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Mental Health Parity
National and State Perspectives

A REPORT

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EXECUTIVE SUMMARY

Nationally, as well as in Florida, the current system for financing the comprehensive care for individuals with severe mental disorders is inadequate for the individual and expensive for the citizens of Florida. As a result of the various limitations and restrictions placed upon private insurance coverage, serious mental disorders not only are costly to individuals but often place undue burden upon emergency and inpatient hospital settings. Nevertheless, studies (as summarized by Keisler and Silbukin [1]) have shown the use of alternative, ambulatory care to be more effective treatment.

Recent attempts at modifying health care delivery in America have focused on fundamental characteristics of a system of care, emphasizing prevention, access to primary care, standardized treatment guidelines, and treatment effectiveness. In addition, health and mental health care delivery systems in the United States have increasingly become "managed" in an effort to reduce precipitous increases in health care costs, increase professional accountability, re-organize services, and redesign health benefits to meet the specific needs of specified populations.

Meanwhile, mental health and substance abuse services have not been accorded equal insurance coverage compared to other physical illnesses. In addition, they have generally been poorly integrated into primary health care services delivery. Parity initiatives, at both the national and state levels, have emerged as one set of strategies to provide *equal coverage for the diagnosis and treatment of mental disorders* (and often including substance abuse services) vis-a-vis other physical (somatic) disorders.

This report contains a summary of the available information on the key issues involved in parity initiatives: the experiences at the national level (see "National Parity Initiatives") as well as the experiences of other states that have developed and/or implemented parity legislation (see "State Parity Initiatives"); the cost experiences resulting in implementing parity for mental disorders (see Costs"); and implications and suggestions for proceeding with the development of mental health parity in Florida (see Evaluating Benefits from Mental Health Parity" and "Conclusions").

A comprehensive, flexible approach has many advantages for both mental health consumers and the public sector. As shown in the following report, adopting a flexible, integrated benefit for mental health care can provide delivery of appropriate mental health services to those most in need. The passage of a mental illness parity law would also benefit the state of Florida by shifting the costs of providing treatment for severe mental illness from the state (and Federal) government to the private sector, specifically to the private business sector.

One estimate of the benefits to the state of Florida from a mental illness parity law can be acquired by reviewing the relevant data from Florida. In 1995 the population of the Florida was 14.16 million persons, 3.37 million persons under the age of 18 and 10.79 million adults.[2] If the standard prevalence rate is used (2.8% for adults and 3.2% for children), then 302,000 adults (2.8 percent times 10.79 million) and 108,000 (3.2 percent times 3.37 million) persons under the age of 18 currently suffer from severe mental illness, a total of 410,000 persons in Florida. It was estimated by Milliman

& Robertson, Inc. that 35.7 percent of Florida's population would be affected by the proposed parity law.[3] (Certain groups are exempted from the proposed legislation, most importantly the self-insured and those covered by Medicare and Medicaid.) Applying this percentage to the number of persons in Florida with severe mental illness results in an estimate of 146,300 persons who will fall under the parity law: approximately 107,800 adults and 38,500 persons under the age of 18. Consider the following:

- ♦ If treatment utilization rates in Florida are roughly comparable to rates for the rest of the country, then 60 percent of these adults (64,700) and 29 percent of the persons under age 18 (11,200) are currently receiving treatment for severe mental illness (annual average).
- ♦ If the parity law, via its reduced price of treatment, increases the number of persons with severe mental illness who seek treatment by 120 percent, then approximately 13,000 additional adults and 2,200 additional persons under the age of 18 will seek treatment, a total of approximately 156,000 persons.
- ♦ If treatment efficacy rates average around 70 percent, then approximately 10,500 of these persons will show substantial improvement in their severe mental illness.
- ♦ An estimated annual social benefit for the state of Florida is approximately $70.5 million, (using the standard $6,700[4] as social cost per person multiplying this figure by the estimated 10,500 persons).

This is a rough estimate, relying on several relationships that should be verified and refined by additional research. It is likely that it also represents a conservative estimate. In 1990, 5.2 percent of the nation's population lived in Florida. As noted above, it was estimated that in 1990 a nationwide parity law would yield $7.5 billion in benefits as a result of reduced social costs (plus an additional $1.2 billion in reduced health care costs for physical illness). If these benefits were allocated on a population basis, Florida's share of the benefits would equal $390 million (plus an additional $62 million in reduced health care costs), more than five times the level of benefits estimate above. Furthermore, the estimate omits several factors that should be accounted for in a more complete analysis:

1) the increased treatment utilization of those who are currently receiving treatment;
2) the improved cost effectiveness in treatment that should occur as a result of the law;
3) the reduction in costs for physical health care; and
4) the financial benefit to the state of the transfer of treatment costs to the private sector.

Parity legislation for individuals with severe mental illness will bring Florida's mental health system into the mainstream of health care and help dispel the prejudice that surrounds treatment of persons with severe mental illness. It will also be necessary to more closely examine the impact of managed care managed care upon the costs associated with parity legislation as more states implement and evaluate public programs under the auspices of managed care frameworks.

INTRODUCTION

Mental health policy and services delivery in the United States continue to undergo rapid changes as well as restructuring. In an era of reduced state mental health budgets and the increased potential for under treatment and redirection of individuals with severe mental disorders into under funded public programs, increased expectations have been placed upon the development of alternative approaches to the organization, financing, and delivery of mental health services. While a number of states have developed contracts and structural arrangements with managed care organizations, other states have focused on increased efforts by mental health advocates, consumers, and professionals to alter mental health insurance benefit design through legislative mandates for a specified minimum coverage and/or through passage of parity legislation, providing equivalent insurance coverage for mental health and (often times) substance abuse disorders via-a-vis insurance coverage for somatic disorders.

This report contains a summary of the available literature on mental health parity initiatives in the United States. The report is divided into seven major sections. The first section, “Epidemiology of Mental Disorders,” provides the readers with a brief summary of the prevalence of mental disorders from several major national studies as well as estimates for specific populations. Section two, “National Parity Initiatives,” summarizes the history of parity efforts at the from a national perspective. Section three, State Parity Initiatives,” discusses the parity activities within various states as well as cost experiences from several states resulting from implementing parity for mental disorders. Although it is beyond the scope of this report to present a comprehensive analysis of managed care, section four, “Managed Care”, presents a brief summary of issues related to managed care and parity issues. Section five, “Costs,” contains the various data available on the costs of mental health in the United States as well as in Florida. Section Six, “Evaluating Benefits from Mental Health Parity,” estimates the costs of implementing mental health parity in the state of Florida. Section Seven, “Conclusions,” suggests areas of continued study in the further examination of the impact of parity legislation upon the costs and service utilization of mental health and substance abuse services in the state of Florida.

This report also contains a summary of mental health and substance abuse parity initiatives and mandated benefits in the individual states in the United States, as well as a series of costs and projected costs for mental health services in both Florida and the United States. Finally, the references utilized in preparing this report have been listed in the references section of this report.

EPIDEMIOLOGY OF MENTAL DISORDERS

Fundamental to any discussion of policy change affecting the health and well-being of a specified population is a clear understanding of epidemiology, the study of factors which determine frequency and distribution of disease in that population. *Prevalence* tells us who is affected and living with the disease, while *incidence* tells us who is at risk of the disease as well as who may have recently developed the disease or disorder.

Stiles and Petrila[5] recently provided an estimate of the prevalence of mental disorders in Florida based upon national data from the ECA study. Unfortunately, as they point out, these prevalence figures do not reflect the unique population characteristics specific to Florida, including seasonal residents, a large Hispanic population from Caribbean descent, as well as year-round migration to the sunshine state. Nevertheless, since no state-wide prevalence studies are available regarding rates of individuals with mental disorders, figures extrapolated from national estimates indicate that 2.8 percent of the total population suffers from severe mental illness (see Table Two for prevalence rates through the year 2010).

PARITY INITIATIVES

Background

Under existing state insurance laws, disability or health care service plans may not discriminate based on race, color, religion, national origin, ancestry, or sexual orientation. These guidelines are derived from federal anti-discrimination laws. Parity, implemented either for mental health and/or chemical dependency, would further prohibit insurers or health care service plans from discriminating between coverage offered for mental illnesses, biologically based mental illnesses, or chemical dependency. In short, parity requires insurers to offer the same benefits for mental illnesses, biologically based mental illnesses or chemical dependency as they do for physical illnesses. Parity, in this paper, refers to parity for coverage of mental illnesses to be the same as those offered for physical illnesses.

Biologically-based brain diseases, biologically-based mental disorders, and *serious mental illness* are terms used frequently in the debates for parity. These terms include but are not limited to the following diagnoses: schizophrenia; schizo-affective disorder; delusional disorder; bipolar affective disorders; major depression; obsessive-compulsive disorder; and anxiety disorder..

The parity debate centers around a number of different issues, including costs and employer mandates, financial impact, inclusion of all mental illness vs. severe mental illness, and the inclusion of chemical dependency services. Five studies have claimed to provide a definitive measure of the cost and impact of mental health parity.[6] Each of the studies based their conclusions upon different preliminary assumptions about treatment, treatment effectiveness, and the impact of managed care. The studies predicted potential increases in health care premiums that ranged from 2.5 percent to 11.4 percent. Flaws have been pointed out in several of the studies during the continued national debate on health care and parity. Recent studies[7] include Watson Wyatt, Coopers Lybrand, Milliman & Robertson, the CBO (Congresional Budget Office) Study , and Price Waterhouse. Each of these studies claim to provide a definitive measurof the cost and impact of mental health

STATE PARITY INITIATIVES

In addition to health care reform initiatives being addressed at the federal level, legislative efforts have been undertaken in a variety of states with regard to managed behavioral health care (including mental health, alcohol, and drug abuse services), mandated mental health and substance abuse insurance coverage, as well as mental health parity issues. While managed behavioral health care legislation has been initiated in approximately 18 states, 42 states have some type of legislative mandate for mental health and/or substance abuse service coverage. A total of 28 states have both mental health and substance abuse insurance mandates. However, there are significant, complex, and often times confusing benefit and coverage limitations which vary from state to state (see Table One).

Parity legislation, in its purest form, would include insurance coverage for mental health, alcohol, and drug abuse services that would be equal to insurance coverage for any physical disorder in terms of annual or lifetime limitations (service and/or dollar maximums, copayments, and deductibles). Nevertheless, many current (as well as pending) parity legislation have been heterogeneous in their coverage provisions (see Table One). Five states (Maine, Maryland, Minnesota, New Hampshire, and Rhode Island) currently have passed parity legislation. Two states (North Carolina and Texas) have passed parity laws that require health plans to offer state and local government employees treatment for mental disorders equal to the treatment for somatic disorders while another 17 states are currently considering mental health parity legislation or are "studying" the issue. Of the 22 states that have either passed mental health parity legislation or are currently considering legislation, 11 states (would) provide parity coverage for all mental disorders and substance abuse, while 11 states (would) provide parity coverage only for individuals with biologically-based severe mental disorders.

