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Mental health parity: National and state perspectives 2000: A report to the Florida Legislature

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Mental Health Parity

National and State Perspectives 2000

A report to the Florida Legislature

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Mental health parity, an important issue for public sector officials.

The current system for financing the comprehensive care for individuals with severe mental illness is not working. It is inadequate for the individual and expensive for the antion as well as Florida. As a result of the limitations in private insurance coverage, serious mental illness often bankrupts covered individuals and their families. With the emphasis on costly, inpatient care, these policies often force an individual to cycle between episodes of acute illness without the ability to use the full range of outpatient services in the community. Study after study has shown the use of alternative, or out-of-hospital care, to be the more effective treatment.

Many people with severe mental illness who deplete their insurance benefits are forced to seek additional care in the public sector. In the public sector, the states and the federal government provide significant financing for services. It has been noted that people with severe mental illness suffer more physical health problems. Eighty-five percent of all studies on offsets demonstrate that medical utilization decreases following mental health treatment, inpatient utilization by 70% and outpatient by over 20%. Findings from a 1991 study reported a 10% reduction in general health care costs as a result of mental health treatment.

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. Or we can continue to pay the cost in high health care expense, lost productivity, and disrupted lives.

By failing to appropriately treat adults and children with severe mental illness, we incur enormous social costs through payments for disability benefits (Medicaid, SSI, SSDI), increased medical expenses, accidents and suicides, avoidable criminal justice proceedings, lost productivity, and increased need for homeless shelters and services. People who are underinsured are forced by arbitrary caps and limits to increasingly rely on the public sector. By providing parity for mental health, Florida will bring mental health into the mainstream of health care and become a leader in dispelling the prejudice that surrounds treatment of persons with severe mental illness.

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EXECUTIVE SUMMARY

Overview

The federal Mental Health Parity Act of 1996 requires insurers to offer the same benefits for mental disorders and substance abuse as they would for physical disorders, including any annual or lifetime limitations and restrictions placed upon such coverage. To date, 32 states across the nation have enacted laws for mental health and/or substance abuse benefits.

Much of the initial concern over parity centered on the costs of implementation. Earlier information on utilization and costs were inconsistent and inconclusive. Estimation efforts were hampered by reliance on a variety of economic and actuarial models (which used data based on the fee-for-service model) and a lack of empirical information on current practice patterns.

Economic Analyses

Recent empirical studies and economic simulations across diverse populations show that the introduction of parity within a managed care environment resulted in modest (if any) cost increases and increased access to services. For example:

- In Maryland, full parity in all state-regulated plans raised costs by 0.6 percent per member per month;
- In Minnesota, Allina Health System reported that operating under the parity law for mental health and chemical dependency added $0.26 per member per month to the health premium, while Blue Cross/Blue Shield **reduced** its insurance premium by five percent under parity;
- In Texas, between 1991 (when mental health parity coverage for state and local government employees was implemented) and 1995, there was a 48 percent **decrease** in mental health and chemical dependency costs;
- Rhode Island reported a less than one-percent increase in total plan costs under parity;
- New Hampshire insurance providers reported no cost increases as a result of implementing parity;
- A Rand study shows that companies complying with parity by equalizing annual limits increased access to mental health services while increasing costs by $1 per year per enrollee;
- Studies show that small businesses are as likely to offer a managed care plan as larger businesses;
- Recent actuarial studies from the National Mental Health Advisory Council and Mathematica Policy indicate that predicted cost increases for full mental health parity benefits range from less than one percent to three percent; and
- Only four benefit-purchasing organizations representing groups of employers have invoked exemption to the Mental Health Parity Act, according to U.S. Labor Department statistics.

Benefits from Parity

While current cost experiences reported modest increases, numerous additional benefits can be realized from implementing parity legislation. They include:

- overcoming discrimination and reducing stigma toward individuals with mental disorders;
- assuring selected health plans do not suffer financial disadvantages from the adverse selection of treating individuals with the most serious mental disorders;
- reducing out-of-pocket expenses for individuals with mental disorders;
- reducing disability through improved access to effective treatment; and
- increasing the productivity to society of individuals with mental disorders.

In addition, mental health parity legislation could substantially reduce the degree to which financial responsibility for the treatment of mental illness is shifted to government, especially to state and local government.

There is also substantial evidence that both mental health and addictions treatment is effective in reducing the utilization and costs of medical services. Based upon this information, there appears to be a ***lack of substantial evidence*** to discourage Florida from pursuing mental health and substance abuse parity legislation.

MENTAL ILLNESS AND SUBSTANCE ABUSE

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 the factors that determine the frequency and distribution of disease in a specific (often at-risk) population(s).

National Studies

The best known and most comprehensive of epidemiologic studies on mental health was the Epidemiological Catchment Area Study (ECA) begun in 1978 (Robins & Regier, 1991; Regier et al., 1988a; Regier et al., 1985). The study examined prevalence and incidence of mental disorders in the community as well as in institutional settings.

