physiological malfunctions, not involving tissue damage, of mental origin (306.0-306.9)

MENTAL RETARDATION (317-319)

Use additional code(s) to identify any associated psychiatric or physical condition(s)

- 317 Mild mental retardation**
High-grade defect
IQ 50-70
Mild mental subnormality
- 318 Other specified mental retardation**
318.0 Moderate mental retardation
IQ 35-49
Moderate mental subnormality
- 318.1 Severe mental retardation**
IQ 20-34 Severe mental subnormality
- 318.2 Profound mental retardation**
IQ under 20
Profound mental subnormality
- 319 Unspecified mental retardation**
Mental deficiency NOS Mental subnormality NOS

6. DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS (320-389)

INFLAMMATORY DISEASES OF THE CENTRAL NERVOUS SYSTEM (320-328)

- 320 Bacterial meningitis**
INCLUDED arachnoiditis
leptomeningitis
meningitis
meningoencephalitis
meningomyelitis
pachymeningitis } bacterial
- 320.0 Hemophilus meningitis**
Meningitis due to Hemophilus influenzae (H. influenzae)
- 320.1 Pneumococcal meningitis**

Advance Data

nchs

From Vital and Health Statistics of the CENTERS FOR DISEASE CONTROL/National Center for Health Statistics

Serious Mental Illness and Disability in the Adult Household Population: United States, 1989

by Peggy R. Burke, M.P.H., Division of Health Interview Statistics, Ronald W. Manderscheid, Ph.D., National Institute of Mental Health, Gerry E. Hendershot, Ph.D., Susan S. Jack, M.S., Charlotte A. Schoenborn, M.P.H., Division of Health Interview Statistics, and Ingrid Goldstrom, M.Sc., National Institute of Mental Health

Introduction

Significance of the problem

Estimates of the prevalence of serious mental illness (SMI) and information on persons with SMI in the United States are critical to the development of policy for this population in a broad range of areas, such as planning and development of necessary mental health, health, and social services, including housing; development of disability policy (for example, Supplemental Security Income and/or Social Security Disability Insurance eligibility); and training, recruitment, and placement of psychiatric and other mental health staff. However, such data have not been readily available because of the difficulty of defining the population, the lack of relevant operational measures, and the lack of appropriate survey mechanisms outside of treatment settings. This report is designed to address this deficit for the civilian noninstitutionalized population of the United States.

Deinstitutionalization of mentally ill persons and demographic trends in the United States, that is, the aging

into adulthood of "baby boomers" and the overall graying of America, have resulted in an increase in the absolute number of SMI persons generally and in those living in the community. Currently, the National Institute of Mental Health (NIMH) estimates that there are between 4 and 5 million SMI persons in the adult population of the United States, including both institutional and community residential settings (1). Thus, some sense of urgency exists to improve knowledge about this large, disabled population.

Definition of the population

Historically, the definition of SMI was based principally upon psychiatric diagnosis. Over the years this definition has evolved to a more refined notion, including psychiatric disabilities. It has become increasingly recognized that the SMI population is a heterogeneous group with different diagnoses, levels of disability, and duration of disability, and therefore, different service needs (2). At present, a more precise definition is being developed by NIMH to encompass this diversity.

Because of the complexity of the interface among psychiatric diagnosis, type and level of disability, and duration of the disability, SMI has been defined for the present survey as any psychiatric disorder present during the past year that seriously interfered with one or more aspects of a person's daily life. In this context, specific measures of disability and their duration represent variable characteristics of persons in the population rather than defining criteria. This approach represents a more flexible application of the diagnosis, disability, and duration criteria employed in the past (3-5).

Previous estimates

The most recent survey prior to the present, the 1978 Social Security Administration Survey of Disability and Work, estimated that 1.1 million persons in households were "seriously disabled mentally ill" (6). The definition of the population was based on persons 20-64 years of age who were limited in the kind or amount of work or housework they could do and who had been disabled or were expected to be so for a



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period of at least 12 months, mainly use of mental illness or nervous or emotional problems.

The estimate of 1.1 million persons was known to be an undercount of the population in the community because data were not collected on functional limitations beyond the work domain, or on limitations of a shorter duration than 1 year, that is, people with recent or episodic disabilities. Elderly persons, the fastest growing segment of the population in the United States were not included and no data were collected on the use of mental health services or participation in programs by persons with psychiatric disabilities.

Present survey

In 1989, NIMH collaborated with the National Center for Health Statistics (NCHS) on a special supplement to the National Health Interview Survey (NHIS). The purpose was to update previous estimates using a more flexible operational definition of the number of SMI persons in the household population of the United States, and to examine the use of mental health services and disability program participation of this population.

Highlights

Based on respondent-reported information collected in the NHIS, in 1989 there were approximately 3.3 million adults 18 years of age or older in the civilian noninstitutionalized population of the United States who had a serious mental illness in the past 12 months, a rate of 18.2 adults per 1,000 persons. Approximately 2.6 million, or 78.8 percent of these adults, have one or more specific limitations in work, school, personal care, social functioning, concentrating, or coping with day-to-day stress attributed to SMI.

Approximately 1.4 million adults between the ages of 18 and 69 were currently unable to work (529,000) or limited in work (529,000) because of their SMI, and over 82 percent of these adults have had this work limitation for a year or longer.

Among the 390,000 adults 70 years of age and over with SMI, about 85 percent had current limitations in one or more of the specific activities described above because of SMI, and approximately 80 percent of these adults had been limited by SMI for a year or longer.

About 703,000 adults with SMI in the household population receive a disability payment through a Government program because of their mental disorder. By race, 76 percent of these adults are white persons and 22 percent are black persons. Almost 43 percent of black adults with SMI receive a Government disability payment compared with about 21 percent of white adults with SMI.