The following paragraphs briefly summarize the mental health parity legislation which was passed in each of the five states.[8] The final parity legislation which was passed in each state were not identical. For example, while Maryland and Minnesota required parity coverage for all mental disorders as well as substance abuse, Maine, New Hampshire, and Rhode Island required parity coverage restricted specifically to biologically-based mental disorders.

Maine. [9]

Maine initially enacted a law in 1992 requiring parity for specific biologically-based mental disorders. This law was later allowed to "sunset." Nevertheless, in 1995, an amendment was passed (effective 1 July, 1996) that mandated health policies (in group contracts covering more than 20 persons) to provide nondiscriminatory coverage for the following mental disorders: schizophrenia; bipolar disorder; pervasive developmental disorder or autism; paranoia; panic disorder; obsessive-compulsive disorder; and major depressive disorder. This legislation also required other (group or individual) policies and nonprofit hospitals and health plans to offer nondiscriminatory mental health coverage. This law does not provide coverage for the treatment of alcoholism or drug dependence.

The Maine parity law provides for at least 60 days per calendar year for inpatient services, and at least $2,000 for any combination of day treatment and outpatient care, with a maximum lifetime benefit of at least $100,000 for the aggregate costs associated with a mental disorder.

Maryland [10]

After 25 years of debate and three years of intensive discussion, Maryland became the first state to enact parity legislation for mental disorders and substance abuse in 1994.[11] The law requires non-discriminatory coverage for any person with a mental illness, emotional disorders, drug abuse, and alcohol abuse. The law also requires companies with 50 or more employees to provide for inpatient coverage for mental health and substance abuse treatment vis-a-vis with inpatient coverage for physical illnesses. The law allows various copayments for outpatient services.

The Maryland parity law provides for at least 60 days of inpatient care, 60 days for partial hospitalization, outpatient medication management (visits equal to visits for physical illnesses), psychotherapy with no annual limitations, and graduated copayments based upon the number of outpatient visits. Partial hospitalization is also a required service benefit.

Minnesota.[12]

In 1995, Minnesota passed legislation requiring parity for all mental disorders and substance abuse. The law stipulates that "cost-sharing requirements and benefit or service limitations for inpatient and outpatient mental health...and chemical dependency services must not place a greater financial burden on the insured or enrollee, or be more restrictive than requirements and limitations for outpatient medical services...and inpatient hospital medical services (p. 38)"

This parity law prohibits cost-sharing and service limitations for inpatient and outpatient mental health and chemical dependency services from being more restrictive or placing a greater financial burden on the insured than those requirements and limitations for inpatient hospital medical services and outpatient medical services.

New Hampshire [13]

New Hampshire passed parity legislation in 1994 (effective 1 January, 1995). In New Hampshire, mental illness was defined as "a clinically significant or psychological syndrome or pattern that occurs in a person and that is associated with present distress, a painful symptom, or disability, impairment in one or more important areas of functioning, or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom (p. 937)." The law requires that insurers, hospitals, medical service corporations, and health maintenance organizations (HMOs) that provide health benefits shall provide nondiscriminatory coverage for the following (biologically-based) mental illnesses: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; and pervasive developmental disorder or autism. The New Hampshire law provides for coverage for diagnostic and treatment services which are equivalent to coverage provided for physical disorders.

Rhode Island. [14]

Rhode Island passed parity legislation in 1994 (effective 1 January, 1995). In Rhode Island, serous mental illness was defined as "any mental disorder that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the illness. The term includes, but is not limited to: schizophrenia; schizoaffective disorder; delusional disorder; bipolar affective disorders; major depression; and obsessive compulsive disorder (p. 2)."

The law requires all health insurers, including HMOs and medical service plans, "to provide coverage for the medical treatment of serious mental illness under the same terms and conditions as coverage for other illnesses and diseases. The law also requires that "insurance coverage offered pursuant to this statute must include the same durational limits, amount limits, deductibles, and co-insurance factors for serious mental illness as for other illnesses and diseases (p. 1)." The law applies to inpatient hospitalization and outpatient medication visits. The law also permits health insurers to seek information from service providers regarding medical necessity and/or the appropriateness of treatment.

North Carolina [15]

This parity law (effective 1 January, 1996) applied to state government employees and covered both mental illness and chemical dependency. "Mental Illness" was defined as "an illness which so lessens the capacity of an individual to use self-control, jugement and discretio in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control (for adults)." For minors, the definition was "a mental condition, other than mental retardation alone that so impairs the youth's capacity to exercise age adequate self-control, or judgment in the conduct of his activities and social relationships so that he is in need of treatment."

Texas [16]

Legislation was passed in Texas (effective 1 September, 1991) which applied to all state and local government employees. In Texas, "biologically based mental illness was defined as "a serious mental illness that current medical science affirms is caused by a physiological disorder of the brain and that substantially limits the life activities of the person afflicted with the illness." Ther term "biologically based mental illness" included: schizophrenia; paranoid and other psychotic disorders; bipolar disorders (manic-depressive disorders); major depressive disorders; and schizo-affective disorders.

Other States [17]

Louisiana, North Dakota, Oklahoma, and Virginia were all states that had task forces and/ or commissions created by their respective state legislatures to study parity legisative proposals. All of the states with the exception ot Louisiana, were examing both mental health and substance abuse parity issues.

Impact of Parity Legislation

As the preceding paragraphs (together with Table One) suggest, there is considerable variability in how states define, determine eligibility standards, and set service limitations for mental health and substance abuse parity legislation throughout the United States. Thus, while parity in Maryland means coverage for all mental disorders and substance abuse treatment vis-a-vis coverage for physical illnesses, parity in New Hampshire refers to treatment coverage for specific biologically-based severe mental disorders. Furthermore, current exemptions in state insurance regulations potentially further limits the number of companies (thus individuals) forced to comply with state mental health parity laws and other (mental health and substance abuse) insurance coverage mandates. For example, in Maryland, companies with fewer than 50 employees have been exempt from the parity law, along with self-insured companies. Also, for those with individual health policies, parity is optional. Finally, the Federal parity law would permit states which have passed more comprehensive or “greater” mental health parity legislation to exempt themselves from Federal law.

What impact do these state parity laws have on the organization, financing, and delivery of mental health and substance abuse services? At the present time, since state parity laws have been enacted only several years, relatively few states have sufficient experience to evaluate the impact parity on service costs. Nevertheless, there have been several cases documented in the literature which highlight the experience of selected organizational health costs since parity has been implemented in selected states.[18]

Minnesota

A large managed health care organization in Minnesota, Allina Health System, recently reported that the parity law for mental health and chemical dependency would add $0.26 per member per month for the 460,000 enrollees. Another major insurer in Minnesota, Blue Cross/Blue Shield, reduced the insurance premium by 5%-6% in health plans it writes for small businesses in the state after one year’s experience under the Minnesota parity law. Additionally, the Minnesota Comprehensive Health Association, which directs the high-risk re-insurance pool for individuals in Minnesota who are uninsurable, raised the lifetime cap for its covered members. Finally, the Minnesota Department of Employee Relations, Employee Insurance Division, reported that, under the Minnesota parity law, there would be a 1%-2% premium increase in the cost of health insurance for all state employees.

Maryland

The Maryland Health Resources Planning Commission has reported continued decrease of inpatient stays in psychiatric units of general hospitals one year after passage of Maryland’s parity law. Only 11 individuals were hospitalized for more than 60 days in 1995, compared to 21 people in

1993. In 1993, the number of individuals staying longer than 20 days in private psychiatric hospitals was 24%, while in 1995, one year after passage of the parity law, it was less than 18%. In Maryland, full parity in all state regulated plans upped costs by .6% per member per month.

Most importantly, in both Minnesota and Maryland legislatures, no attempt has been made to repeal or amend their respective parity laws. This suggests that insurers and employers have not had difficulty in complying with nor have experienced significant cost and utilization increases because of the implementation

MANAGED CARE

The concept of "managing" health care can be traced to the early part of the twentieth century and the evolution of prepaid health plans in the United States. While the growth of manage care has gone through a number of major evolutionary stages, managed care strategies have remained an evolving array of health care review and service coordination mechanisms which utlimately attempt to control (reduce) health services utilization and costs. The predominant managed care systems include health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

With the proliferation of state mandated mental health and substance abuse benefits in the 1980s, managed behavioral health care companies were created to manage the behavioral health benefits within health insurance plans as well as to manage mental health and substance abuse benefits which were contracted out or "carved-out" from HMOs and PPOs. The number of people receiving mental health benefits through managed care arrangements has grown from 78 million people in 1992 to 124 million people in 1996. [19]

More recently, the continued rise in the costs of health and mental health care has created managed care opportunities for Medicare and Medicaid enrollees. For example, a recent national survey [20] has found that 43 states had obtained Medicaid waivers to provide innovative approaches to organize and finance mental health services through various carve-out strategies.

As managed care continues to evolve and change in order to meet the continuing need to control health and mental health costs while maintaining quality care, what impact will the increasing number of parity initiatives have on the use of managed mental health care? In addition, what impact will current trends in mergers and acquisitions in the managed care industry have upon parity efforts in states across America? While these important questions need to be addressed beyond the confines of this report, it appears that state mental health parity legislation, by eliminating (or modifying) discriminantory caps (annual/lifetime limitations) for mental health coverage, will provide health plans and employers opportunities to control service utilization and cost through managed mental health care.[21] Nevertheless, the use of benefit design limitations, copayments, and deductibles remain important options for modifying parity legislation.

COSTS

United States

Health expenditures in the United States have increased dramatically over the past three decades. National health expenditures were approximately $131 billion in 1975, $428 billion in 1985, and $949 billion in 1994. As a percentage of the United States gross domestic product, national health care expenditures have increased from 8.0% in 1975 to 10.2% in 1985 to 13.7% in 1994. While both hospital care and physician services as a percentage of national health expenditures have decreased between 1990 and 1994, long term (nursing home) care as a percentage of national health expenditures has increased.[22]

Costs associated with mental disorders and substance abuse have been substantial. In 1990, the nation spent $54 billion in direct costs for mental health and substance abuse services. These disorders cost the American economy (in 1990) over $314 billion a year in total direct and indirect costs ($150 billion for mental disorders, $99 billion for alcohol abuse and alcoholism, and $67 billion for drug abuse), including mental health treatment costs, other treatment costs (related health care costs), housing assistance, law enforcement and public safety, and lost productivity (due to injury, illness, or premature death).[23] These total costs to society for mental disorders and substance abuse far exceed the costs of cancer ($104 billion), respiratory disease (99 billion), AIDS ($66 billion), or coronary heart disease ($43 billion).