> During any twelve month period, 5.4 % of Floridians will experience a mental illness and 7 % of Floridians will experience a substance abuse disorder.
>
> Committee on Children and Families 1999

A second significant study was the National Comorbidity Survey (NCS) (Kessler et al., 1994). Comorbidity refers to anyone with both substance disorder and any psychiatric illness as described in the *Diagnostic and Standards Manual*. The NCS was designed to improve on the ECA efforts by incorporating *DSM-III-R* (*Diagnostic and Standards Manual 3rd revision*) nomenclature, and by more extensively examining risk factors that affect particular mental disorders and to determine the comorbidity of psychiatric disorders (Blazer et al., 1994). Results from the NCS indicated higher lifetime prevalence rates for mental disorders than the ECA, particularly for depression, alcohol dependence, and phobia. The NCS's prevalence rate of 3.2 percent has been used as the standard for all national and state prevalence studies on comorbid disorders.

Comorbidity

Kessler and associates (1996a) have estimated that approximately 15 percent of individuals with a mental disorder also have a co-occurring disorder in any given year. Kessler et al. (1996b) also reported that the total number of persons with co-occurring disorders was between 7 million and 9.9 million people, depending on the definition of alcohol abuse.

Florida

A recent report by the Committee on Children and Families (1999) estimated the prevalence of serious mental illness in Florida. For persons residing in a private household, the Committee estimated that approximately 5.4 percent (approximately 544,798 persons) would experience a serious mental illness over a twelve-month period. For persons living in jails, prisons, hospitals, nursing homes, other residential care facilities, or for persons who are homeless, the figure increases to more than 795,117. Additionally, the Committee estimated that 7 percent of Floridians (approximately 1,074,439) would experience a substance abuse disorder in a twelve-month period.

Unfortunately, neither of the prevalence figures in these studies reflects the unique population characteristics specific to Florida, including seasonal residents, a large Hispanic population of Caribbean descent, as well as year-round migration to the sunshine state. Approximately one-third of Florida's migration is from international movement, and the remaining two-thirds is migration from other states.

The Office of Economic and Demographic Research projects the total state population to be 15,524.481 on April 1, 2000, an increase of 2,586,555 over the 1990 census count of 12,937,926 664 (2000). Additionally, Florida's Hispanic population grew to an estimated 2,304,515 persons, and the African American population grew to an estimated 2,137,368 persons (Office of Economic and Demographic Research, 2000). Nevertheless, since no statewide prevalence studies are available regarding rates of individuals with mental disorders, figures extrapolated from national estimates indicated that 2.8 percent of the total population suffers from severe mental illness.

Florida's population is also compounded by age distribution that reflects the continuation of an aging trend in the population. In 1980, there were 1,687,573 Floridians aged 65 and older (17.3 percent of the total population). The 1990 census enumerated 2,355,926 elderly (18.2 percent of total), and by April 1, 2010, this age group will number 3,395,208, constituting 18.9 percent of the total population. These changes represent increases of 39.6 percent between 1980 and 1990 and 19.4 percent between 2000 and 2010.

The population aged 85 and older was one of the fastest growing age segments during the 1980's, increasing by 75.1 percent. This group was expected to increase by more than half again during the last decade of the twentieth century, numbering 330,220 by April 1, 2000. High rates of growth will continue for this age group through the first decade of the next century, with the age 85 and older population projected at 489,635 by 2010 (Office of Economic and Demographic Research, 1999).

In contrast, the youth population (ages 0-19) will continue to increase in size, but not as rapidly as the elderly population. It is estimated that in 2000 there will be 3,877,483 persons age 19 and younger, continuing to represent 25 percent of the total state population (Office of Economic and Demographic Research, 1999).

Estimates of the Number of Persons with Severe Mental Illness (SMI) by Age, Race, and Sex, 1995-2010

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

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.*

Source: Petrila & Stiles, 1995

HEALTH CARE EXPENDITURES FOR MENTAL HEALTH

United States

As we enter the twenty-first century, mental disorders remain significant public health problems. According to a recently published report from the U.S. Surgeon General (U.S. Department of Health and Human Services, 1999), mental disorders comprise four of the 10 leading causes of disability for individuals who are five years and older, with depression the leading cause of disability, and suicide one of the leading preventable causes of death in the United States.

The Global Burden of Disease, a publication of the World Bank and the World Health Organization, reported on a study of the indirect costs of mental disorders associated with years lived with a disability, with and without years of life lost due to premature death. The metric developed for this report, Disability Adjusted Life Years (DALYs), are now being used to describe the burden of disability and premature death resulting from the full range of mental and physical disorders throughout the world.

A striking finding from the study has been that mental disorders account for more than 15 percent of the burden of disease in established market economies. Among the top ten causes of disability worldwide were unipolar major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder (Murray & Lopez, 1996).