Data and methods

Design

The NHIS is a continuous cross-sectional nationwide survey of the resident household population of the United States. Every year since 1957, basic demographic and health information has been collected from a nationally representative sample of households in face-to-face interviews conducted by staff of the U.S. Bureau of the Census. Certain types of noninstitutional group quarters, such as small group homes and halfway houses, are included and residents interviewed when these places fall into the sampling frame. The term "household" is used to denote all residential places in the NHIS sample. Information is collected on each member of the family (or families) residing in the household, by proxy if the person is not at home at the time of the interview or is not competent to self-respond. For the NHIS-Mental Health, the same respondent or respondents present for the basic interview were asked questions on mental health about all family members.

Respondents

In 1989, information was collected on about 113,000 persons for the NHIS-Mental Health. This

represented a response rate of 97 percent of respondents for which information was collected on the basic questionnaire and about 92 percent of the total NHIS sample. Nonresponse for the basic NHIS was about 5 percent.

In the entire 1989 NHIS sample, over 58 percent of all adults responded for themselves, and about 68 percent of adults reported to have SMI responded for themselves. As might be expected, self-response was lower among those persons most seriously disabled by SMI. Of those reported to be unable to carry out one or more activities for a year or longer, 52 percent responded for themselves compared with 77 percent of those for whom no specific current limitations were reported.

Validity of the data

Clearly, the quality of these data is dependent on the person with SMI or a family member's awareness of and willingness to report both the condition and the resulting disability. Because there is still some stigma attached to mental illness and because this survey was not designed to "diagnose" mental disorders, these data are likely to underestimate the true prevalence. In this survey, both diagnosed and undiagnosed conditions were reported; but among those persons with a current limitation due to the mental disorder, about 95 percent reported that a health professional had diagnosed the disorder. Among all persons reported to have SMI, over 92 percent reported that the disorder had been diagnosed.

Methods

The three main concepts in the NIMH definition of "serious mental illness," diagnosis, disability, and duration of disability (3-5) were operationalized in the survey in the manner described below.

Information about a mental or emotional disorder diagnosis was determined using a checklist of specific severe mental disorders and

Section 100 MENTAL HEALTH		PERSON 1		PT 100 A-1 B-1 C-1
Give: person number(s) of respondent(s).				Person number(s) of respondent(s)
These questions are about mental and emotional disorders.				
1a. DURING THE PAST 12 MONTHS, did anyone in the family have --				
a "Yes," and 1b and c.				
b. Who is this?				
Mark box in appropriate person's column.				
c. DURING THE PAST 12 MONTHS, did anyone else have --				
A. Subsyndromal (self-reflective "mood")		☐ Yes	☐ No	A. ☐ Subsyndromal ☐ 1
B. Periodic or subclinical disorder, other than subsyndromal		☐ Yes	☐ No	B. ☐ Periodic disorder ☐ 10
C. Chronic episodes or milder depression, also without bipolar disorder		☐ Yes (Specify) ☐ No		C. ☐ Chronic episodes ☐ 11 ☐ Milder depression ☐ 12
D. Major depression		☐ Yes	☐ No	D. ☐ Major depression ☐ 13
Mark if necessary: A depressed mood and loss of interest in almost all activities FOR AT LEAST TWO WEEKS.				
E. Anti-social personality, chronic-complex personality, or any other SEVERE personality disorder		☐ Yes	☐ No	E. ☐ Personality disorder ☐ 14
F. Alcoholism's like "K" (severe) disorder or another type of mental disorder		☐ Yes	☐ No	F. ☐ Severe ☐ 15
G. Alcohol abuse disorder		☐ Yes	☐ No	G. ☐ Alcohol abuse ☐ 16
H. Drug abuse disorder		☐ Yes	☐ No	H. ☐ Drug abuse ☐ 17
I. Does anyone in the family FROM home sexual satisfaction?		☐ Yes	☐ No	I. ☐ Sexual satisfaction ☐ 18
2a. DURING THE PAST 12 MONTHS, did anyone in the family have any OTHER (mental or emotional disorder) besides ANY of these disorders which frequently functions with a person's ability to work or attend school or to manage their day-to-day activities.				
b. Who is this? Anyone else? Mark box in appropriate person's column.		☐ Yes	☐ No (Check item 1)	
c. Are the each person with "Other" in 2a:				
d. What would you call this disorder -- "Yes"?				
CHECK ITEM 1	Refer to 1a-f and 2a.	CR 1	☐ One or more apply in 1a-f or 2a. Check item 20	☐ 19
CHECK ITEM 2	Same standard(s) from 1a-f and 2a. DO NOT RECORD G, H, OR I.	CR 2	☐ All others, 19 or Section IV	☐ 20-22

Figure 1. Mental disorder checklist

Additional question about the presence of "any other mental or emotional disorder" that seriously interfered with a person's ability to work or attend school or to manage their day-to-day activities. The reference period for these questions was during the past 12 months. The mental disorder checklist appears in figure 1.

Questions were subsequently asked about if and when the reported disorder was diagnosed by a health professional, if and when a mental health or other health professional was last seen for the disorder, the type of mental health professional last seen, and the use of prescription medication for the disorder.

Alcohol abuse disorder, drug abuse disorder, and mental retardation were asked on the checklist but no followup questions were asked about these conditions. Persons reporting only one or more of these disorders are excluded from the data in this report because they are not included in the NIMH definition of "serious mental illness." These conditions were asked on the checklist in order to avoid having them reported as "other" mental or emotional disorders, which would have required coding before deleting them from this analysis.

Among those with SMI, disability was measured through a series of questions about current limitations in activities and functions and a series of questions about the receipt of Government disability payments. The limitation questions asked whether the person was entirely prevented from working or limited in work, and, for persons 18-24 years old and not in the labor force, in attending school or college; whether they appropriately and adequately took care of personal care needs (eating, dressing, bathing, and going to the toilet) and specific instrumental activities of daily living (managing money, doing everyday household chores, shopping, and getting around outside the home); and the degree of difficulty with certain aspects of social and cognitive functioning. The time reference for the disability questions was "now,"

that is, the present time. Each of these questions was phrased to refer only to limitations due to the reported mental disorder. Obviously, to the extent that persons have multiple health problems and cannot parcel out disability resulting from each, this was a difficult question to answer. Similar questions have been used previously by NIMH as part of surveys of SMI in treatment settings (7) as well as in household surveys (8).