For example, the economic cost of treating depression in the United States in 1995 was $44 billion, more than the costs for treating strokes or osteoporosis.[24] In 1990, the total direct and indirect costs of treating schizophrenia was $33 billion.[25]

The total impact of individuals with mental disorders on the criminal justice and corrections system have been estimated at between $1.2 billion to $1.8 billion (1993-1994). Approximately 8 to 20 percent of state prison inmates suffer from a serious mental disorder, resulting in a total state corrections cost of $245 million to $619 million (in 1995-1996). About 40 to 65 percent of the prison population are chemically dependent. Additionally, approximately 7 to 15 percent of county jail inmates have a serious mental disorder, resulting in probation costs ranging from $59 million to $118 million. About 10 percent of all arrestees have a serious mental disorder.[26]

Florida

While Florida currently ranks 9th in total state mental health expenditures, it ranks 42nd in per capita state expenditures for mental health services. Estimates of the cost of mental health services (not including alcohol and drug abuse services) have recently been examined by Stiles and Petrila.[27] They used a combination of two 1994 data sources to estimate the mental health costs in Florida: the Alcohol, Drug Abuse, and Mental Health Program Office of the Florida Department of Health and Rehabilitative Services (ADM) and the Agency for Health Care Administration (AHCA). The ADM

data source consisted of information collected from organizations which received financial support from ADM, excluding general and private hospitals during 1994. The 1994 AHCA data contained information from all non state-supported hospitals and based upon Medicare and insurance revenues reported by the hospitals which had individuals with mental disorders. However, substance abuse diagnoses were not included in this data set.

The estimated costs of mental health services have been provided in Charts 1 through 8. [28] Chart 1 contains the total costs of mental health services in Florida by type of service, and Chart 2 shows the percent of expenditures for mental health services by patient care type, with a continued emphasis on the treatment of mental disorders in hospital settings.

Chart 3 contains the estimated costs of mental health services in Florida by type of service and source of revenue. It is clear from this chart that most funds for mental health services in Florida supported state hospitals, while community hospitals received funds from entitlement programs and insurance providers.

Charts 4 and 5 contain the percentage of total expenditures for mental health services in Florida by source of revenue and by type of service. Local government and state ADM expenditures accounted for approximately one third of the total expenditures for mental health services in Florida. Additionally, while hospital mental health services were funded evenly by state ADM, Medicaid, third party insurers, and Medicare funding, nearly two-thirds of expenditures for outpatient mental health services in Florida were funded by state ADM and third party insurance.

Charts 6 and 7 (ADM data only) illustrate the projected costs of mental health services in Florida, while Chart 8 displays the projected costs of mental health services by type of service setting. These charts illustrate the doubling of costs by the year 2010, with current costs exceeding one billion dollars.

Entitlement Programs

Established in 1965 as Title XIX of the Social Security Act, Medicaid programs have been required by law to provide eligible individuals with certain act and long term benefits. This program is administered by the Health Care Financing Administration. Nationally, approximately 6 million people qualified for Medicaid in 1994. In Florida, there were 1,870,113 individuals who qualified for Medicaid in the 1993-1994 fiscal year, at a cost of $4,761,614,293. [29]

Nationally, in fiscal year 1994, disabled individuals comprised about 15 percent of the Medicaid population and accounted for 39 percent of the Medicaid expenditures, including long-term care. [30] The Medicaid expenditures (per person) for individuals with disabilities averaged $2,072 for inpatient services; $443 for physician, lab, and x-ray services; $773 for outpatient services; $1,183 for prescription drugs, case management, therapy, and other practitioner care, and $3,485 for long-term care, for a total of $7,956 for all services. Unfortunately, information for breakout by mental disability was not available.

In Florida (1993), there were 200,518 disabled workers receiving Social Security benefits, at a total cost of $130,518,000 per month to the state of Florida. In 1994, there were 166,160 individuals

with disabilities in Florida who received Supplemental Security Income at a total of $104,001,000.[31] Unfortunately, no information was available for individuals with mental disorders.

In 1994, in Florida, there were a total of 43,879 individuals with a mental disorder (other than mental retardation) receiving Supplemental Security Disability Income, including 31,000 adults and 12,879 children.

What Can Be Gained from Parity

Although the signing of the amendment is a historic event for the mental health field, eliminating lifetime and annual caps for mental health coverage was already in place in the federal employees' health benefits plan in an executive order signed by President Clinton in 1993. Insurance companies immediately lowered the number of inpatient and outpatient visits for mental illness and raised copayments.

As one reads through the Senate and House activity throughout the debate on health care reform, one sees the issue of parity surfacing again and again with the inclusion of parity in the Medicaid debates, the inclusion of parity in the federal employees' health coverage plan, and the overwhelming support of the concept of parity in services shown by the votes in both the Senate and the House.

The ending of the caps on lifetime benefits is just a start. The larger issue parity proponents face is *affordability* of coverage which can still be problematic through discriminatory copayments, deductibles, and time limits.

There were, and are, a number of different aspects of the parity issue. The first was the struggle with American business interests who were resistant to any change. However, the passage of the Health Insurance Reform Act bans insurance companies from excluding people with a pre-existing conditions and allows insurance portability. The second front was the struggle to keep the language inclusive.

The debate over President Clinton's Health Security Act proposal and subsequent Congressional proposals showed that mental health and substance abuse coverage was a, if not the, major stumbling block to health care reform. There are three areas of disagreement in the various cost estimate studies that were produced. These were:

- the impact of managed care;
- the cost of insuring the uninsured; and
- offset effects (services that, when used, reduce costs in other areas of insurance plans).

Managed care companies have insisted that parity for mental health is feasible. In an open letter to Senator Kassebaum dated September 5, 1996, the AMBHA stated that most artificial benefits limits are arbitrary definitions imposed from the past and are not grounded in documented clinical practice.[32] Managed behavioral health care organizations operate on three assumptions:

- mental illness diagnoses are relatively objective and consistent;

- medical necessity criteria can be operationally defined; and
- the benefits for the treatment of mental illness can be managed for appropriateness and effectiveness.

E. Clarke Ross, executive director of AMBHA, suggested that eliminating discriminatory caps on lifetime and annual caps would not have much of an effect on health plans. Studies have indicated only a fraction of 1 percent of plan enrollees ever exceed the kinds of mental health caps found in the marketplace.[33]

Business interests say that many mental disorders are not clearly definable and treatments can be abused. However, Ian Schaffer, chief medical officer at Value Behavioral Health, [34] says that there are clear, measurable diagnoses and treatments for severe mental illness. Diagnoses which were abused in the past to justify extended hospitalizations, can be met with focused treatment. Though managed care can limit a patient's choice of providers, after a business adopts managed care, mental health care access increases by 15 percent while the business costs drop.[35]

There are social and economic benefits to be gained as a result of insurance parity for mental illness. Children and adults can be successfully treated and integrated back into communities.[36] Employers who offer comprehensive mental health benefits find that employee productivity increases, health improves, and health care costs decrease.[37] When people are denied mental health coverage under private insurance, these costs have the potential to shift over to the public sector. Untreated mental illness can result in physical illness, the inability to work, impaired relationships, and sometimes crime, prison sentences, and homelessness.

EVALUATING BENEFITS FROM MENTAL HEALTH PARITY

The benefits to be achieved from parity in health insurance coverage for severe mental illness can be viewed from a number of levels. Two levels are considered here: the benefits to be gained by society as a whole, and the benefits to be gained specifically by the public sector. The public sector may experience benefits (or losses) in addition to those of society as a whole as a result of shifting of the costs from (to) the public sector to the private sector.

From the societal perspective, the purpose of the mental health parity proposal is to expand and improve the treatment of persons with severe mental illness (SMIs). The benefits of such legislation will be a function of the following variables:

1) increased treatment - the increase in the number of people seeking treatment or the increase in treatment for those already receiving treatment;
2) treatment efficacy rates - the probability that increased treatment will ameliorate the number of persons suffering from SMI;
3) social costs of SMIs - SMIs impose several costs on society - on the individual in treatment, the family; the employer; federal, state, and local governments, and ultimately the taxpayer. Effective treatment of a larger percentage of persons with SMIs can reduce these costs.

Increased Treatment

Approximately 2.8 percent of the adult population in the United States[38] and 3.2 percent of the under 17 population suffer from an SMI. [39] It has been estimated that in a given year approximately 60% of these adults receive outpatient treatment for their SMI and 17 percent receive inpatient care. For children, the respective figures are 29 percent and 10 percent. [40] The limited coverage for SMIs in many current health insurance policies increases the cost of treatment to the patient and/or the health care provider, and thus provides a disincentive to seeking treatment. The National Advisory Mental Health Council relying on results from a Rand study, estimates that the outpatient utilization rate would increase to 80 percent under parity.[41] However, this calculation appears to be in error. The Rand study stated a 20 percent increase in utilization, not a twenty percentage point increase. If the service utilization rate was 60 percent, this indicates a percentage increase to 72 percent. An increase to 80 percent utilization indicates a 33 percent increase. The state of Massachusetts reported a 5 percent increase in the number of persons using services after implementing a more comprehensive, flexible plan for dealing with the treatment of mental illness.[42] In addition to this "pent-up" demand, the more comprehensive coverage provided under a parity plan can also increase the utilization of services by persons who currently seek treatment, e.g. the 30-day limit on inpatient care is a characteristic of some current insurance plans which is alleged to restrict treatment to those who run up against this constraint. A report by Milliman and Robertson[43] estimated that, for the state of Florida,

the parity law would increase the total number of days for inpatient mental health service stays for those currently utilizing the system by 4.7 percent.

Treatment Efficacy Rates

Treatment of severe mental illnesses (SMIs) can be effective. The National Institute of Mental Health reports the following treatment efficacy rates [44]:

Schizophrenia	60 percent
Major Depression	65 percent
Bipolar Disorder	80 percent
Panic Disorder	70-90 percent

Furthermore, the availability of more comprehensive coverage can result in more effective treatment methods being utilized, thus improving the probability of success as well as reducing costs.

Social Costs

Using the classification developed by Clarke et al,[45] the costs associated with severe mental illness can be classed as follows:

A. Direct Treatment Costs: Inpatient and Outpatient
B. Related Medical Treatment or Assistance Costs
  1. Medical Treatment for Related Physical Illness
  2. Costs to Families (Monetary, time, mental stress)
C. Indirect Costs
  1. Maintenance Costs: including costs of housing assistance, administrative costs of transfer payments
  2. Legal. Law Enforcement, and Public Safety: costs associated with increased arrests, court appearances of people with SMIs; and
  3. Lost Productivity and Productive Capacity: the cost to employers of increased absenteeism and less effective work performance by persons with mental illness (and their families) as well as reduction in the labor force as a result of premature death of those with SMIs.