In 1994, the total costs to society for mental disorders and substance abuse far exceeded the costs of cancer ($104 billion), respiratory disease ($99 billion), AIDS ($66 billion), or coronary heart disease ($43 billion) (Rouse, 1995). McKusick et al. (1998) reviewed the direct costs of treatment by analyzing national spending trends during this decade by studying health services used to diagnose and treat mental health and substance abuse conditions. They estimated that, in 1996, expenditures for mental health and substance abuse diagnosis and treatment totaled $79.3 billion. The largest share went to mental illness ($66.7 billion), $5.0 billion went to alcohol abuse, and $7.6 billion went for abuse of other substances.

In addition, it has been estimated that 16.1 percent of the population in the United States is uninsured (U.S. Census Bureau, 1999), and mental health coverage is limited for those who are insured (Frank & McGuire, 1994). The public sector paid for more than half of the funding for mental health and substance abuse treatment (with Medicaid and state and local government funding accounting for nearly 20 percent each, Medicare funding accounting for 14 percent of mental health costs, and other federal government programs accounting for 2 percent). Private health insurance paid 47 percent of the direct expenditures for mental disorders (McKusick et al., 1998).

U.S 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 short- and long-term benefits. The Health Care Financing Administration (HCFA) administers this program. In 1996, public spending for Medicaid totaled $121 billion. Two years later, total Medicaid spending was $170.6 billion in 1998, an increase of 6.6 percent over the 1997 level. Medicaid paid for 15 percent of all health spending in 1998 (Health Care Financing Administration, 1999c).

Of the 31,117,679 persons enrolled nationally in Medicaid programs, 16,834,390 (54.1%) are enrolled in a managed care program (Health Care Financing Administration, 1999b) compared to 10 percent in 1991 (HCFA in Freund & Hurley, 1995). Fiscal

pressures have been the main impetus for states to adopt managed care for their Medicaid populations, with the loss of federal "matching dollars" and the move to Medicaid waivers (Ridgley & Goldman, 1996).

The aged, blind, and disabled recipients of Medicaid together consume the lion's share of Medicaid resources. Nationally, disabled individuals comprised about 15 percent of the Medicaid population and accounted for 39 percent of the Medicaid expenditures, including long-term care (GAO, 1996).

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, no information on breakout by type of mental disability (or updated figures) was available. (GAO, 1996).

Florida

While Florida currently ranks 9th in total state mental health expenditures, it ranks 42nd in per capita state expenditures for mental health services. Petrila and Stiles (1996) have examined estimates of the cost of mental health (not including alcohol and drug abuse services). [1] The estimated costs of mental health services clearly show that most funds for mental health services in Florida are to support state hospitals, while community hospitals received funds from entitlement programs and insurance providers. Local government and state ADM expenditures accounted for approximately one-third of the total expenditures for mental health services in Florida.

Total Dollars Spent on Adult Mental Health by Service Type

State Hospital	$ 252,116,426
Community Hospital	$ 781,049,656
Community Outpatient	$ 567,081,892

Although there is likely significant Medicare outpatient expenditure, figures estimating the costs for Medicare outpatient services were not available for inclusion in any charts.

Source: Petrila & Stiles, 1995. Data source: Alcohol, Drug Abuse and Mental Health (ADM), 1993-1994; Agency for Health Care Administration (AHCA) Certificate of Need, 1994.

Additionally, while hospital mental health services were funded equally 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. Petrila and Stiles projected costs of mental health services in Florida by type of service setting. Based upon current patterns of spending, they extrapolated the doubling of costs by the year 2010, with current costs exceeding one billion dollars.

Florida's Entitlement Programs

In 1998, there were 1,440,331 persons enrolled in Medicaid of which 865,358 (60.08%) are enrolled in a managed care plan (Health Care Financing Administration, 1999b). Out of the statewide total, 257,265 were blind or disabled persons (Health Care Financing Administration, 1999a).[2]

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

2 There was no further breakout by HCFA for this group.

In fiscal year 1996, Florida paid $3,707,000 in Medicaid costs (Florida Statistical Abstract, 1999a). According to the Florida Consensus Estimating Conference (1999), revised projections of Medicaid expenditures for the 1998-99 fiscal year were projected at $6.88 billion, a reduction of $49 million from the appropriation. Of this amount, the federal government will pay $3.8 billion or 55.7 percent. The Medicaid program was expected to average 1.53 million cases this year, or about 10 percent of the state's population. For the 1999-2000 fiscal year, Medicaid expenditures were forecasted at $7.47 billion, or $513.1 million greater than the 1998-1999 appropriation base (Florida Consensus Estimating Conference, 1999).

In 1998, in Florida, there were 265,055 disabled workers receiving Social Security benefits, at a cost of $191,854,000 per month to the state of Florida (Florida Statistical Abstract, 1999b). In 1998, there were 266,325 individuals who were blind and/or disabled in Florida who received Supplemental Security Income at a total of $131 million (Florida Statistical Abstract, 1999c). As with the data for the Health Care Financing Administration, there was no further breakout of the data. 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 (Social Security Administration, 1995).

