

Abortion Restrictions and the Drive for Mental Health Parity: A Conflict in Values?

By Cynthia Dailard

Mental health issues will enjoy tremendous visibility in the coming months as a result of a White House conference on mental health in June, the expected release of a report by the surgeon general on mental health in the fall, and the introduction of high-profile legislation in Congress designed to secure complete parity between insurance coverage of mental and physical health benefits.

This heightened attention may appear somewhat ironic to women's rights and prochoice advocates, given the decidedly negative treatment of women's mental health concerns in the context of current abortion politics. Indeed, a number of measures have been introduced in recent years—largely by prochoice legislators—that treat women seeking abortions for mental health reasons differently from those with physical health concerns. While these initiatives first grew out of a perceived need among many prochoice legislators for a political alternative to the Partial-Birth Abortion Ban Act, they have significant implications within the larger abortion-rights context—and beyond.

Parity Support Grows...

Mental health advocates have made significant gains in recent years toward overcoming biases directed at people with mental illness—biases fueled by the stigma historically associated with mental illness, the tendency to dichotomize physical and mental disorders, and a lack of understanding about the science underlying mental illness. Nowhere are these gains more visible than in

the rise in public and political support for measures designed to overcome the differential treatment of physical and mental illness in the health insurance context—commonly referred to in the mental health world as “parity.”

This increasing support culminated in the passage of federal legislation known as the Mental Health Parity Act in 1996. Sponsored by legislators from opposite ends of the political spectrum—Sens. Pete Domenici (R-NM) and Paul Wellstone (D-OR)—the bill, as introduced, guaranteed full parity between mental and physical health benefits in all private insurance plans. Enjoying broad bipartisan support, including that of conservative members such as then-Senate Majority Leader Bob Dole (R-KS) and current Senate Majority Leader Trent Lott (R-MS), it passed the Senate by an overwhelming vote of 65–33 as an amendment to the Health Insurance Portability and Accountability Act in 1996.

While the provision was never voted on in the House and was subsequently dropped in conference, a somewhat narrower version proposed by the sponsors was signed into law one month later as part of an annual appropriations bill. The law prohibits health plans from imposing stricter annual and lifetime limits on total spending for mental health benefits than they set for other medical benefits. However, plans may still place annual limitations on the length of hospital stays and the number of outpatient visits, as well as impose higher levels of cost sharing for mental health benefits than for general health services.

Passage of the Domenici-Wellstone provision did not slow the momentum to achieve full parity. Numerous states have passed, and many more are considering, measures designed to achieve parity in insurance benefits, several of which go beyond the protections contained in the federal law. Moreover, Domenici and Wellstone have joined together once again to introduce legislation, much anticipated within the mental health community, aimed at strengthening their 1996 act.

The drive toward full mental health parity in the insurance coverage context is historic because it highlights an increased understanding

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and acceptance of mental illness. This may be attributed in large part to recent breakthroughs in brain research that point increasingly to the physical origin of many mental disorders. Explains Chris Koyanagi, policy director for the Judge David L. Bazelon Center for Mental Health Law, “We are increasingly understanding the interrelatedness of various physical and mental health disorders, and it is becoming increasingly difficult to separate one from the other. All body systems, including the brain, are based on the same biological process, which we are now interpreting. This distinction between systems based on the terms ‘physical’ and ‘mental’ is meaningless. Science is a long way ahead of policymakers in terms of understanding mental illness.”

...but Not in Abortion Context

While mental health advocates have had to fight to have mental illness treated on a par with physical illness in the insurance context, parity between physical and mental health

has been a central feature of abortion jurisprudence for almost 30 years (*TGR*, Vol. 1, No. 6, December 1998). Under *Roe v. Wade*, women have a constitutional right to choose an abortion, but after the fetus reaches viability, states may restrict or even prohibit abortion except when necessary to protect a woman's life or health. *Roe's* companion case, *Doe v. Bolton*, clarified that "health" must be broadly defined to include both physical and mental health concerns: "Medical judgment may be exercised in the light of all the factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to health."

In light of these rulings, any attempt to qualify the health exception—or, more specifically, to exclude mental health—would appear to conflict directly with the current state of constitutional law. The health exception, however, has long been a target of abortion foes, who claim it is so broad as to allow women to obtain "late" abortions for any reason. In fact, a 1996 ad sponsored by the National Conference of Catholic Bishops claims that the health exception can be defined "as just about anything," including a psychological crisis caused when a teenager realizes that she "won't fit into a prom dress" or "hates being 'fat.'"