The relationship of each of these costs to parity proposals is addressed below.

Direct Treatment Costs

It has been estimated that in 1990 the direct costs for severe mental illnesses for the country equaled $20 billion.[46] Because the primary purpose of parity legislation was to increase utilization of treatment services, direct treatment costs would presumably increase under a parity bill. Indeed, such increases would be considered a cost associated with the legislation, rather than a benefit. No attempt is made here to estimate those costs, but other studies have indicated that such costs, in the form of increased premium payments, would be relatively small. However, as noted, the increased flexibility and comprehensiveness of treatment allowed by parity plans do hold out the promise of more cost-effective treatment. For example, if under a parity plan patients have more access to outpatient

services, rather than being forced into inpatient treatment due to insurance restrictions, then treatment may become more cost effective as well as medically effective. The experience of Massachusetts, referred to earlier, resulted in a 22 percent reduction in expenditures, despite a 5 percent increase in the number of persons utilizing the services.[47] Furthermore, it is possible that a parity proposal will alter the mix of service providers. A parity proposal will shift some of the costs of caring for persons with SMIs from the public sector to the private sector. Private sector coverage has in the past relied more heavily on community outpatient service than has publicly funded insurance. State expenditures in particular are highly weighted toward state hospital inpatient treatment. This potential shift in service providers should prove to be cost effective.

Related Medical Treatment or Assistance Costs

It has been estimated that the treatment of mental disorders can reduce general health care costs by approximately 10 percent[48] as a result of improved physical condition of the patient. Furthermore, improved treatment can reduce the burden of care imposed on the families of persons suffering from severe mental illnesses. A recent study estimated the cost of family care giving in 1990 at $2.5 billion.[49] Another study found that families of persons with severe mental illness spend over $300 per month on support and over 40 hours of informal care.[50] While direct monetary treatment costs would presumably be included in the direct treatment of cost figures given above, the 40 hours of time, along with any supplemental care (costs), would represent additional costs to society which improved treatment should reduce.

Indirect Costs

Persons with SMIs often require assistance in funding, if not outright provision of, housing. They are also likely to utilize the services of state and federal social services agencies, and they can become involved with the criminal justice system due to their erratic and occasionally violent behavior. These costs were estimated to total approximately $1.0 billion in 1990.[51] This figure does not include the actual transfer payments made by social service agencies. Such payments, from society's perspective, either represent a transfer payment, not a resource cost, or are already included in direct treatment costs.

Persons with SMIs often face problems at work, either due to decreased effectiveness while working or due to increased absenteeism. Furthermore, the increased mortality rates associated with SMIs lowers the productive capability of the economy. In 1990, the costs of lost productivity to the economy from SMIs was estimated to be $44 billion.[52] A more recent report by the Massachusetts Institute of Technology Sloan School of Management reported lost productivity from clinical depression was $28.8 billion in 1995.[53]

An Overall Estimate

The National Advisory Mental Health Council has attempted to estimate for the United Sates the annual benefits from mental illness parity. They estimated that the annual savings in indirect costs

would be $7.5 billion, and the annual saving in general health care costs would be an additional $1.2 billion.[54] It is worth noting that these benefits would be gained at an additional cost to society of $6.5 billion, thus yielding a net gain to society from mental illness parity of $2.2 billion annually.

Further Benefits from the State's Perspective

The passage of a mental illness parity law would also benefit the state of Florida in a manner not noted above. Such legislation would shift some of the costs of providing treatment for SMIs from the state (and federal) government to the private sector, specifically to the private business sector (either employer or employee). Currently, the burden of paying for treatment costs that are not covered under private insurance plans often falls on state or federal agencies. For the country as a whole, state and local governmental sources accounted for 31 percent of the funding for treatment of SMIs in 1990. The Federal government, namely Medicaid and Medicare programs, accounted for an additional 26 percent. Nationally, 64 percent of persons with SMIs have private insurance .[55] The increased coverage under private plans should result in some of these costs being transferred to private insurance coverage, and thus indirectly to the businesses that provide such coverage. These increased costs upon the private sector will be reflected either in increased premiums (paid for by either the employer or employee) or reduced coverage for other covered illnesses, which in effect passes the increased costs onto the employee.

A Preliminary Estimate of Benefits for Florida

An idea of the magnitude of the benefits to the state of Florida from a mental illness parity law can be acquired by applying the information above to the relevant data from Florida. In 1995 the population of the Florida was 14.16 million persons, 3.37 million persons under the age of 18 and 10.79 million adults.[56] If Florida has the same incidence of severe mental illness as exists in the country as a whole, then 302,000 adults (2.8 percent times 10.79 million) and 108,000 (3.2 percent times 3.37 million) persons under the age of 18 currently suffer from SMIs, a total of 410,000 persons in Florida. It was estimated by Milliman & Robertson, Inc. that 35.7 percent of Florida's population would be affected by the proposed parity law.[57] (Certain groups are exempted from the proposed legislation, most importantly the self-insured and those covered by Medicare and Medicaid.) Applying this percentage to the number of persons in Florida with SMIs results in an estimate of 146,300 persons with severe mental illness who will fall under the parity law: approximately 107,800 adults and 38,500 persons under the age of 18.

If treatment utilization rates in Florida are roughly comparable to rates for the rest of the country, then 60 percent of these adults (64,700) and 29 percent of the persons under age 18 (11,200) are currently receiving treatment for severe mental illness (annual average). If the parity law, via its reduced price of treatment, increases the number of persons with severe mental illness who seek treatment by 120 percent, then approximately 13,000 additional adults and 2,200 additional persons under the age of 18 will seek treatment, a total of approximately 156,000 persons. If treatment efficacy rates average around 70 percent, then approximately 10,500 of these persons will show

substantial improvement in their SMI. Nationwide, the annual per person social costs of severe mental illness has been estimated to be approximately $6,700. (Note: This figure was derived by dividing the estimated $47 billion "indirect and related costs" from the NMHAC report of severe mental illness in 1990 by the 7 million persons -- 5 million adults and 2 million persons under age 18 -- who suffered from severe mental illness. Multiplying this figure by the estimated 10,500 persons who will show significant improvement from treatment for severe mental illness they will now seek because of parity legislation yields an estimated annual social benefit for the state of Florida of $70.5 million).

This is obviously a very rough estimate, relying on several relationships that should be verified and refined by additional research. It is likely that it represents a lower bound estimate. In 1990, 5.2 percent of the nation's population lived in Florida. As noted above, it was estimated that in 1990 a nationwide parity law would yield $7.5 billion in benefits as a result of reduced social costs (plus an additional $1.2 billion in reduced health care costs for physical illness). If these benefits were allocated on a population basis, Florida's share of the benefits would equal $390 million (plus an additional $62 million in reduced health care costs), more than five times the level of benefits estimate above. Furthermore, the estimate omits several factors that should be accounted for in a more complete analysis. Most notable among these are:

1) the increased treatment utilization of those who are currently receiving treatment;
2) the improved cost effectiveness in treatment that should occur as a result of the law;
3) the reduction in costs for physical health care; and
4) the financial benefit to the state of the transfer of treatment costs to the private sector.

CONCLUSIONS

Florida, together with 21 other states in America, has the opportunity to establish a policy for parity in health benefits for mental health vis-a-vis somatic health services. Based upon the limited experiences of other states, this initiative will provide both insurance coverage particularly for individuals with severe mental disorders as well as reduce the total costs to residents who live in Florida.

Parity for severe mental illnesses could also yield high economic and societal benefits. Many Americans will be able to participate more productively at home, at work, and in the community. Substantial numbers will no longer need to impoverish themselves to obtain coverage under Medicaid or marginally subsist on SSDI. According to a National Advisory Mental Health Council report,[58] parity for severe mental illness can produce a 10 percent decrease in the use and cost of medical services for these individuals. The report predicts that annual savings in indirect costs and general medical services could amount to approximately $8.7 billion. Thus, with the anticipated expense of adding parity coverage at $6.5 billion, the net savings would be approximately $2.2 billion.

There is substantial evidence in the literature that both mental health and addictions treatment are effective in reducing the utilization and cost of medical services. In other words, the reduction in medical costs would offset the cost of providing mental health (or substance abuse) services.[59] [60] Additionally, savings have been found in “collateral cost-offsets,” where there is a reduction in the utilization and costs of medical services by families of individuals when a family member receives treatment for substance abuse.[61]

In an effort to continue to assess both the clinical and policy impact of state parity laws on treatment effectiveness and outcomes, the Substance Abuse and Mental Health Services Administration has recently awarded a $250,000 one year contract to Mathematica Policy Research to examine the impact of parity on the costs of mental disorders and substance abuse.[62] This analysis will summarize the various studies of parity at the national level and prepare cost estimates for parity as well as examine the impact of parity laws on mental health costs based upon the experiences in the five states mentioned above.

Parity efforts in the individual states vary dramatically, due to the changing definitions of mental disorders, the scope of the parity provision (total provision of mental health and substance abuse service coverage or partial provision of only mental health services), the existence of managed mental health initiatives within the state, and existing insurance mandates. As consumers, payors, and providers of mental health services increasingly become focused on outcomes-oriented data, states will need to reorganize massive amounts of data and link databases in order to monitor mental health care and assess outcomes associated with that care.[63] Florida is an excellent position to answer questions on the prevalence of mental disorders as well as the costs of such services within the various behavioral health care delivery systems throughout the state.