Projected Need of Adult Mental Health in Florida, 1995-2010

Services by Cost Center	% of Need Met	Projected Number of Persons in Need of Adult Mental Health Care			
	1995	1995	2000	2005	2010
Assessment	8.05	42,761	47,173	51,148	55,722
Case Management	10.09	171,042	188,692	205,671	222,887
State Hospitals	145.31	3,269	3,629	3,955	4,286
Crisis Stabilization	84.37	48,791	54,430	59,328	64,294
Crisis Support	42.18	50,436	55,640	59,328	65,723
Day-Night	34.76	42,761	47,173	51,148	55,722
Drop-In/Self	499.71	14,254	15,724	17,139	18,574
Forensic	90.05	1,664	2,419	2,637	2,858
Intervention	14.41	24,450	26,601	29,005	31,433
Outpatient	44.33	142,535	157,243	171,393	185,739
Outpatient Medical	0.	118,414	128,214	139,751	151,449
Overlay	5.51	46,596	52,011	56,691	61,437
Prevention & Prevention/Interv. Day	0	0	0	0	0
Residential Level 1	37.13	3,289	3,629	3,955	4,286
Residential Level 2	58.07	4,386	4,838	5,274	5,715
Residential Level 3	30.83	6,579	6,048	6,592	7,144
Residential Level 4	0	7,675	8,467	9,229	10,001
Respite	0	0	0	0	0
Sheltered Employment	5.86	5,700	6,048	6,592	7,144
Supported Employment	7.60	14,254	15,724	17,319	18,574
Supported Housing	0.48	75,105	83,460	90,970	98,585
TASC	0	0	0	0	0
TOTAL	**19.59**	**823,961**	**907,171**	**988,803**	**1,071,572**

Source: Petrila & Stiles, 1995

MANAGED CARE

Health insurance benefit design is generally based upon an acute care model and confined to traditional medical services. Generally, it has not been defined within a long-term care treatment environment. The largest unmet needs of persons with severe mental illness involve community rehabilitation and long-term services that are typically not covered under private health insurance policies (Mechanic, 1998).

OVERVIEW

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 (Levin in Manderscheid and Sonnenschein, 1992). Today, managed care has become the most dominant form of health and mental health coverage for individuals with private insurance. This continued growth of managed care "…has [increasingly] blurred the distinction between organizations bearing financial risk for health care (insurers), organizations managing care (health maintenance and utilization management organizations), and organizations making clinical treatment decisions (provider groups or individual clinicians)" (Sturm, 1999, p. 362). At the same time, the rapid growth of managed care in America has raised concerns that reduction in health and mental health care costs may have resulted in cost shifting to public programs and/or consumers themselves.

Managed care now covers 75 to 80 percent of all U.S. employees (Jensen et al., 1997). The Hay/ Huggins Benefits Reports documented trends from 1992-1997 in primary health benefit plans for over 1,000 medium- to large-size employers. During this period, fee-for-service (FFS) plans dropped from being the most prevalent primary medical plan (62 percent) in 1992 to being the least prevalent (20 percent) in 1997. Preferred-provider organization (PPO) plans rose from 13 percent to 34 percent of primary medical plans, with a similar rapid rise in health maintenance organization (HMO) plans from 9 percent to 24 percent. Point-of-service (POS) plans rose more slowly as the principal medical plan, from 16 percent in 1992 to 22 percent in 1997. Managed care organizations have become more active in their expansion into the public sector, where more and more public mental health systems have shifted their priorities from providing mental health and substance abuse services to purchasing these services, and from maintaining institutions and other services to the utilization of a systems of care approach to service delivery (Essock and Goldman, 1995).

During the last 15 years, an increasing number of employers and government programs have "carved-out" or separated mental health service benefits from general health care benefits through contractual arrangements with specialized vendors that may assume some level of financial risk. Specialty managed mental health organizations have subsequently emerged under the rubric of "managed behavioral health care organizations" (MBHOs).

MBHOs have attempted to reduce the costs of mental health care through the utilization of mental health practitioners at discounted fees, through the reduction in the length of mental health treatment, through the decreased use of hospital treatment, as well as through the increased use of ambulatory mental health care treatment. While initially contracting with employers in the private sector as well as subcontracting with HMOs and other models of managed care health plans, studies have reported significant declines in the costs of mental health care under

these MBHOs (Cuffel, Goldman, & Schlensinger, 1999; Goldman, McCulloch, & Sturm, 1998; Grazier, Eselius, & Hu, et al., 1999; and Ma & McGuire, 1998.)

Nearly all states have implemented managed behavioral health programs. In recent years, public sector enrollment in managed care plans has increased dramatically, accounting for approximately 13 percent of the 38 million Medicare beneficiaries, and approximately 54 percent of the 31 million Medicaid beneficiaries (Health Care Financing Administration, 2000b).