The duration of disability concept was measured simply by asking how long any identified limitation due to the mental disorder had been present.

The "Technical notes" section that appears at the end of this report contains more information on the survey design, sampling procedure, and NHIS questionnaire documents. Methods for constructing approximate standard errors and tests of significance for estimates and percents presented in this report also appear in these notes. Unless otherwise noted, the comparisons made within the text are significant at the .05 level.

This report presents estimates of the 12-month prevalence, demographic and socioeconomic characteristics, current disability, service utilization, and disability program participation of the adult SMI household population of the United States. A facsimile of the mental health questions is provided in "Current Estimates From the National Health Interview Survey, 1989" (9).

Results

Prevalence and demographic characteristics

The 1989 12-month prevalence estimate of SMI in the U.S. adult household population is 18.2 per 1,000 persons. About 79 percent of these persons had one or more current limitations attributed to their mental disorder but these estimates varied greatly between subgroups of

the population (table 1). The rate of SMI was generally higher in the oldest age group than in any other. More females than males were reported to have SMI (20.6 compared with 15.5 per 1,000 persons).

Neither the prevalence of SMI nor the proportion of persons with resulting current disability is significantly different for black and white persons. The prevalence rate among "other" races is about one-half that of black or white persons.

Both the prevalence of SMI and resulting disability are clearly related to poverty status. SMI was over 2 1/2 times as likely among adults in poverty than among those not in poverty, and proportionally more poor than nonpoor adults with SMI had resulting disability.

Lower educational attainment is strongly related to prevalence and disability from SMI. Among adults with less than 12 years of education, the rate of SMI is almost twice that among those with more than 12 years; and the percent with disability among the least educated group is 86.5 percent compared with 70.7 percent of the highest educated group.

Respondent-assessed health status

Data on assessed health status are acquired in the basic NHIS by asking respondents to assess their own health and that of family members living in the same household as excellent, very good, good, fair, or poor. Respondent-assessed health status has been shown to be highly correlated with more objective measures of health status and to predict mortality (10, 11).

Table 1 shows a strong negative correlation between reported health status and prevalence rate of SMI, and the same pattern holds for the proportions of persons reporting current limitations. Among adults with "poor" health status, the rate of SMI was 118.3 per 1,000 persons, or more than six times the rate for the total adult population; and almost

Table 1. Number and percent distribution of the adult household population, adults with serious mental illness and rate per thousand, adults currently limited by serious mental illness and percent limited, by selected characteristics: United States, 1989

Characteristic	Adult household population		All adults with serious mental illness			Adults currently limited by serious mental illness		
	Number in thousands	Percent distribution	Number in thousands	Percent distribution	Rate per thousand	Number in thousands	Percent distribution	Percent
Total ¹	179,521	100.0	3,284	100.0	18.2	2,571	100.0	78.9
Age²								
18-24 years	28,401	14.2	381	11.1	14.2	281	11.3	80.8
25-34 years	42,814	23.8	707	21.7	16.5	601	19.5	70.8
35-44 years	36,962	20.6	744	22.6	20.7	600	23.3	80.8
45-54 years	46,114	25.7	919	28.2	19.9	748	29.1	81.5
55-64 years	9,903	5.5	142	4.4	14.3	99	3.9	70.0
65-74 years	7,823	4.4	102	3.1	12.9	82	3.2	79.8
75 years and over	11,591	6.5	288	8.8	25.3	249	9.7	88.6
Sex²								
Male	85,257	47.5	1,390	40.4	16.5	1,106	43.0	83.7
Female	94,272	52.5	1,844	59.6	20.5	1,468	57.0	76.4
Race²								
White	153,763	85.6	2,812	86.1	18.3	2,194	85.3	78.0
Black	19,932	11.1	293	12.0	10.7	326	12.7	82.8
Other	5,834	3.2	89	1.8	10.1	62	2.0	67.1
Poverty status²								
Below poverty threshold	15,484	8.6	608	21.0	39.4	528	22.1	86.3
At or above poverty threshold	147,070	90.8	2,284	79.0	15.5	1,760	78.9	76.7
Education²								
Less than 12 years	39,808	22.4	1,083	33.0	27.2	937	37.3	88.6
12 years	68,563	38.0	1,130	34.9	16.3	888	34.5	77.4
More than 12 years	69,369	39.0	1,002	31.3	14.4	708	29.2	70.7
Respondent-assessed health status²								
Excellent	62,277	34.8	337	10.3	5.4	192	7.5	66.9
Very Good	60,841	28.5	620	19.1	12.2	414	16.1	66.7
Good	43,789	24.6	812	24.9	18.6	617	24.1	75.9
Fair	15,585	8.7	755	23.2	48.6	648	25.3	85.9
Poor	8,207	4.6	734	22.6	118.3	696	27.1	94.7

¹Includes persons with unknown poverty status, education, and/or self-assessed health status.
²Percent denominators exclude persons with this characteristic unknown.

95 percent of those adults have a current limitation resulting from the SMI.

Work and other limitations

An estimated 47.2 percent of persons 18-69 years of age with SMI, or 1.4 million persons, were reported to be unable to work (28.9 percent) or limited in work (18.4 percent) because of their mental disorder (table 2). By race, more black persons with SMI (43.4 percent) were unable to work because of their mental disorder than white persons with SMI (26.8 percent).

Among SMI persons who are able to work, 94.1 percent reported additional limitations, and

among those limited in work, 91.3 percent reported additional limitations (table 3). Not surprisingly, persons with SMI who are unable to work or limited in work are more likely to have one or more of the other specific limitations shown in table 3 than their peers who do not report work limitations. However, more than one-half (58 percent) of persons 18-69 years of age with SMI who reported no current work limitation, and about the same proportion of those who reported not working for other reasons or for whom work limitation was unknown, reported other limitations. For these two groups of persons, "coping with day-to-day stress" was the most

frequently reported limitation, (52.6 and 54.3 percent), although between 21 and 32 percent were reported to have difficulty making and keeping friendships ("social functioning") and "concentrating long enough to complete tasks."