APPENDIX 1 Tables and Charts

Table 1 - Parity and Mandated Benefits- a State and State Listing

Table 2 - Estimates of the Number of Persons with Mental illness by Age, Race, and Sex, 1995-2010

Chart 1 - Total Dollars Spent on Adult Mental Health by Service Type

Chart 2 - Percent of Total Dollars Spent on Adult Mental Health by Patient Care Type

Chart 3 - Estimated Cost of Mental Adult Health per Service Type

Chart 4 - Percent of Adult Mental Health Dollars by Revenue Source

Chart 5 - Percent of Adult Mental Health Dollars Spent by Service Type Revenue Source

Chart 6 - Projected Cost of Adult Mental Health to 2010 Excluding AHCA, Medicare, Insurance and Other

Chart 7 - Projected Cost of Mental Health to 2010 Excluding Medicare and Third Party

Chart 8 - Projected Cost of Mental Health to 2010 by Service Type

Table 1
Summary of State Parity Legislation and State Benefit Mandates

STATE: PARITY/MANDATE LEGISLATION	COVERAGE	STATUS	IMPACT OF PARITY
ALABAMA parity: no data available	parity: no data available	parity: no data available	no data available
mandate: 27-20A-1 to 27-20A-4 (group)[1]	mandate: alcoholism: IP--30 days or formula: 3 OP = 1 IP day, 1 IP day = 2 days P/R [2].	mandate: alcoholism: mandated offering, limited to certain types of policies [1]	
ALASKA parity: no data available	parity: no data available	parity: no data available	no data available
mandate: alcoholism/drug abuse: 21-42-365 [3]	mandate: alcoholism/drug abuse coverage: IP/R-- $7,000/2-year period; $ 14,000 lifetime max [2]; payments, deductible, co-payments equal to other illnesses [3]	mandate: alcoholism/drug abuse: man-dated coverage, limited to certain types of policies [1]	
ARIZONA parity: HB 2436, SB 1040 introduced 1996 [7]	parity: proposed bills for all mental disorders and substance abuse/ addictive disorders [7]	parity: cost benefit review in progress [4]	no data available
mandate: no data available	mandate: no data available	mandate: no data available	
ARKANSAS parity: no data available	parity: no data available	parity: no data available	no data available
mandate: mental illness: 23-86-113; alcoholism/drug abuse: 23-79-139[3]	mandate: mental illness: max 20% co-payment, max not less than $7,500/ year[3] / alcoholism/drug abuse: min $6,000/2-year period, max $3,000/ any 30-day period; lifetime max not less than $12,000; same basis as other illnesses [3]	mandate: mental illness and substance abuse: mandated offering, limited to certain types of policies [1]	
CALIFORNIA parity: SB 381 carry-over from 1995 [7]	parity: proposed bill: biologically-based severe mental disorders only [9]	parity: no movement since referred to the Committee on Public Employees Retirement and Security [10]	no data available
mandate: mental illness: 10125, 10123.15[3] alcoholism/drug abuse: 10123.6 et. al.[3]	mandate: mental illness: acute care, IP/ OP; same cov. for bio-based SMI as for other brain disorders; alcoholism: negotiated between group and carrier[3]	mandate: mental illness and substance abuse: mandated offering, limited to certain types of policies [1]	
COLORADO parity: SJR 17, carry-over from 1995 [7]	parity: proposed bill: all mental disorders [7]	parity: pending	data not available
mandate: mental illness: 10-8-116; alcoholism: 10-8-301	mandate: mental illness: IP--45 days; can trade 2 days P/R for 1 IP day; 59% co-pay for major medical; alcoholism: IP--45 days, OP--$500 limit; 50% co-pay[3]	mandate: mental illness: mandated coverage, limited to certain types of policies; substance abuse: mandated offering, limited to certain types of policies [1]	
CONNECTICUT parity: HB 5389 introduced 1996 [7]	parity: proposed bill: all mental disorders [7]	parity: pending	data not available
mandate: mental illness: 38-174D et. al.; alcoholism: 38-262B; drug abuse: 38-174I	mandate: mental illness: IP--60 days, OP--50% to $2,000, P/R--120 days (2 days P/R = 1 day IP). Alcoholism: P/R--45 days, IP--same as other illnesses, must offer OP benefits. Drug abuse: IP--30 days, $OP--500[3]	mandate: mental illness: mandated coverage, limited to certain types of policies; substance abuse: mandated coverage [1]	
DELAWARE parity: HB 340, carry-over from 1995 [7]	parity: proposed bill: all mental disorders and substance abuse and addictive disorders [7]	parity: in Economics Committee since 6/95 [10]	data not available
mandate: no data available	mandate: no data available	mandate: no data available	
FLORIDA parity: HB 19, SB 204 introduced 1996 [7]	parity: proposed bill: biologically-based severe mental disorders only [7]	parity: pending	data not available
mandate: mental illness:	mandate: mental illness: IP--30 days,	mandate: mental illness and substance	

627.668; alcoholism/drug abuse: 627.669[3]	same as other illnesses, OP--$1,000 annual (co-pays may vary from other illnesses); P/R-- max cost of 30 IP days. Alcoholism/drug abuse: OP--44 visits, $35/visit[3]	abuse: mandated offering, limited to certain types of policies [1]	
GEORGIA parity: SR 437 introduced 1996 [7]	parity: proposed bill: all mental disorders and substance abuse and addictive disorders [7]	parity: pending	SR 437 introduced in form of resolution--would lack the force of law if passed [7]
mandate: mental illness: 33-24-28.1 [3]	mandate: mental illness: IP--30 days (individual), 60 days (group); OP--48 (individual), 50 (group)[3]	mandate: mental illness: mandated offering [1]	
HAWAII parity: SB 3260 proposed 1996 [7]	parity: proposed bill: all mental disorders and substance abuse and addictive disorders [7]	parity: pending	data not available
mandate: mental illness, alcoholism, drug abuse: 393-7(6)[3]	mandate: mental illness, alcoholism, drug abuse: IP--30 days, OP--12 visits; trade 2 days P/R for 1 IP day; deductibles and co-pays not exceed those for other illnesses [3]	mandate: no data available	
IDAHO parity: no data available	parity: no data available	parity: no data available	no data available
mandate: no data available	mandate: no data available	mandate: no data available	
ILLINOIS parity: SB 294 carry-over from 1995; HB 3630 introduced 1996 [7]	parity: proposed bill: biologically-based severe mental disorders only [7]	parity: in Senate Rules Committee [10]	data not available
mandate: mental illness: 370C; alcoholism: 67 (8)[3]	mandate: mental illness: payment must be at least 50% IP, OP, P/R, annual max $10,000 or 25% lifetime max; alcoholism: not excluded [3]	mandate: mental illness: mandated offering, limited to certain types of policies; substance abuse: mandated coverage, limited to certain types of policies [1]	
INDIANA parity: no data available	parity: no data available	parity: no data available	no data available
mandate: no data available	mandate: no data available	mandate: no data available	
IOWA parity: no data available	parity: no data available	parity: no data available	no data available
mandate: no data available	mandate: no data available	mandate: no data available	
KANSAS parity: no data available	parity: no data available	parity: no data available	no data available
mandate: mental illness, alcoholism/drug abuse: 40-2, 105 [3]	mandate: mental illness, alcoholism/ drug abuse: IP--30 days, 100% first $100, 80% next $100, 50% next $1,640/yr; OP--lifetime max $7,500 [3]	mandate: mental illness and substance abuse: mandated coverage [1]	
KENTUCKY parity: no data available	parity: no data available	parity: no data available	no data available
mandate: mental illness: 304.17-318 et. al.; alcoholism: 304.32.1 58[3]	mandate: mental illness and alcoholism: same as other illnesses[3]	mandate: mental illness: mandated offering; substance abuse: mandated offering, limited to certain types of policies [1]	
LOUISIANA parity: no data available	parity: no data available	parity: no data available	no data available
mandate: mental illness: 22:669; alcoholism/drug abuse: 22:215.5[3]	mandate: mental illness: same as other illnesses; alcoholism/drug abuse: coverage when prescribed by physician[3]	mandate: mental illness and substance abuse: mandated offering, limited to certain types of policies [1]	
MAINE parity: HB 432 1995 [7] (amended 1993 law for mental illness [3])	parity: IP/OP care for biologically-based severe mental disorders only [5] . Max/lifetime limits same as for other illnesses; applicable to groups with 21+ enrollees [3].	parity: effective July 1, 1996 [5]	no data available yet on cost or premium increases [9]
mandate: mental illness: Ch. 24-A, 2843; alcoholism/drug abuse: Ch. 24-A, 2842[3]	mandate: mental illness: IP--30 days, 80% payment; OP $1,000 with 50% payment with $100 deductible Alcoholism/drug abuse: P/R--30 days, 90% payment with $100 deductible, OP--$1,000, 80% payment	mandate: mental illness: mandated coverage; substance abuse: mandated coverage, limited to certain types of policies [1]	
MARYLAND parity: HB 1359 enacted in 1993;	parity: HB 1359 (1993) coverage for all mental disorders; H 756 (1994) coverage for all mental disorders as well	parity: effective July 1, 1994 [5]	1) law applies to companies with 50+ employees [5] 2) allows varying co-payments [8]

H 756 enacted in 1994 [7]	as substance abuse/addictive disorders [7] All co-pays for care equal with exception psychotherapy (special co-pays); applicable groups of 50+ employees [3]		3) law was built upon substantial mental health benefit already in place--law allowed expansion of services [8] 4) trend of shorter stays in inpatient facilities [8] 5) there has been no attempt to repeal or amend this law [8] 6) costs an average of $1.43 per member per month [9]
mandate: mental illness: Ch. 48A, 354D et al; alcoholism/drug abuse: Ch. 48A, 490F [3]	mandate: mental illness: IP--30 days; OP--65% payment for 20 visits, 50% thereafter; P--30 days, 120 days at 75% (halfway house) [3]	mandate: mental illness and substance abuse: mandated coverage, limited to certain types of policies [1]	
MASSACHUSETTS parity: HB 3371 carry-over from 1995 [4]	parity: proposed bill: all mental disorders [4]	parity: pending	data not available
mandate: mental illness: Ch. 175, 47B; alcoholism: Ch. 175, 110H [3]	mandate: mental illness: IP--60 days; OP--$500 alcoholism: IP--30 days; OP--$500[3]	mandate: mental illness and substance abuse: mandated coverage [1]	
MICHIGAN parity: HB 4911, 4912, 4913 carry-over from 1995 [4]	parity: proposed bill: biologically-based severe mental disorders only [4]	parity: in House Committee on Insurance since 5/95 [10]	no data available
mandate: alcoholism/ drug abuse: 500.3425 [3]	mandate: alcoholism/drug abuse: IP--group option; OP--$1,500/yr, with CPI inflator (1990 benefit $2,258)[3]	mandate: substance abuse: mandated offering [1]	
MINNESOTA parity: SB 845 enacted in 1995 [4]	parity: all mental disorders as well as substance abuse and addictive disorders [5] All co-pays, max/ lifetime limits equal to any health problem [3]	parity: effective August 1, 1995 [5]	1) Allina Health System estimates parity adds 26 cents pm/pm for their 460,000 members [8] 2) BC/BS, using managed care utilization, reported 5-6% reduction for small businesses [8] 3) Minnesota Comprehensive Health Association raised its lifetime cap for members in high-risk insurance pool [8] 4) no attempt to either repeal or amend law since its implementation [8]
mandate: mental illness: 62A.152, 62A.151; alcoholism/drug abuse: 62A.149 [3]	mandate: mental illness: IP--no information; OP--80% payment first 10 hours, 75% next 30 hours individual session, double for group session; 62A.151 for children: OP and P/R--same as other illnesses for EH children. Alcoholism/drug abuse: IP--greater of 28 days or 20% total IP days; OP--130 hours[3]	mandate: mental illness: mandated coverage, limited to certain types of policies; substance abuse: mandated coverage and mandated offering [1]	
MISSISSIPPI parity: no data available	parity: no data available	parity: no data available	no data available
mandate: mental illness (no citation); alcoholism: 83-9-27 et al [3]	mandate: mental illness: IP--30 days/yr; OP--50% payment for 25 visits @$50/visit; P/R--60 days; $50,000 max. Alcoholism: same as other illnesses, up to $1,000/yr[3]	mandate: mental illness: mandated offering; substance abuse: mandated coverage, limited to certain types of policies [1]	
MISSOURI parity: no data available	parity: no data available	parity: no data available	no data available
mandate: mental illness: 376.381; alcoholism: 4 CSR 190-14.090; alcoholism/drug abuse: 376.779[3]	mandate: mental illness: IP--same as other illnesses, up to 30 days; OP--50% payment for 20 visits; P/R--50% payment up to $1,500/yr. Alcoholism: IP--same as other illnesses up to 30 days; OP--(in 376.779) 80% payment up to $2,000/yr[3]	mandate: mental illness: mandated offering; substance abuse: mandated coverage [1]	
MONTANA parity: SB 845 enacted in 1995 [3]	parity: coverage for mental illness, alcoholism and drug abuse [3]. Changes in coverage: IP reduced to 21 days, but allows trade 2 days Partial Hosp for 1 IP day; OP mandated minimum benefit	parity: no data available	no data available