The complexity of the contractual arrangements between state and local governments and MBHOs has varied considerably (Findlay, 1999). Some states contract directly with MBHOs or sub-contract with HMOs, paying a capitated fee to provide mental health services, with the MBHO or HMO assuming the risk. However, other states prefer to retain full risk and contract with MBHOs (or sub-contract with HMOs or other managed care plans) to manage mental health or behavioral health benefits. Other MBHOs have been contracted only to conduct utilization review and case management services.

Over the past thirty years, Medicaid, Medicare, Social Security Disability Insurance (SSDI)/Supplemental Security Income (SSI), and other welfare programs have significantly influenced the ways in which public sector treatment for mental illness is paid (Mechanic, 1999). In 1998, 36 states operated 46 Medicaid waivers to provide innovative approaches to organize and finance mental health services through various behavioral health carve-out strategies. Eight states ran voluntary Medicaid HMOs and 26 states had managed care programs in place in related state systems (National Conference of State Legislatures, 1999).

Among the states (including Florida) with approved or pending Section 1115 waiver requests, the most common approach was to offer acute but limited mental health benefits to all Medicaid recipients, but to carve-out persons with more severe mental illness and treatment needs (Ridgley & Goldman, 1996). Florida is also testing the 1915(b) waiver that requires certain Medicaid recipients to enroll in one of two managed care plans: Medicaid HMOs or MediPass. The 1915(b) program is currently under evaluation.

Managed care arrangements have proven successful in managing service utilization and plan expense (CBO, 1995; National Advisory Mental Health Council, 1998). A recent study by the Hay Group (1998) indicates that health care costs increased by only 0.7 percent per year from 1994-1997 under managed care. Prior to the implementation of managed care (1988 to 1993), healthcare costs increased by 16.8 percent per year. Studies from Peat Marwick (Jensen et al., 1997), William M. Mercer (1997), two by the Rand Corporation (Sturm, 1997; Goldman, McCulloch, Sturm, 1998), and the Lewin Group (1997) have provided support regarding the success of these arrangements.

For example, a study by the Rand Corporation (Sturm, 1997) examined claims from 24 managed care carve-out plans that offered unlimited mental health benefits with minimal copayments. Results of the study indicated that companies which complied with the federal mental health parity law by removing an annual limit of $25,000 for mental health care would incur an approximately $1 per enrollee per year increase in mental health care costs. In addition, removal of more costly limitations (i.e. 30 inpatients days and 20 outpatient visits) would translate into a cost increase of less than $7 per enrollee per year.

The Rand study also found that access to mental health services increased in these managed care carve-out plans. A second RAND study (Goldman, McCulloch, Sturm, 1997) tracked access, utilization, and costs for mental health care for one large employer in California during a period in which behavioral health care benefits were carved-out of the

medical plan and managed care was increased. Prior to the carve-out, costs increased by 20 percent annually. Post carve-out costs decreased by 40 percent. Cost reduction was not due to decreased access.

Highlights of Benefit/Cost Analysis and Actuarial Studies

It has been argued that limited coverage for mental illness in 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. Because the primary purpose of parity legislation is to ensure the availability of treatment services, direct treatment costs may potentially increase under a parity bill. However, 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 individuals 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 less restrictive.

A 1998 Parity Workgroup (National Advisory Mental Health Council, 1998), ran a simulation study using the Hay/Huggins Mental Health Benefits Value Comparison (MHBVC) actuarial model to estimate explicitly the premium costs of mental health services under HMOs and managed behavioral carve-out plans based on benefit design and newer managed care approaches.[1] The baseline cost data from Hay/Huggins were then adjusted to reflect the experience of HMOs and managed behavioral carve-out plans from empirical studies. Another 1998 report from the Hay Group examined the trends in the proportion of employer health care dollars spent on behavioral health care costs of health care from 1988 through 1997. Data came from the Hay benefits reports and the Mutual of Omaha's "Current Trends in Health Care Costs and Utilization." The Hay Group found that the Mutual of Omaha reports reflect national trends with one important advantage: the Mutual of Omaha reports provide consistent detail on the use of specific components of health care for a large insured base over a period of years. Mutual of Omaha's data analysis reflected the same trends in the Hay Benefits Report regarding plan design and management. While utilization declined across all categories of care, mental and behavioral utilization declined at a faster pace.

Despite opposition by those who have claimed that parity would increase expenditures, additional studies (Sing et al., 1998; NAMHC, 1998; Sturm, 1997; Lewin Group, 1997; CBO, 1996; Goldman et al., 1998; Grazier, 1998; Sturm & McCulloch, 1998; and Ma & McGuire, 1998) have shown this to be inaccurate. A 1999 study, *Effects of the Mental Health Parity Act of 1996*, based on data from the Mercer/Foster Higgins *National Survey of Employer-Sponsored Health Plans*, indicated that the effects of the federal Mental Health Parity Act has been positive.

Eighty-six percent of plans surveyed indicated that they had made no compensatory changes to their benefit because they expected the cost increases to be minimal or non-existent. The remainder did make some type of compensatory changes in benefits or administration; most commonly increasing limits on inpatient days and/or outpatient visits. According to the *National Survey*, the Mental Health Parity Act had an unintended beneficial effect of also improving coverage for substance abuse benefits in many plans. In summary, based on new knowledge derived from empirical case studies and updated actuarial cost-prediction models, the costs of parity are controllable.