Reporting of each type of limitation is higher for persons with SMI who are unable to work than for those who are limited in work, but the differences in difficulty "coping with day-to-day stress" and "concentrating long enough to complete tasks" are not statistically significant.

Considering the range of limitations asked about in this survey, persons with SMI who are unable to

Table 2. Number and percent distribution of adults 18-69 years of age with serious mental illness by current work limitation status according to race: United States, 1990

Work limitation status ¹	Total ²			Total ²		
	White	Black		White	Black	
	Number in thousands			Percent distribution		
Total	2,674	2,471	346	100.0	100.0	100.0
Total with work limitation due to serious mental illness	1,868	1,116	216	47.2	46.2	62.1
Unable to work	829	663	160	26.9	26.8	43.4
Limited in work	829	454	65	18.4	18.4	18.7
No current work limitation	1,032	834	79	38.9	37.8	23.0
Does not work for other reasons or work limitation status unknown ..	485	420	51	18.9	17.0	14.8

¹ Approximately 1 percent (11,000) of those shown in "unable to work" or "limited in work" were persons aged 18-24 who were not in the labor force and who were reported as being "unable" or "limited" in school grades.

² Includes "other" race.

Table 3. Number of adults 18-69 years of age with serious mental illness by current work limitation status and percent reporting other limitations, and number and percent of adults 70 years of age and over with serious mental illness reporting limitations: United States, 1990

Age and work limitation status ¹	SAS ² population	Any other limitation	Personal care activities of daily living ³	Instrumental activities of daily living ⁴	Social functioning ⁵	Coping with day-to-day stress	Concentrating long enough to complete tasks
	Number in thousands				Percent		
Total 18-69 years of age	2,674	74.8	2.7	22.9	46.9	67.7	46.5
Unable to work	829	94.1	7.7	48.8	70.4	88.6	72.9
Limited in work	829	91.9	2.6	30.2	61.2	80.1	67.2
No current work limitation	1,032	58.0	--	4.8	28.8	52.6	21.4
Does not work for other reasons or work limitation status unknown	485	58.7	--	8.8	30.7	54.3	32.0
≥ 70 years of age and over	390	84.8	24.3	62.9	69.8	70.8	69.8

¹ Approximately 1 percent (11,000) of those shown in "unable" or "limited" in work were persons age 18-24 who were not in the labor force and who were reported as being "unable" or "limited" in school grades.

² SAS is seriously mentally ill.

³ Includes eating, dressing, bathing, and going to the toilet.

⁴ Questions about personal care limitations were not asked of adults 18-24 years of age with no work or school limitations resulting from the serious mental illness.

⁵ Includes managing money, doing everyday household chores, shopping, and getting around outside the home.

⁶ Includes forming and keeping friendships.

Table 4. Number and percent distribution of adults with serious mental illness by selected services, according to limitation status, and percent currently limited by serious mental illness: United States, 1990

Selected services	Total		Currently limited		
	Number	Percent distribution	Number	Percent distribution	Percent
Receipt of Government disability payment ¹					
Yes	703	23.2	686	27.8	97.8
No	2,594	76.8	1,782	72.2	78.7
Use of prescription medication for the mental disorder in the past year ²					
Yes	1,891	68.2	1,573	67.9	83.2
No	661	31.8	744	32.1	64.6
Last visit to a mental health professional ³					
Less than one month	1,086	53.5	686	58.6	66.6
One month to less than one year	836	27.2	683	26.4	79.3
One year or more	809	16.8	436	17.4	54.7
Never	700	22.7	520	20.7	74.2

¹ Percent denominators exclude adults with this characteristic unknown.

² Percent denominators include only adults who have ever seen a doctor for the disorder, and exclude adults with this characteristic unknown.

³ Among the 760,000 adults who reported never seeing a mental health professional, 447,600, or 60.1 percent, did report seeing another doctor or health professional for the mental disorder and 89.8 percent of these adults reported limitations.

work are the most likely to be disabled in other activities by their mental disorder, even more so than persons with SMI who are 10 years of age and over (94.1 percent compared with 84.8 percent reporting other limitations). However, persons 70 years of age and over with SMI were much more likely than younger persons to be limited in personal care and instrumental activities of daily living. More than three times as many persons 70 years of age and over were reported to be unable to take care of their personal care needs because of the mental disorder than SMI persons 18-69 years of age who were unable to work.

Receipt of disability payments

About 703,000, or 23.2 percent of adults with SMI in households currently receive disability payments through a Government program because of their mental disorder. (table 4). About 98 percent of these persons had current limitations due to the disorder. The discrepant two percent is due to proxy respondents who reported "don't know" to the limitation questions.

Respondents were asked whether this payment was through Social Security Disability Insurance (SSDI), through Supplemental Security Income (SSI), through the Veterans' Administration (VA), or through some other program. The Social Security Administration (SSA) administers several programs that provide cash payments or other benefits to persons who are, by SSA standards, disabled. Persons with adequate work histories usually receive monthly cash payments as social security benefits (SSDI), and persons with minimal resources and insufficient work history usually receive a monthly payment under the SSI program. VA disability payments are provided for service-incurred disability. As shown in table 5, most respondents with a disability payment reported SSDI (46.0 percent) or SSI (43.5 percent) as the source.

Data in table 6 indicate that adults with SMI who are 35-64 years of age, male, black, in poverty, have

Table 5. Number and percent of recipients of disability payment for mental illness, by source of payment: United States, 1989

Source	Number in thousands	Percent ¹
Social Security Disability Insurance	328	46.0
Supplemental Security Income	306	43.5
Veterans' Administration	85	12.3
Other	83	7.5

¹Percent added to more than 100 because of multiple sources of payment.