The debate over the health exception took on a surprising new twist, however, when *prochoice* legislators began seeking to exclude mental health from the equation in the context of "late" abortions. Searching for "common ground" in the debate over so-called partial-birth abortions, Senate Minority Leader Tom Daschle (D-SD) drafted the Comprehensive Abortion Ban Act, which would make all abortions after viability illegal unless continuation of the pregnancy would threaten the woman's life or "risk grievous injury to her *physical* health" (emphasis

added). Daschle's proposal, which was offered but rejected in May 1997 as an amendment to the Partial-Birth Abortion Ban Act, would have excluded the possibility of a postviability abortion for any mental health condition, no matter how severe. (The mental health exception is also critical because it has been the aegis under which most abortions in cases of severe fetal abnormality have been justified.)

Just over one year later, in September 1998, Sen. Dick Durbin (D-IL), another consistent supporter of reproductive rights, went a step

But recently, key lawmakers have voted for mental health parity in the insurance context—but against it in debates over abortion.

further. With a bipartisan group of *prochoice* senators, he introduced the Late-Term Abortion Limitation Act, which incorporates Daschle's proposal, including its distinction between physical and mental health conditions, but adds another requirement—that a second physician, not involved in performing the abortion, be consulted to certify that the reason for the abortion meets the narrow requirements of the bill. Durbin is expected to reintroduce his bill again within the coming months.

The willingness of some *prochoice* members to sacrifice the mental health exception in order to appear "reasonable" in the context of the postviability abortion debate is beginning to have significant repercussions beyond that specific issue, seriously reviving a legislative attack on abortion rights that largely has been dormant for two decades. For example, the Medicaid abortion funding ban (commonly known as the Hyde amendment) has included an exception to the prohibition in cases

of life endangerment since it was first enacted in 1976. Taking a predictable turn in the wake of the Daschle initiative, Hyde successfully narrowed his language in 1997 to permit abortions to be funded under Medicaid only when a woman's life is endangered by "a *physical* disorder, a *physical* injury, or *physical* condition caused by or arising from the pregnancy itself" (emphasis added). It had not been since the late 1970s, when the Hyde amendment in FY 1978 and FY 1979 also contained an exception for "severe and long-lasting *physical* health damage" (emphasis added), that the legitimacy of a mental health exception had been seriously debated and rejected.

The Challenges Ahead

In a recent *Legal Times* article, Janet Benshoof and Laura Ciolkowski, of the Center for Reproductive Law and Policy, charge that some *prochoice* legislators have consciously bought into the antiabortion movement's "devaluation of women's mental health." Whether or not this is true, recent actions beg the question of why providing equitable treatment for people with mental illness is gaining currency in virtually every public policy context except abortion, where it is fast losing ground. Indeed, the voting records of the 29 senators who voted both for the Daschle amendment and on the Mental Health Parity Act highlight this troubling contradiction: 23 of those 29—all of whom were *prochoice* or had mixed voting records—voted in favor of the Parity Act. In other words, they took the position that in the insurance context, mental health concerns are sufficiently legitimate to warrant equitable treatment with physical health concerns but that mental health concerns can *never* present a sufficiently grave threat to a woman's health to justify a postviability abortion.

In recent federal debates, *prochoice* advocates—unwilling to condone

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any retreat from *Roe*, but recognizing the appeal of a prochoice political alternative to the partial-birth abortion legislation—largely remained on the sidelines and, thus, did little to speak out about the importance of maintaining the mental health exception. For their part, mental health advocates to date have remained silent on the issue. “While the mental health community has not looked specifically at the abortion context,” says Koyanagi, the

effort to distinguish mental from physical health concerns “certainly flies in the face of our advocacy

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efforts to secure equitable treatment of mental and physical illnesses, and to educate policymakers regarding

the interrelatedness of physical and mental health problems.”

The challenge ahead may be for prochoice and mental health advocacy groups to join together in educating policymakers about the importance of maintaining parity in the abortion context—in order to preserve the gains made on behalf of people with mental illness *and* for women who may need abortions for mental health reasons. Much would appear to be at stake for both communities. ☪