1 The MHBVC produces a standardized benefits value based on the input of over 125 items describing the benefit design of a health plan. These include deductibles, coinsurance, maximum out-of-pocket and coverage limitations. For behavioral health care plans, the model includes over 25 items, for example day, dollar, and visit limits. The standardized benefits value is equivalent to the average premium for healthcare for medium and large employers in the United States.

COST OF TREATMENT ISSUES

Overview

The costs of mental health services can be partitioned into budgeted or direct costs (or actual costs) and social or indirect costs (the cost of mental disorders due to lost productivity, etc.) (Dickey et al., 1986; Clarke et al., 1994; Dickey et al., 1996). McKusick et al. (1998) estimated that in 1996 expenditures for mental health and substance abuse diagnosis and treatment were $79.3 billion. The largest share went to mental illness ($66.7 billion), $5.0 billion went to alcohol abuse, and $7.6 billion went for abuse of other substances. Rouse (1995) estimated percentage breakouts of expenditures included 34 percent of the costs from loss of productivity, 26 percent of the costs due to the somatic health consequences of mental disorders, and 22 percent of the costs due to crime, criminal justice costs, and property damage.

Persons with severe mental illness 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 can become involved with the criminal justice system due to inconsistent and occasionally violent behavior (Teplin, 1990). This figure does not include the actual transfer of payments made by social service agencies. Such payments, from society's perspective, represent either a transfer payment, a resource cost, or are already included in direct treatment costs.

Direct Costs

According to Mark et al. (1998), spending for direct treatment was $69 billion for mental health services (more than 7 percent of total health spending). Spending for direct treatment of substance abuse was almost $13 billion (more than 1 percent of total health spending).

Direct Treatment Costs

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 was 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, 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. Massachusetts, for example, contracted in 1992 for a Medicaid managed mental health program that included disabled in the covered population. A study of the first year of the Massachusetts program claimed a 22 percent saving to Medicaid. The savings came from 37 percent reductions among the disabled and 16 percent reductions among the non-disabled. Clearly, some of these savings were attributable to lower reimbursement rates for the same services, but some were also due to shifting of care to lower cost settings and providers, and some to reduction in "unnecessary" care (Center for Health Policy, 1996).

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 severe mental illness 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

There is ample evidence that, as a group, those with mental or substance abuse disorders consume a disproportionate amount of other medical services (Manning & Wells, 1992; Simon et al., 1995). This is especially true for those with severe mental or addictive disorders, and for those with other forms of disabilities that lead to eligibility for Medicaid and/or Medicare. It is also estimated that non-mental health providers deliver at least half of the mental health care services used in the United States (Center for Health Policy Studies, 1996).

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 (Borus, 1985; Holder & Blose, 1987; Massad et al. 1990; Pallak et al., 1994; Mechanic et al., 1995; and Olfson, 1999). Cummings et al. (1993) showed that, depending upon the subgroup of users, the costs of providing managed mental health services were recovered in terms of reduced medical offset within 5-21 months. Shemo (1985) suggested that the offset effect may be higher in managed care programs and that the more intense the mental health intervention, the higher the savings on subsequent physical health expenditures. In other words, the reduction in medical costs would offset the cost of providing mental health (or substance abuse) services (Mumford et al., 1984; and Pallak, 1993).

In addition, savings have been found in "collateral cost-offsets," where there is a reduction in the utilization and costs of medical services when a family member receives treatment for substance abuse (Langenbucher, 1994; and Zuvekas et al., 1998).

These observations, and the failure to control for them, could have profound impacts on the cost-effectiveness observed for managed behavioral health plans in comparison with traditional FFS indemnity insurance plans. If the financial incentives in one managed care plan are for generalists to treat minor mental health or substance abuse problems, but are structured to encourage the referral to mental health or substance abuse specialists in another, very different conclusions might be reached by looking only at the mental health or substance abuse service costs, or by looking at all health costs combined (Center for Health Policy Studies, 1996).

Treatment Efficacy Rate

The National Institute of Mental Health reports the following treatment efficacy rates: schizophrenia -60 percent; major depression - 65 percent; bipolar disorder - 80 percent; and panic disorder - 70 to 90 percent (Hyman, 1996). These are fully comparable to efficacy rates of treatment in many areas of medicine (Goodwin, 1993). The NIMH, recognizing that the total costs of depression are skewed to various indirect cost categories, has stated that "the shift in even a small portion of the … indirect costs into direct treatment costs could produce a profound improvement in the lives of those currently untreated and undertreated" (Regier et al., 1988b).