	$2,000/yr for MI and $1,000 for alcohol/drug abuse ; and 2 year and lifetime limit for alcohol/drug abuse is $4,000 in 2 yr. Period, $8,000 lifetime max [3] .		
MONTANA continued mandate: mental illness, alcoholism/drug abuse: 33-22-701 [3] (check to see if current)	mandate: mental illness, alcoholism/ drug abuse: IP--30 days/yr; OP--50% payment of at least $1,000; $10,000 or 25% of contract max [3]	mandate: mental illness and substance abuse: mandated coverage, limited to certain types of policies [1]	
NEBRASKA parity: no data available	parity: no data available	parity: no data available	no data available
mandate: alcoholism: 44-770 et. seq.[3]	mandate: alcoholism: "must either provide 30 IP days & 60 OP days or notify applicants that it does not"[3]	mandate: substance abuse: mandated offering [1]	
NEVADA parity: no data available	parity: no data available	parity: no data available	no data available
mandate: alcoholism/drug abuse: 689A.030 et al [3]	mandate: alcoholism/drug abuse: IP--$9,000/yr; OP--$2,500/yr; P/R--$1,500/yr for detox; $39,000 lifetime max [3]	mandate: substance abuse: mandated coverage [1]	
NEW HAMPSHIRE parity: SB 767 enacted in 1994 [4]	parity: biologically-basedSMD only [4] Limit of 90 IP days/yr [3].	parity: effective January 1, 1995 [4]	BC/BS initial data indicated a 1.5% premium increase--actual increase appears much less, but final data not yet available [9]
mandate: mental illness: 415:18 et al [3]	mandate: mental illness: IP--same as for other illnesses; OP--15 hours/yr, paid same as for other illnesses; P/R--must be covered; major medical not less than $3,000/yr [3]	mandate: mental illness: mandated coverage, limited to certain types of policies [1]	
NEW JERSEY parity: no data available	parity: no data available	parity: no data available	no data available
mandate: alcoholism: 17B:26-2 1 et al [3]	mandate: alcoholism: "same as for other illnesses"[1]	mandate: substance abuse: mandated coverage [1]	
NEW MEXICO parity: no data available	parity: no data available	parity: no data available	no data available
mandate: alcoholism: 59-18-24 [3]	mandate: alcoholism: IP--30 days/yr; OP--30 visits/yr; max is 60 days, 60 visits [3]	mandate: substance abuse: mandated offering, limited to certain types of policies [1]	
NEW YORK parity: AB 3039 carry-over from 1995 [4]	parity: proposed bill: biologically-based SMD only [4]	parity: in Assembly Committee since 1/96 [10]	no data available
mandate: mental illness: 3221K(5) et al; alcoholism: 3221K(6) et al [3]	mandate: mental illness: IP--30 days/ yr; OP--30 visits, 3 emergency visits/yr; max is no less than $1,500/yr. Alcoholism: IP--7 day detox, 30 day rehab; OP--60 visits [3]	mandate: mental illness and substance abuse: mandated offering, limited to certain types of policies [1]	
NORTH CAROLINA parity: HB 823 carry-over from 1995 [4]	parity: proposed bill: all mental disorders [4]	parity: pending	voluntary parity for state employees for several years--decrease in MH portion of total health care plan payout noted, approximate cost of $4.60/ month pm/pm [9]
mandate: alcoholism/ drug abuse: 58-251.8 [3]	mandate: alcoholism/drug abuse: "same as for other illnesses"; max in no less than $8,000/yr, lifetime max is $16,000 [3]	mandate: substance abuse: mandated offering, limited to certain types of policies [1]	
NORTH DAKOTA parity: no data available	parity: no data available	parity: no data available	no data available
mandate: mental illness, alcoholism/drug abuse: 26.1-36-0 8 et al [3]	mandate: mental illness, alcoholism/ drug abuse: IP--60 days/yr; OP--30 visits @100% payment for first 5 visits, 80% thereafter; P/R--trade 2 days for 1 IP day [3]	mandate: mental illness and substance abuse: mandated coverage, limited to certain types of policies [1]	
OHIO parity: HB 286 carry-over from 1995 [4]	parity: proposed bill: biologically-based severe mental disorders only [4]	parity: in Insurance Committee since 4/95 [10]	

mandate: mental illness: 3923.28; alcoholism: 3923.29 [3]	mandate: mental illness and alcoholism: $550/yr [3]	mandate: substance abuse: mandated coverage, limited to certain types of policies [1]	
OKLAHOMA parity: SB 799 introduced 1996 [4]	parity: proposed bill: biologically-based severe mental disorders only [4]	parity: pending	main issue: cost 1) law would not apply to groups of 25 or fewer people [4] 2) would affect only small number of employers due to ERISA exemption, high number of self-insured/ small businesses [4]
mandate: no data available	mandate: no data available	mandate:	
OREGON parity: no data available	parity: no data available	parity: no data available	no data available
mandate: mental illness: 743.556; alcoholism/ drug abuse: 743.556 [3]	mandate: mental illness: IP--$4,000 adults, $6,000 children; OP--$2,000; P/R--$1,000 adults, $2,500 children; max $10,500 adults, $12,500 children (including chem dependency tx). Alcoholism/drug abuse: IP--$4,500 adults, $6,000 children; OP--$1,500 adults, $2,000 children; P/R--$3,500 adults, $2,500 children; max $6,500 adults, $10,500 children (chem dependency tx only) [3]	mandate: mental illness: mandated coverage, limited to certain types of policies; substance abuse: mandated offering, limited to certain types of policies [1]	
PENNSYLVANIA parity: HB 2237 carry-over from 1995 [4]	parity: proposed bill: all mental disorders [4]	parity: pending	no data available
mandate: alcoholism: 40-62-10 1 et al [3]	mandate: alcoholism: IP--7 days for detox; 30 visits/cycle plus 30 visits above max; P/R--30 days/yr plus 15 days beyond max; lifetime limits are 4--IP and OP and 3 P/R cycles [3]	mandate: substance abuse: mandated coverage, limited to certain types of policies [1]	
RHODE ISLAND parity: HB 7708 1994 [4]	parity: biologically-based severe mental disorders only [5]	parity: effective January 1, 1995 [5]	preliminary estimates show 30 cents per member per month increase in premiums [9]
mandate: alcoholism/drug abuse: 27-38-1 et al [3]	mandate: alcoholism/drug abuse: IP--21 days or 3 detox periods/yr; OP--30 hrs individual session, 20 hrs family session; P/R--30 days, 90 day lifetime max [3]	mandate: mental illness and substance abuse: mandated coverage [1]	
SOUTH CAROLINA parity: no data available	parity: no data available	parity: no data available	no data available
mandate: no data available	mandate: no data available	mandate: mental illness and substance abuse: mandated offering, limited to certain types of policies [1]	
SOUTH DAKOTA parity: no data available	parity: no data available	parity: no data available	no data available
mandate: alcoholism: 58-17-30 .5 et al [3]	mandate: alcoholism: IP--30 days/6-mo; P/R--same as IP; lifetime max is 90 days [3]	mandate: substance abuse: mandated offering [1]	
TENNESSEE parity: no data available	parity: no data available	parity: no data available	no data available
mandate: mental illness, alcoholism/drug abuse: 56-7-100 3 et al; alcoholism/drug abuse: 56-7-100 1 et seq [3]	mandate: alcoholism/drug abuse: OP--min 30 visits; benefits no less than for physical illnesses [3]	mandate: mental illness and substance abuse: mandated offering, limited to certain types of policies [1]	
TEXAS parity: no data available	parity: no data available	parity: no data available	no data available
mandate: mental illness: Art. 3.70-2(F); alcoholism/drug abuse: Art. 3.51-9 [3]	mandate: mental illness: day tx covered at ½ IP benefits; alcoholism/ drug abuse: "covered the same as other illnesses" [3]	mandate: mental illness: mandated offering, limited to certain types of policies; substance abuse: mandated coverage, limited to certain types of policies [1]	
UTAH parity: no data available	parity: no data available	parity: no data available	no data available
mandate: alcoholism/drug	mandate: "coverage in licensed facilities	mandate: substance abuse: mandated	

abuse: 31- 22-715 [3]	or accredited hospitals" [3]	offering, limited to certain types of policies [1]	
VERMONT parity: no data available	parity: no data available	parity: no data available	no data available
mandate: mental illness: 8-4089; alcoholism: 4097 et seq [3]	mandate: mental illness: IP--45 days/ yr; OP--100% payment first 5 visits, 80% to $500 thereafter; P/R--45 day equiv. Alcoholism/drug abuse: IP--5 days detox/incident; 90 hrs/ occurrence; P/R--28 rehab days per occurrence [3]	mandate: mental illness: mandated offering, limited to certain types of policies; substance abuse: mandated coverage [1]	
VIRGINIA parity: SJR 285 1995 [4]	parity: study of parity [4]	parity: no data available	no data available
mandate: mental illness: 38.2-3412; alcoholism/ drug abuse: 38.2-3412, 38.2- 3413 [3]	mandate: mental illness: IP--up to 30 days/yr; OP--up to $1,000 at 50% payment; same as for other illnesses. Alcoholism--IP--included in mental health package(max 90 days lifetime max); in 38.2-3413 (group contracts only)--IP--45 days/yr; OP--45 visits/yr; P/R--included in IP benefit [3]	mandate: mental illness: mandated coverage; substance abuse: mandate offering [1]	
WASHINGTON parity: no data available	parity: no data available	parity: no data available	no data available
mandate: mental illness: 48.21.240; alcoholism/ drug abuse: 48.21.160 et. al.[3]	mandate: mental illness: benefits not specified[3] alcoholism/drug abuse: $5,000/24-months, $10,000 lifetime limit, covered same as physical illness[3]	mandate: mental illness: mandated offering, limited to certain types of policies; substance abuse: mandated coverage, limited to certain types of policies [1]	
WEST VIRGINIA parity: no data available	parity: no data available	parity: no data available	no data available
mandate: 33-15-4A et. al. for mental illness; 33-16-3C for alcoholism [3]	mandate: mental illness: IP--45 days; OP--50% to $500 for 50 visits/year[3] alcoholism: IP--30 days, OP--50% up to $750, $10,000 lifetime limit [3]	mandate: mental illness and substance abuse: mandated offering, limited to certain types of policies [1]	
WISCONSIN parity: no data available	parity: no data available	parity: no data available	no data available
mandate: 632.89 for mental illness, alcoholism, drug abuse [3]	mandate: mental illness, alcoholism/ drug abuse: IP--30 days or $7,000; OP--90% payment to $1,000[3]	mandate: mental illness and substance abuse: mandated coverage, limited to certain types of policies [1]	
WYOMING parity: no data available	parity: no data available	parity: no data available	no data available
mandate: no data available	mandate: no data available	mandate: no data available	