Table 6. Number and percent of adults with serious mental illness who received Government disability payment for the mental disorder, by selected characteristics: United States, 1989

Characteristic	Number in thousands	Percent ¹
Total ²	703	23.2
Age		
18-24 years	98	11.8
25-34 years	123	18.1
35-44 years	186	28.3
45-64 years	288	35.1
65 years and over	46	6.4
Sex		
Male	402	53.3
Female	301	46.8
Race		
White	637	80.6
Black	188	43.8
Other	19	22.7
Poverty status³		
Below poverty threshold	185	33.6
At or above poverty threshold	406	19.2
Education⁴		
Less than 12 years	817	30.9
12 years	212	20.8
More than 12 years	142	15.8
Respondent-assessed health status⁵		
Excellent	34	11.9
Very good	89	16.1
Good	140	18.3
Fair	189	27.3
Poor	241	35.1
Use of prescription medication in the past year for the mental illness⁶		
Yes	648	29.7
No	142	18.4
Last saw mental health professional for the mental disorder⁷		
Less than one month	386	24.7
One month to less than one year	186	25.2
One year or more	92	18.9
Never	25	3.8

¹All percent denominators exclude persons with unknown receipt of disability payment (237,000, or 7.3 percent of adults with serious mental illness).

²Percent denominator for total includes persons with unknown poverty status, education, health status, time since last saw a mental health professional, and use of prescription medication.

³Percent denominator excludes persons with this characteristic unknown.

NOTES: Estimates of less than 41,000 and persons based on these estimates have 50 percent or more relative standard error (RSE); see Technical notes for description of the calculation of standard errors. Estimates with 50 percent or more RSE are indicated with an asterisk.

less than a high school education, have poor overall health status, used prescription medication in the past year for their mental disorder, or have recently (past month) seen a mental health professional, are disproportionately likely to receive Government disability payments. The most striking finding in this table is that almost 44 percent of black adults with SMI receive disability payments compared with about 21 percent of white adults with SMI. Overall, 22.1 percent of adults with SMI receiving disability payments for the disorder were black persons, although black adults are not significantly overrepresented among SMI in general or in the proportion of the SMI population with current limitations.

Comparing the source of disability payments by race, table 7 shows that black adults with SMI are more than twice as likely to report receiving SSI for their mental disorder than white adults with SMI. The higher proportions of black adults receiving SSDI and VA disability payments are significant at a .10 level.

These findings related to SSDI and SSI benefits are consistent with those from a recent report by the General Accounting Office (GAO) (12). In April 1992, the GAO issued findings from a study of racial differences in disability decisions for SSDI and SSI benefits. This report analyzed the circumstances surrounding the lower allowance rate for black applicants compared with white applicants for disability benefits. One of the findings was that while black applicants are less likely to be awarded benefits than white applicants, in the general population a higher proportion of black adults

were receiving benefits than white adults. The report attributed this higher rate in the population to the fact that black adults apply at a higher rate than white adults, and it goes on to speculate that this may be due in part to poorer economic circumstances among black persons. Additional work is in progress to identify factors that might account for these racial differences.

As noted in table 2, a higher proportion of black adults with SMI in this survey are unable to work because of their disorder than white adults with SMI. Black adults are more likely than white adults (both in the general population and among adults with SMI) to be in poverty, to have less than a high school education, and to have fair or poor self-assessed health. Since all of these factors are related to receipt of disability payments, it is not surprising that black persons with SMI are more likely to receive disability payments because of their mental disorder.

Prescription drug use

Prescription drug use was highly prevalent in the population reporting SMI; about 68 percent of the adult SMI population who saw a doctor or other health professional for the mental disorder used prescription medication for the disorder during the past 12 months (table 8). Taking prescription medication was not related to limitation status. The lowest use of prescription medication for the disorder during the past year was among the youngest and oldest age groups (table 8). The proportion using prescription medication generally increased with age through the age group 65-69 years and decreased thereafter. Persons with

SMI in "poor" health, those who received Government disability payments, and those who recently saw a mental health professional were most likely to have used medication.

The various types of prescription drugs used by persons with SMI during the past 12 months for the mental disorders reported are shown in table 9. Actual drug names were obtained from respondents and then coded by major class of drugs. Antidepressants were used by almost 41 percent of the 1.9 million persons using prescription medication in the past year, and were the most commonly reported type of drug used. This is not surprising, since "major depression" was reported for approximately 45 percent of persons reported to have SMI. Antianxiety and antipsychotic drugs were used by 26.3 and 25.2 percent of persons, respectively. Various other drugs, not considered to be drugs for mental health problems, were used for the mental disorders by about 18 percent of those who used prescription drugs. Table 10 shows that almost one-half of all persons with SMI using prescription medication for the disorder during the past year used more than one drug.

Visits to mental health professionals

About 77 percent of the SMI population in households (2.4 million persons) have seen a mental health professional for the mental disorder reported (table 4). Among the 700,000 persons with SMI who have never seen a mental health professional, most (about 64 percent) had seen a doctor or other health professional for the disorder. In table 11, characteristics of the SMI population who have seen a mental health professional for the reported mental disorder(s) are displayed. In the oldest age group, only 37 percent of persons with SMI had seen a mental health professional for the reported disorder but about 90 percent of this age group had seen another type of doctor or health professional for their disorder.