Indirect Costs

When economists calculate the costs of an illness, they also attempt to identify indirect costs. Indirect costs include morbidity as well as other resource use costs. Morbidity costs comprise about 80 percent of the indirect costs of all mental illness. This indicates an important characteristic of mental disorders. Although mortality is relatively low, onset is often at

a younger age, and most of the indirect costs are derived from lost or reduced productivity at the workplace, school, and home as well as increased absenteeism (Rupp et al., 1998; and Greenberg, 1995). Furthermore, the increased mortality rates associated with severe mental illness lowers the productive capability of the economy (Glied, 1996). Certain events, such as involuntary hospitalization or arrests, have predictable sequences of resource use, such as psychiatric and medical evaluation, transportation by law enforcement officers from point of contact to hospital or jail, preliminary hearing, and court proceeding.

Public and Private Sector Issues

Funding for mental health service systems comes from both public and private sources. In 1996, approximately 53 percent ($37 billion) of the funding for mental health treatment came from public payers. Of the 47 percent ($32 billion) of expenditures from private sources, more than half ($18 billion) was from private insurance (Regier et al., 1993; and Kessler et al., 1996). Most of the remainder was out-of-pocket payments. These out-of-pocket payments include co-payments from individuals with private insurance, co-payments and prescription costs not covered by Medicare or Medigap (i.e., supplementary) insurance, and payment for direct treatment from the uninsured or insured who choose not to use their insurance coverage for mental health care (Mark et al, 1998).

During the past twenty years, the role of direct state funding of mental health care has been reduced and Medicaid funding of mental health care has increased. In addition, changes in reimbursement policies, legislative and regulatory requirements, and population demographics saw the growth of mental health funding from public sources from 49 percent to 53 percent (Mark et al., 1998). Since Medicaid program design is critical in shaping the delivery of mental health services, state mental health authorities have acquired more administrative responsibility for mental health services (Shore & Cohen, 1994).

People who receive their care in the public sector differ significantly from those who receive their care in the private sector in both the kinds of mental disorders from which they suffer and in terms of their sociodemographic characteristics (Minkin et al., 1994), e.g., individuals with long-term and severe mental disorders such as schizophrenia, treatment resistant bipolar disorder, combined mental illness and substance abuse disorders, and severe character disorders that can lead to criminal activity and impairment in social functioning and those who have no families, social support systems, or other social or economic resources (Minden & Hassol, 1996).

The limited coverage for mental illness in many current health insurance policies increases the cost of treatment to the consumer and/or the health care provider, and thus provides a disincentive to seeking treatment. Because the primary purpose of parity legislation is to ensure the availability of treatment services, direct treatment costs may potentially increase under a parity bill. However, 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 parity, plan individuals have more access to outpatient services rather than being forced into inpatient treatment due to insurance restrictions, treatment may become more cost effective as well as less restrictive. The experience of Massachusetts resulted in a 22 percent reduction in expenditures, despite a 5 percent increase in the number of persons utilizing the services (Coalition, May 1996a). Furthermore, it is possible that a parity proposal will alter the mix of service providers.

The passage of a comprehensive mental illness parity law could shift some of the costs of providing treatment for mental illness 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 not covered under private insurance plans often falls on state or federal agencies. Nationally, state and local governmental sources accounted

for 31 percent of the funding for treatment of serious mental illnesses in 1990. The federal government's Medicaid and Medicare programs accounted for an additional 26 percent. Nationally, 64 percent of persons with severe mental illness have private insurance (National Advisory Mental Health Council, 1993).

Revenue streams for the costs of providing treatment are divided into private sources (commercial insurance payments, philanthropy, and out-of pocket payments) totaling 44.3 percent and public sources (state and local government general revenues, Medicaid, Medicare, Veterans Affairs, and ADM block grants) totaling 55.7 percent (Frank et al., 1994). The incredible diversity of financing mechanisms and the functional differentiation of the mental health and substance abuse service systems have made the development of a comprehensive policy very difficult (Ridgley & Goldman, 1996; and Drake et al., 1998).

> ... while state mental health parity laws address minimum coverage for the treatment of mental and/or substance abuse disorders, it will be the responsibility of managed behavioral health care to deliver the actual mental health benefits.
>
> NAMHC, 1997

The estimated savings for private sector plans are larger than have been reported for most but not all Medicaid managed care programs. This may be due to many reasons. First, the practices of many Medicaid fee-for-service (FFS) programs are to pay well below market reimbursement rates and to offer limited coverage. Second, Medicaid beneficiaries sometimes need to receive care in some circumstances for which Medicaid is not billed. Third, many Medicaid recipients receive mental health and/or substance abuse services from general medical providers which is not identified as a mental health and/or substance abuse cost (Center for Health Policy Studies, 1996).

Upon examining 1987 National Medical Expenditure Survey data, Olfson and Pincus (1994) determined that the proportion of the sample population considered to have used a mental health outpatient service during the year varied from 1.3 percent to 9 percent, depending on the definition used for a mental health outpatient service. Further, most Medicaid managed care programs over the past ten years have begun by enrolling AFDC and "AFDC-like" populations, groups with relatively low use of mental health or substance abuse services, in comparison with the disabled and the general assistance eligibility categories. In addition, many Medicaid managed care programs have excluded mental health or substance abuse benefits, retaining these as fee-for-service reimbursed unmanaged services (Center for Health Policy Studies, 1996).