Summarized 12/96
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Table 2
Estimates of the Number of Persons with Mental illness
by Age, Race, and Sex, 1995-2010

	1995	2000	2005	2010	Percent
Total Florida Population	11,014,012	12,095,616	13,184,043	14,287,630	100%
Severe Mentally Ill (2.8%)	308,392	338,677	369,163	400,053	
Age Distribution					
18-64	305,962	340,543	367,038	394,392	97%
65+	9,965	10,884	11,751	13,050	3%
Gender Distribution					
Male	111,949	113,823	122,726	143,654	35%
Female	203,978	228,701	244,966	263,788	65%
Race Distribution					
White	249,234	272,078	295,509	315,423	81%
Non-White	58,742	66,403	74,572	83,335	19%

Source: Population projections from Florida Consensus Estimating Conference (1995). Figures are based on the ECA estimation of 2.8% of the total population suffers from severe mental illness.

Notes: *(a)* *Prevalence rates for individuals in the youngest end of the distribution (e.g. 18-29) are higher than for individuals in the older ages.*

(b) *It should be noted that affective disorders make up a greater proportion of the severely mentally ill population than schizophrenia. One explanation between the large spread between men and women is explained by the greater number of females with affective disorders.*

(c) *The mathematical variability within 2.8% is such that none of the numbers in the aggregate per demographic distribution will add to the figure derived from 2.8% of the total population. However, when you divide the categorical numbers by their representative totals, each of the numbers equates to approximately 2.8% of the population.*

taken from Petrila, J and Stiles, P Chronically mentally ill: projected needs and costs 1995-2010 In Long-term care in Florida: a policy analysis. Tampa, FL: Florida Policy Center on Aging, 1995.

Chart 1
Total Dollars Spent on Adult Mental Health
by Service Type

Chart 2
Percent of Total Dollars Spent on Adult Mental Health Care by Patient Care Type

Chart 3-
Estimated Cost of Adult Mental Health per Service Type

Chart 4 - Percent of Adult Mental Health Dollars by Revenue Source

Chart 5 - Percent of Total Adult Mental Health Dollars Spent by Service Type Revenue Source

Chart 6 - Projected Cost of Adult Mental Health to 2010 Excluding AHCA Medicare, Insurance and Other

Chart 7 - Projected Cost of Mental Health to 2010 Excluding Medicare and Third Party

Chart 8 - Projected Cost of Mental Health to 2010 by Service Type

APPENDIX 2 - Epidemiology of Mental Illness

National Studies

The best-known and most comprehensive of these epidemiologic studies during the past 15 years was the Epidemiological Catchment Area Study (ECA)[64] begun in 1978. The ECA was unique in several respects. First, it was a very large initiative, with over 20,000 respondents over five catchment areas (New Haven, Durham, Baltimore, Los Angeles, and St. Louis). Second, the study examined prevalence and incidence of mental disorders in the community as well as in institutional settings. The ECA was designed to gather the following information:[65]

> 1.prevalence rates of specific mental disorders as defined by the Diagnostic and Statistical Manual, Revision III (DSM-III);
> 2. residents of households and institutions;
> 3. longitudinal data on the course of specific mental disorders in terms of new cases (incidence), recurrence, and remission rates;
> 4. data on service utilization persons with specific mental disorders, not only of specialty mental health services, but the entire range of health and other human services that comprise the de facto mental health systems; and
> 5 the utility of the DSM-III diagnostic categories, to see if the DSM criteria were useful diagnostic indicators.

The major objective of the ECA was to obtain prevalence rates of specific mental disorders rather than prevalence rates of global impairment. This emphasis was important in an effort to improve the understanding of the etiology, clinical course, and response to treatment of mental disorders. Overall, 20 percent of the people interviewed had an active mental disorder during a given year, with a lifetime prevalence of 32 percent for a mental illness and/or substance abuse. The median age for initial symptoms was 16 years, with 90 percent of the sample experiencing initial symptoms by 38 years of age. The ECA study estimated the prevalence rate for severe mental illness was 2.8 percent. The overall lifetime prevalence rate for severe mental disorders schizophrenia was estimated at about 1.5 percent of the adult population, with a prevalence rate of approximately 1 percent in any given year. For example, schizophrenia is most prevalent in persons between 18-45 with no significant gender or race differences. The impact of schizophrenia varied based on age of onset and race/ethnicity of the person. Variables such as socioeconomic status, education, and marital status were seen as outcomes rather than contributing factors of the disorder.

More than 15 million adult Americans reported symptoms of alcohol abuse or alcoholism. Men between the ages of 18 and 29 had a prevalence rate in excess of 23 percent.[3] Approximately 75 percent of individuals in need of alcohol and drug abuse services do not receive treatment, which has potential for an enormous impact upon the health and stability of individuals, families, and communities.

Another significant study on serious mental illness and co-occurring disorders was the National Comorbidity Survey (NCS).[66] The NCS was designed to improve on the ECA efforts by incorporating DSM-III-R nomenclature and by more extensively examining risk factors that affect particular mental disorders and to determine the comorbidity of psychiatric disorders.[67] Over 8,000 persons between 15 and 54 who lived in the continental United States were interviewed between 1990 and 1992.

Results from the NCS indicated higher lifetime prevalence rates for mental disorders than the ECA, particularly for depression, alcohol dependence, and phobia. The NCS reported a prevalence rate of 3.2 percent compared with the ECA report of 2.8 percent. The lifetime prevalence was 48 percent for any disorder (mental illness or substance abuse), and 29 percent of the respondents reported

at least one mental disorder during the previous 12-month period. Approximately 40 percent of those who reported a lifetime prevalence of at least one mental disorder sought treatment in the mental health specialty sector.

Comorbidity

The National Institute of Mental Health estimated the number of persons with severe mental illness and a co-occurring substance disorder at 1.8 million. In their 1988 study, 15.4 percent (25.6 million) of 166 million Americans over the age of 18 met the criteria for at least one alcohol, drug abuse, or mental disorder.[68] Persons who suffered from a mental illness were more likely to abuse drugs and alcohol. Other findings from the NCS and follow-up reports indicate that 83.5 percent of those with lifetime comorbidity say that their first mental disorder preceded their first addictive disorder, and in general, co-occurring disorders tend to be more chronic than pure psychiatric disorders. [69]

Kessler et al[70] used data from NCS to look at the prevalence of co-occurring addictive and mental disorders, the temporal relationship between these disorders, and the extent to which 12-month co-occurrence was associated with the utilization of services. Mental disorders that were tracked were mood disorders, anxiety disorders, and antisocial personality disorders. Kessler et al. stated that the total number of persons with co-occurring disorders (anyone with both substance disorder and any psychiatric illness as described in DSM) was between 7 million and 9.9 million people, depending on the definition of alcohol abuse [71].

While space does not permit extensive reviews of the results of epidemiologic studies with regard to special populations (e.g., see Levin and Petrila[72]), the paragraphs which follow will briefly summarize the epidemiologic rates in selected populations.

Children and Adolescents

The prevalence of diagnosable mental disorders in children and adolescents has been estimated by Brandenburg and associates[73] to be between 14 and 20 percent and has been estimated by Costello[74] to be between 17 to 22 percent. A report issued in June of 1991 by the U.S. House Select Committee on Children, Youth, and Families [75] stated at least 75 million children, 12 percent of those under age 18, had a diagnosable mental disorder. Half were severely disabled by their disorder. A recent estimate, based upon the Center for Mental Health Services definition of serious emotional disturbance, estimated the prevalence rate of serious emotional disturbance in children and adolescents (ages of 9 and 17 years) was between 9 and 13 percent.[76] Additionally, the suicide rate for young people aged 15 to 24 has tripled during the past thirty years.

Elderly

Individuals 65 years of age and older comprise over 13 percent of the population of the United States, and if present patterns continue, will approach one-third of the population in America by 2050.[77] The prevalence of mental disorders in the elderly have been estimated between 15 to 25 percent.[78] Smyer et al.[79] reported that nearly 88 percent of all individuals in nursing homes have a mental disorder (including dementia as a mental disorder). Additionally, the prevalence of depression among individuals residing in nursing homes ranged between 12 to 22 percent.[80]

Women

Patterns of mental illness do vary considerably by gender, with men and women showing vulnerability to different conditions, e.g. depression occurs at twice the rate in women as it does in men. According to the Commission on Women's Health,.[81] women turn to the health care system more than men do, especially for conditions that do not meet the diagnostic thresholds for mental disorder but are associated with significant distress and functional impairment. Many serious mental health conditions

affect women during their childbearing years. Untreated mental illness in mothers may increase the risk that their children will have psychological problems. As for service use, women are more likely to use outpatient services and primary care providers while men utilize inpatient care and specialists.[82]

Homeless

Studies have shown that one out of every three individuals who are homeless in the United States suffer from a severe mental illness, such as schizophrenia or manic-depression.[83] Persons who are homeless with a serious mental illness can also have an alcohol or drug abuse problem, low socioeconomic status, contact with the criminal justice system, diminished social supports, and be a racial or ethnic minority. Research findings suggest that homelessness is associated with an earlier age of onset of mental illness, co-occurring personality disorders., alcohol or substance abuse disorders, physical illnesses (e.g. AIDS, tuberculosis), and a history of childhood disturbances. [84]

Nationally, there are over 200,000 persons who are homeless and suffer from a serious mental ill-ness. According to the 1995 Florida Statistical Abstract, there are 60,000 individuals who are homeless in Florida. According to Tessler and Dennis,[21] 33 percent of these homeless individuals have a serious mental illness.