Table 7. Percent of adults with serious mental illness receiving disability payment for their mental disorder, by race and source of payment: United States, 1988

Source	Percent	
	White	Black
Social Security Disability Insurance	18.9	16.7
Supplemental Security Income	8.9	20.0
Veterans' Administration	2.4	7.9
.....	1.8	2.7

Table 8. Number and percent of adults with serious mental illness who used

prescription medication during the past year for the mental disorder, by selected characteristics: United States, 1989

Characteristic	Number in thousands	Percent ¹
Total ²	1,800	68.2
Age		
18-24 years	166	55.7
25-34 years	347	61.8
35-44 years	483	68.2
45-54 years	638	78.8
55-64 years	100	82.1
70-74 years	62	75.0
75 years and over	112	80.0
Sex		
Male	732	67.4
Female	1,158	68.8
Race		
White	1634	68.2
Black	231	70.9
Other	25	78.4
Poverty status ³		
Below poverty threshold	373	70.1
At or above poverty threshold	1313	68.4
Education ⁴		
Less than 12 years	858	68.4
12 years	648	68.9
More than 12 years	353	68.1
Respondent-assessed health status ⁵		
Excellent	182	81.4
Very good	357	87.7
Good	448	68.4
Fair	420	64.8
Poor	802	77.0
Receipt of Government disability payment ⁶		
Yes	548	79.4
No	1303	64.1
Last saw mental health professional for the mental disorder ⁷		
Less than one month	848	65.0
One month to less than one year	886	74.8
One year or more	201	40.2
Never	225	82.8

¹As percent distribution excludes persons who have not seen any health professional for the disorder (948,000, or 7.5 percent of adults with serious mental illness and exclude persons with unknown "use of prescription medication for the disorder" (847,000, or 7.5 percent of adults with serious mental illness).

²Percent distribution for total includes persons with unknown poverty status, education, health status, disability pay, and time since last saw a mental health professional.

³Percent distribution excludes persons with this characteristic unknown.

NOTES: Estimates of less than 41,000 and persons based on "less estimates have 50 percent or more relative standard error (RSE) are reported in parentheses for description of the estimates of standard error. Estimates with an RSE of 50 percent or more are indicated with an asterisk.

Table 9. Number and percent of adults with serious mental illness who took prescription drugs in the past year for mental disorder, by type of drug: United States, 1989

Type of drug	Number in thousands	Percent
Antidepressant	788	40.8
Anxiolytic	487	26.3
Antipsychotic	477	26.2
Anesthetic	233	12.3
Other psychotropic drug	85	3.4
Other drug	337	17.8
Unknown drug name	46	2.4

Table 10. Number and percent distribution of adults with serious mental illness who took prescription drugs in the past year for the mental disorder, by number of drugs reported: United States, 1989

Number of drugs	Number in thousands	Percent distribution
Total	1,800	100.0
Number of drugs		
One	876	48.3
Two	478	25.3
Three	251	13.3
Four	85	4.5
Five or more	68	3.8
Unknown	135	7.1

Persons 35-64 years of age were more likely than any other age group to have seen a mental health professional.

Persons who used prescription medication for their mental disorder during the past year and persons who received disability payments for the disorder were more likely to have seen a mental health professional than others with SMI.

Summary and conclusions

The major significance of the current report is that it provides estimates and characteristics for that portion of the civilian SMI population living in households. Survey results show that approximately 3.3 million adult Americans have mental disorders that seriously interfere with one or more aspects of daily life and that about 2.6 million of these persons are currently limited in one or more functional areas. These results suggest that the household component of the SMI population is

comprised of between 2.6 and 3.3

million adults, depending upon the criteria employed for inclusion. Undoubtedly, both of these numbers are conservative because of the likelihood of underreporting in the survey.

Placed in the context of the entire adult population, these findings suggest that the SMI population can be conservatively estimated to include 4 to 5 million adult Americans, or 2.1 to 2.6 percent of the adult population. In addition to the household population, it is estimated that 200,000 SMI persons are homeless on any given day (13). An additional 1 million to 1.1 million are residents of nursing homes (14), approximately 50,000 to 60,000 are patients of mental hospitals, and approximately 50,000 are inmates of State prisons (15).

A major remaining need is to collect similar data on all SMI persons, whether their residence is a household, an institutional or noninstitutional group quarter, or some other setting, including streets and shelters. In order to formulate more effective national policy to address the needs of these disabled Americans, a need exists to examine the longitudinal relationship between course of disorder and functioning as they relate to service and program participation.

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Table 11. Number and percent of adults with serious mental illness who have ever seen a mental health professional, by selected characteristics: United States, 1988

Characteristic	Number in thousands	Percent ²
Total ¹	2,980	77.3
Age		
18-24 years.....	276	80.3
25-34 years.....	308	78.8
35-44 years.....	330	87.8
45-54 years.....	718	82.6
55-64 years.....	88	88.5
70-74 years.....	70	88.5
75 and over.....	88	87.8
Sex		
Male.....	928	77.8
Female.....	1,421	76.8
Race		
White.....	2,042	76.8
Black.....	282	80.8
Other.....	48	78.7
Poverty status³		
Below poverty threshold ..	470	79.1
At or above poverty threshold.....	1,833	78.1
Education³		
Less than 12 years.....	788	74.9
12 years.....	804	78.4
More than 12 years.....	782	80.8
Respondent-assessed health status⁴		
Excellent.....	344	88.8
Very good.....	484	78.7
Good.....	808	78.2
Fair.....	830	74.4
Poor.....	830	75.8
Use of prescription medication for the mental disorder⁵		
Yes.....	1,848	88.2
No.....	687	76.7
Receipt of Government disability payment⁶		
Yes.....	888	88.4
No.....	1,888	71.8

¹As percent denominator excludes persons with unknown time since last saw a mental health professional (104,000), or 3.5 percent of total adults with serious mental illness.

²Percent denominator for total includes persons with unknown poverty status, education, health status, prescription use, or public disability pay.

³Percent denominator excludes persons with only 0-12 years of education.

⁴Percent denominator includes only persons who have ever seen a doctor or other health professional and excludes persons with the chronic health condition.

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Symbols

- Data not available
- ... Category not applicable
- Quantity zero
- 0.0 Quantity more than zero but less than 0.05
- Z Quantity more than zero but less than 500 where numbers are rounded to thousands
- Figure does not meet standard of reliability or precision

Technical notes

Source and description of data

The estimates presented in this report are based on data from the 1989 National Health Interview Survey (NHIS), an ongoing survey of households in the United States conducted by the National Center for Health Statistics (NCHS). Each week, a probability sample of the civilian noninstitutionalized population of the United States is interviewed by personnel of the U.S. Bureau of the Census. Interviewers obtain information about the health and other characteristics of the households included in the NHIS sample.