Incarcerated Population

Evidence from Robins and Regier[3] also emphasize the increased rate of prevalence of mental disorders and substance abuse and dependence in jail and prison populations vis-a-vis prevalence rates of mental disorder and substance abuse and dependence in the general population. For example, the lifetime prevalence rate for schizophrenia from the ECA study was 1.4 percent in the general population and 6.7 percent in prisons. Similarly, the lifetime prevalence rate for drug abuse and dependence from the ECA study was 7.6 percent in the general population and 56 percent in prisons.

APPENDIX 3 Overview of Parity Legislation

Legislative History

In **1993**, a number of bills offering mental health benefits were introduced. President Clinton introduced the *Health Security Act* (HR 3600). In this plan, mental health and addiction benefits included a combined benefit of thirty days of inpatient care, sixty days of partial care and/or 120 days of outpatient care. Senator Wellstone and Rep. McDermott offered the *American Health Security Act*. This plan offered up to 15 days of inpatient care and 20 days of outpatient care guaranteed. The *Managed Competition Act*, sponsored by Sen. Breau and Rep. Cooper, was dependent upon coverage to be determined by a National Health Board. Rep. Chaffee's *Senate Health Care Task Force Plan* had coverage for severe mental illness and substance abuse services as "medically necessary" and appropriate. Sen. Nickles offered a *Consumer Choice Health Security Plan*. Mental health benefits in this plan were dependent upon the type of insurance purchased. It did exclude the insurer's right to exclude based on prior condition. The last two plans, *House Republican Plan* sponsored by Rep. Michel and the *Reform Proposal* sponsored by Sen. Gramm, offered no mental health benefits.

1994 had a number of reports and surveys on the issue of inclusion of mental health and addictions benefits. A report issued by Families USA, entitled *Better Benefits: Millions Helped by Clinton Reform*, stated that the coverage offered by President Clinton's proposal would give 153 million Americans better mental health and addictions coverage.[85] This figure did not include Medicaid beneficiaries or the uninsured. The report, done by Lewin-VHF, advocated for health and long-term care.

A poll released by the Judge David L. Bazelon Center for Mental Health Law showed that 65 percent of the voters supported inclusion of mental health and addictions benefits in health care reform. The survey, performed by Mellman, Lazarus, and Lake, showed that 62 percent of those polled agreed that mental illnesses should be treated on par with physical illnesses. More importantly, 60 percent of those surveyed said they supported inclusion even if it would cost them $100 more a year. Eighty one percent of those surveyed supported covering outpatient and clinical services as alternatives to hospitalization and 73 percent of those surveyed wanted to see these services covered to the same extent as hospitalization. Surprisingly, 75 percent of those surveyed favored reviewing a patient's treatment at appropriate times, rather than limiting coverage for thirty days.

The House Ways and Means Subcommittee on Health added a $2.5 billion mental health and addictions benefit to House Ways and Means Committee Chair Stark's health care reform plan. The Stark plan had a broad benefits package and gave states the option to create managed mental health programs for adults with severe mental illness and children with serious emotional disturbances.

The Senate Labor and Human Resources Committee supported a comprehensive benefits package for mental health and addictions treatment. However, by April 1994, there was little optimism that comprehensive health care reform with mental health and addictions benefits would be passed. The general feeling was that the Stark bill would undergo major revisions in the full committee markup but elements would appear in whatever plan emerged from the House Ways and Means Committee. Subcommittee Chair Williams of the House Education and Labor Subcommittee on Labor-Management Relations also substantially revised HR 3600, deleting the plan's mandatory health alliances and enhancing basic benefits packages. In addition, Williams' revision included an "organized system of care" provision for the delivery of mental health and addictions services. This system of care ensured that education, child welfare, juvenile justice and other appropriate, related agencies were involved when people under the age of 22 received services. Three amendments offered by Rep. Miller were added, essentially replacing the benefits package devised by Rep. Stark and approved by the House Ways and Means Committee.

Meanwhile, in the Senate, the benefits package unveiled by Senator Kennedy and cosponsored by Sen. Wellstone and Rep. McDermott was the most comprehensive proposal for coverage of mental health and addiction benefits.

By June, the Senate Finance Committee drafted a health care reform bill that called for parity for mental health and addiction benefits. Finance Committee Chair Moynihan offered a draft which placed mental health services to be treated on par with physical illnesses. The House Ways and Means Committee chaired by Rep. Gibbons also began marking up a reform bill whose mental health and addictions package built upon a previous plan submitted by the panel's subcommittee on health (the Stark plan). In July, the Senate Finance Committee endorsed parity for mental health and substance abuse benefits.

Senators Domenici**,** Kennedy, Moynihan, and Wellstone sponsored an amendment in August defining the Mitchell bill's promise of parity for mental health and addiction services. An alternative plan by Sen. Chaffee called for a national commission to make parity a priority within the actuarial constraints set in the act. It also had two levels of benefit plans, encouraged medically necessary or appropriate services and psychologically appropriate services, and use of outpatient treatment whenever possible.

1995 saw the reintroduction of the health care debate. In January, Senator Daschle reintroduced a bill considering parity for mental illness and substance abuse services with respect to cost-sharing and duration of treatment. His bill offered a benchmark plan, modeled on the congressional health plan offered by Blue Cross and Blue Shield.

The report, *Turning the Corner: New Ways to Integrate Mental Health and Substance Abuse in Health care Policy* was released by the Judge David L. Bazelon Center for Mental Health Law.[86] In its section on adapting federal debate to state reform efforts, the report urged that all comprehensive-reform legislation include a comprehensive mental health and substance abuse benefit with coverage of services normally funded though the public system; incorporate the benefit into basic health care to facilitate an integrated health system; and place no arbitrary restrictions on outpatient and community services.

In March, Representatives Fawell and Thomas introduced bills which limited the state's right to mandate benefit packages.

1996 included more debate on health care reform. Mental health parity did not exist in SB 1171, The Health Insurance Reform Act sponsored by Senators Kassebaum and Kennedy. The original intent of SB 1171 included the following:

- workers would be able to keep their insurance coverage if they lost or changed jobs (portability);
- health insurance companies would be limited in their ability to deny coverage because of pre-existing conditions; and
- allow individuals to purchase individual policies form their group insurance provider. Mental health parity and medical savings accounts were not in the original bill.

Senators Domenici and Wellstone believed the time had come to eliminate the discrimination for mental health coverage. They introduced, as an amendment to SB 1171, full parity coverage for all mental illnesses. This included the following:

- annual inpatient benefits would be the same as physical illness;
- annual outpatient benefits would be the same as physical illness;
- copayments would be the same as physical illness;
- deductibles would be the same as physical illness;
- annual financial caps would be the same as physical illness;

- lifetime financial caps would be the same as physical illness;
- stop loss would be the same as physical illness;
- services may be limited to those that are "medically necessary;" and
- managed care is allowed, i.e. plans are not in any way prevented from managing mental illness treatment services, from requiring preauthorization for treatment, or from negotiating discounts with providers.

In April, the amendment passes the Senate. A report issued by the American Academy of Actuaries stated that private sector parity for mental health could save the public sector up to $16.6 billion a year. Reps. Roukema, Wise, and Fox secured signatures from 101 members of the House supporting parity. Rep. Roukema cited treatment statistics for bipolar disorder which had an 80% success rate for treatment while angioplasty had only a 41% success rate.

In June, Senators Domenici and Wellstone offered a compromise which offered :

- parity on lifetime and annual benefits only;
- insurers would not be required to offer a standard behavioral health benefit;
- managed care would be allowed;
- parity for substance abuse is not required; and
- small businesses under 25 employees would be exempt.

The compromise measure submitted by Senators Domenici and Wellstone retained parity coverage for aggregate lifetime and annual payment limits but allowed mental health care to be managed at the discretion of the health plan. The change sharply lowered the projected cost to the federal government from $16.7 billion to $1.8 billion, according to the Congressional Budget Office.[87] The compromise version would increase premiums 0.4 percent but employers would only see a 0.16 percent increase in premium costs. The compromise did not determine what a plan must charge for mental health services, did not require parity for copays and deductibles, did not require parity for inpatient days or outpatient limits, excluded substance abuse and chemical dependency, excluded Medicare and Medicaid, included the Federal Employee Health Benefits Program, allowed for managed care and mental health carveouts, did not apply to individual coverage, and exempted businesses with 25 or less employees.

No specific parity language was used for substance abuse treatment in either the original parity amendment or in the compromise version. The Senate's health insurance reform bill was negotiated in a joint House-Senate conference committee. Senator Kassebaum wanted to drop parity and instead include a provision for a study. Several days later she changed her position and agreed to bar lifetime and annual limits for coverage but allow discriminatory copayments.

A report, *Paying for Parity*, released by the Judge David L. Bazelon Center for Mental Health Law, indicated that the price of parity would not come at as high a cost as its detractors have argued.[88]

In July, mental health parity won approval from the Senate for a third time when the Finance Committee approved a mental health parity amendment in its Medicaid reform bill. The amendment was sponsored by Senators Simpson and Conrad. It included mental health parity, a more flexible

definition of community-based services, and an easing of the Institution of Mental Diseases (IMD) exclusion which prevents facilities that use more than 50 percent of their available psychiatric beds from receiving Medicaid reimbursement for adults aged 22-64 years.

The months of debate and conflicting statistics finally concluded with the removal of the mental health parity amendment by the House-Senate conference committee negotiating the health insurance reform bill.

On August 1, Senators Domenici and Wellstone introduced the Mental Health Parity Act of 1996, S. 2031, which was a free standing legislation of the mental health parity compromise offered in July. The bill was referred to the Senate Labor and Human Resources Committee. The measure did not make it out of committee.

In September, Senators Domenici and Wellstone drafted a compromise amendment which prohibited insurers from setting lifetime and annual caps for mental illnesses. The amendment was attached to HR 3666, the Veterans Administration and Housing and Urban Development appropriations bill. The amendment was passed by the House and by the Senate. Another amendment, sponsored by Senator Gramm, allowed businesses to drop mental health parity if their insurance costs rose more than 1%.

Support for the bill came from the American Managed Behavioral Health Care Association (AMBHA). AMBHA stated that most artificial benefits limits are arbitrary definitions imposed from the past and are not grounded in documented clinical practice. [89]

The amendments were passed in the House and the Senate on a non-binding “motion to instruct” to vote favorably on the amendment and the other two health measures.

On September 26, 1996, President Clinton signed a compromise parity amendment attached to the VA/HUD appropriations bill for fiscal year 1997. The amendment takes effect January 1, 1998 and sunsets in the year 2002. It eliminates lifetime and annual caps for coverage of mental illness but leaves in place the ability of insurance plans to impose discriminatory benefit limits and copayments. Businesses with less than fifty employees are exempt from the law. The parity amendment can still come under scrutiny when the 105th Congress convenes in January.

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[2] Florida Statistical Abstract. 1996.

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