NHIS consists of two parts: (a) a basic health and demographic questionnaire that remains the same each year and is completed for every household member and (b) special topics questionnaires that vary from year to year, some of which may be completed only for selected persons in each family. In 1989, the special topics included health care coverage, adult immunization, mental health, dental health, diabetes, orofacial pain, digestive disorders, and knowledge and attitudes about acquired immunodeficiency syndrome (AIDS).

The total interviewed sample for 1989 for the basic health and demographic questionnaire consisted of 45,711 households containing 116,929 persons. The noninterview rate was 5.1 percent. NHIS Mental Health (NHIS-MH) interviews were completed for 113,231 persons, or 96.8 percent of those interviewed on the basic questionnaire. The overall response rate for the NHIS-MH was 91.9 percent (the product of the response rates for the basic and mental health questionnaires).

Sampling errors

Because estimates shown in this report are based on a sample of the

population rather than on the entire population, they are subject to sampling error. When an estimate or the numerator or denominator of a percent is small, the sampling error may be relatively high. In addition, the complex sample design of NHIS has the effect of making sampling errors larger than they would be had a simple random sample of equal size been used. Estimates and figures based on estimates that do not meet the reliability criteria of 30 percent relative standard error are marked on the tables.

Approximate standard errors of the estimated numbers (x) in the tables (except for age, sex, and race for all persons when the standard error is assumed to be 0.0) may be calculated using the formula

$$SE(x) = \sqrt{.0000307(x)^2 + 3640(x)}$$

For example, it is estimated that 3,264,000 adults had a SMI in the last 12 months (table 1). Using this formula, the standard error for the estimated number is

$$SE(3,264,000) =$$

$$\sqrt{.0000307(3,264,000)^2 + 3640(3,264,000)} \\ = 110,490$$

Approximate standard error of the estimated percents in the tables may be calculated using the formula

$$SE(p) = \sqrt{\frac{3640(p)(100-p)}{y}}$$

where p is the percent of persons and y is the base population from which the percent is calculated.

For example, it is estimated that 78.8 percent of adults with SMI have one or more specific limitations resulting from the SMI (table 1). Using this formula, the standard error for the estimated percent is

$$SE(78.8) = \sqrt{\frac{3640(78.8)(100-78.8)}{3,264,000}} \\ = 1.86$$

If x_1 and x_2 are two estimates, then the approximate standard error of the difference ($x_1 - x_2$) can be computed as follows:

$$SE(x_1)^2 + SE(x_2)^2 - 2r SE(x_1)SE(x_2)$$

where $SE(x_1)$ and $SE(x_2)$ are computed using the appropriate formulas previously presented in this section and r is the correlation coefficient between x_1 and x_2 . Assuming $r = 0.0$ will result in an accurate standard error if the two estimates are actually uncorrelated. If they are correlated, the standard error of the difference will be underestimated or overestimated. These calculations can also be performed for differences in percents using the appropriate standard error formulas for percents.

In this report, unless otherwise noted, a difference was considered statistically significant at the 5-percent level if the difference ($x_1 - x_2$) was at least twice as large as its standard error. Further information on how the standard error parameters are constructed is available in "Current Estimates From the National Health Interview Survey: 1989" (9).

Related documentation

More detailed discussion of the sample design, estimating procedures, procedures for estimating standard errors, nonsampling errors, and definitions of other sociodemographic terms used in this report have been published in *Vital and Health Statistics*, Series 1, no 18; Series 2, no 110; Series 10, nos 160 (16-18) and 176 (9).

A public use data file based on the 1989 Mental Health Survey questionnaire was released in April 1991. Information regarding the purchase of the public use data tape may be obtained by writing the National Center for Health Statistics, Division of Health Interview Statistics, 6525 Belcrest Road, Hyattsville, Maryland, 20782.

Table 1

Analysis of Mental Health Costs

Adult Population Base: 202807

 1997 202807
 1990 184000
 1980 159000

	Prevalence Rate % Pop	Inpatient Services Only
Inpatient Services w/ O/P Inpatient Only		
Any DIS ADM Disorder	0.281	0.025
Any DIS Disorder (exc Alcohol or Drug)	0.221	0.029
Any Mental Disorder w/ comorbid SA	0.033	0.067
Any SA Disorder	0.095	0.029
Any Alcohol Disorder	0.074	0.028
Any Drug Disorder	0.031	0.038
Schizophrenic Disorders	0.011	0.169
Affective Disorders	0.095	0.047
Any Bipolar	0.012	0.076
Unipolar Major Depression	0.050	0.058
Dysthymia	0.054	0.05
Anxiety Disorders	0.126	0.032
Phobia	0.109	0.033
Panic Disorder	0.013	0.084
Obsessive-Compulsive Disorder	0.021	0.074
Somatization Disorder	0.002	0.104
Antisocial personality Disorder	0.015	0.061
Cognitive Impairment (Severe)	0.027	0.029
All SMI	0.028	
Schizophrenia	0.015	
Manic Depressive	0.010	
Major Depression	0.011	
Panic	0.004	
Obsessive Compulsive	0.006	
Sub-threshold Cases		

Treatment Rates (% with Prevalence Receiving Treatment in 1 Year Period)								
Any Mental or Addictive Service	Specialty Mental Addictive	General Medical	Health Systems Subtotal		Human Services	Any Professional Subtotal	Volunteer Support Network	
0.007	0.007		0.007			0.007		
0.002	0.002		0.002			0.002		
0.285	0.127	0.127	0.219		0.059	0.247	0.089	
0.319	0.145	0.142	0.249		0.068	0.279	0.094	
0.374	0.206	0.163	0.294		0.077	0.327	0.114	
0.236	0.112	0.099	0.175		0.044	0.198	0.084	
0.220	0.109	0.098	0.168		0.038	0.188	0.080	
0.298	0.142	0.116	0.215		0.060	0.244	0.089	
0.643	0.460	0.290	0.600		0.137	0.629	0.070	
0.457	0.231	0.219	0.378		0.094	0.413	0.128	
0.609	0.324	0.335	0.541		0.100	0.589	0.096	
0.539	0.278	0.253	0.450		0.116	0.490	0.166	
0.421	0.193	0.212	0.347		0.083	0.378	0.097	
0.327	0.149	0.148	0.257		0.067	0.286	0.093	
0.311	0.139	0.149	0.249		0.062	0.273	0.089	
0.588	0.336	0.297	0.518		0.126	0.544	0.131	
0.451	0.253	0.183	0.364		0.103	0.413	0.108	
0.697	0.425	0.494	0.634		0.153	0.672	0.153	
0.311	0.175	0.110	0.229		0.076	0.256	0.106	
0.170	0.069	0.072	0.129		0.029	0.145	0.042	
	0.436	0.326	0.624					
	0.456	0.337	0.645					
	0.398	0.406	0.654					
	0.645	0.342	0.791					
	0.550	0.505	0.798					
	0.390	0.281	0.541					
0.093	0.032	0.039	0.066		0.019	0.078	0.023	

Analysis of Mental Health Costs

1997	202807
1990	184000
1990	159000

	# (1000s)	Only	Any Service	Service	Any Service	Addictive	SMA	Medical	Subtotal	PS	Services	Subtotal	Persons
Inpatient Services/w O/P	202807	1419.649	0.7%	1419.649	0.7%	1419.649	0.7%		1419.649	0.7%		1419.649	
Inpatient Only	202807	405.614	0.2%	405.614	0.2%	405.614	0.2%		405.614	0.2%		405.614	
Any DIS ADM Disorder	56989	1425	0.7%	16242	8.0%	7238	3.6%	7238	12481	6.2%	3362	14076	5072
Any DIS Disorder (exc Alcohol or Drug)	44820	1300	0.6%	14298	7.0%	6499	3.2%	6364	11160	5.5%	3048	12505	4213
Any Mental Disorder w/ comorbld SA	6693	448	0.2%	2503	1.2%	1379	0.7%	1091	1968	1.0%	515	2188	763
Any SA Disorder	19267	559	0.3%	4547	2.2%	2158	1.1%	1907	3372	1.7%	848	3815	1618
Any Alcohol Disorder	15008	420	0.2%	3302	1.6%	1636	0.8%	1471	2521	1.2%	570	2821	1201
Any Drug Disorder	6287	239	0.1%	1874	0.9%	893	0.4%	729	1352	0.7%	377	1534	560
Schizophrenic Disorders	2231	377	0.2%	1434	0.7%	1026	0.5%	647	1339	0.7%	306	1403	156
Affective Disorders	19267	906	0.4%	8805	4.3%	4451	2.2%	4219	7283	3.6%	1811	7957	2466
Any Bipolar	2434	185	0.1%	1482	0.7%	789	0.4%	815	1317	0.6%	243	1433	234
Unipolar Major Depression	10140	588	0.3%	5466	2.7%	2819	1.4%	2566	4563	2.3%	1176	4969	1683
Dysthymia	10952	548	0.3%	4611	2.3%	2114	1.0%	2322	3800	1.9%	909	4140	1062
Anxiety Disorders	25554	818	0.4%	8356	4.1%	3807	1.9%	3782	6567	3.2%	1712	7308	2376
Phobia	22106	729	0.4%	6875	3.4%	3073	1.5%	3294	5504	2.7%	1371	6035	1967
Panic Disorder	2636	221	0.1%	1550	0.8%	886	0.4%	783	1366	0.7%	332	1434	345
Obsessive-Compulsive Disorder	4259	315	0.2%	1921	0.9%	1078	0.5%	779	1550	0.8%	439	1759	460
Somatization Disorder	406	42	0.0%	283	0.1%	172	0.1%	200	257	0.1%	62	273	62
Antisocial personality Disorder	3042	186	0.1%	946	0.5%	532	0.3%	335	697	0.3%	231	779	322
Cognitive Impairment (Severe)	5476	159	0.1%	931	0.5%	378	0.2%	394	706	0.3%	159	794	230
All SMI	5679	1215	0.6%	5679	2.8%	2476	1.2%	1851	3543	1.7%			
Schizophrenia	3042	681	0.3%	3042	1.5%	1387	0.7%	1025	1962	1.0%			
Manic Depressive	2028	396	0.2%	2028	1.0%	807	0.4%	823	1326	0.7%			
Major Depression	2231	706	0.3%	2231	1.1%	1439	0.7%	763	1765	0.9%			
Panic	811	219	0.1%	811	0.4%	446	0.2%	410	647	0.3%			
Obsessive Compulsive	1217	233	0.1%	1217	0.6%	475	0.2%	342	658	0.3%			
Sub-threshold Cases	145816			13561	6.7%	4666	2.3%	5687	9624	4.7%	2771	11374	3354
Threshold & Treatment	56989			16242	8.0%	7238	3.6%	7238	12481	6.2%	3362	14076	5072
Total All Persons	202807			29803	14.7%	11904	5.9%	12924	22105	10.9%	6133	25450	8426
Sub-Threshold % of Population				6.7%		2.3%		2.8%	4.7%		1.4%	5.6%	1.7%
Threshold % of Population				8.0%		3.6%		3.6%	6.2%		1.7%	6.9%	2.5%
% Pop Receiving Treatment				14.7%		5.9%		6.4%	10.9%		3.0%	12.5%	4.2%

Distribution of Employer Benefit Plan Coverage for Mental Health by Maximum Dollar Benefits

<u>Behavioral Health Plan Dollar Maximums</u>	<u>% of Plans</u>
\$0 - 24,999	7.0%
\$25,000	14.0%
\$25 - 49,999	12.0%
\$50,000	40.0%
\$50 - 999,999	16.0%
\$1,000,000	9.0%
More than \$1M	2.0%

Based upon a Mercer Survey of Large Employers