An NAMHC (1997) report suggested that while state mental health parity laws address minimum coverage for the treatment of mental and/or substance abuse disorders, it will be the responsibility of managed behavioral health care to deliver the actual mental health benefits. Thus, it is critical to understand how managed behavioral health care impacts the cost and quality of mental health care in America. This is dependent upon a number of factors, including: mental health service utilization levels prior to implementation of managed behavioral health care; demographic and employment characteristics of the enrolled population; local and regional variations in mental health services delivery; and specific financial incentives within the managed behavioral health contracts (NAMHC, 1997).

Although there are two studies which have examined the impact of specific managed behavioral health care on the utilization and costs of mental health services (Huskamp, 1997; Sturm, 1997), there has been inadequate empirical evidence which examines the impact of managed care on the utilization and costs of mental health services in states with and without mental health parity legislation. Thus, any estimation of a change in costs resulting from the implementation of parity legislation must include the impact of specific managed behavioral health care on mental health costs.

EXPERIENCES OF STATES, the PUBLIC SECTOR, and the PRIVATE SECTOR

"Experience from the states that have already moved to managed care suggest that savings in the range of 5 percent may not result in drastic service cuts or significant under funding of the new system" (Frank ,McGuire, & Goldman, 1996).

Thirty-two states (Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, and Virginia) currently have parity laws for mental health and/or substance abuse. A table of states' parity laws is found in the Appendix of this report.

States' Experiences with Nondiscriminatory Benefits

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-à-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 limit 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 permits states that have passed more comprehensive or a greater level of mental health parity legislation to be exempt from federal law.

Do these state parity laws have any impact on the organization, financing, and delivery of mental health and substance abuse services? At the present time, since most state parity laws have been recently enacted, relatively few states have sufficient experience to evaluate the impact parity has on service costs. Nevertheless, there have been several cases documented in the literature that highlight the experience of selected public and private sector organizational health costs since parity has been implemented (Shore, 1994; and NMHAC, 1997).

Public Sector Experiences with Nondiscriminatory Benefits

California

A recent RAND study found removing annual benefit limitations of $10,000 on substance abuse treatment increased expenditures by only $0.06 cents per member per year. Furthermore, annual costs for behavioral health plans in the study were $0.43 cents per member per month (Sturm et al., 1999).

Colorado

A study of Colorado's Medicaid managed mental health pilot program found that costs decreased $6.5 million in the first year of the pilot program's inception. During this time period, the variety of services available increased, access to services increased, inpatient costs dropped from 50 percent to 17 percent

of Colorado's public mental health spending. The study showed similar outcomes for the managed care pilot program as for the fee-for-service system ("Colorado aims," 1997).

Maryland

The Maryland Health Resources Planning Commission has reported continued decreases 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 percent, while in 1995, one year after passage of the parity law, it was less than 18 percent. In Maryland, full parity in all state regulated plans increased costs by 0.6 percent per member per month. However, the National Institutes of Health reported in 1997 that for Maryland's most experienced managed care company, the percent of total medical premium attributable to the mental health benefit decreased 0.2 percent after the implementation of full parity (APA, 1999a).

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 five to six percent in health plans it writes for small businesses in the state after one year's experience under the Minnesota parity law. In addition, the Minnesota Comprehensive Health Association, which directs the high-risk reinsurance 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 one to two percent premium increase in the cost of health insurance for all state employees (APA, 1999a).

North Carolina

The utilization and costs of mental disorders were studied in the North Carolina state employee health plan after implementing both parity and managed mental health legislation in 1992. Per member per month costs decreased from $5.93 in 1991 to $4.58 (including cost of administrative overhead) in 1996. Mental health payments as a portion of total health payments decreased from 6.4 percent to 3.4 percent, representing a 47 percent reduction in costs. (NAMHC, 1998).

Pennsylvania

The first state-level study of parity, conducted in the fall of 1998, found only minimal impact (0.1 percent) on the number of uninsured if parity legislation were to be enacted (APA, 1999b).

Texas

Between the inception of mental health parity coverage for state and local government employees from 1992 to 1995, there was an approximately 50 percent decrease in per member per month cost of mental health services for Texas state employees (NAMHC, 1998).

Summary of States and Impact

States	Impact
California	minimal increase
Colorado	minimal increase
Maryland	decrease
Minnesota	minimal increase
North Carolina	decrease
Pennsylvania	minimal increase
Texas	decrease

Private Sector Experiences with Nondiscriminatory Benefits

- A 3-year study of a large national employer instituting managed behavioral healthcare implemented through a carve-out program decreased outpatient costs by 28 percent and the average number of outpatient visits by 19 percent, while increasing outpatient treated prevalence by 1.1 percent (Grazier, 1999).

- Major corporations such as DuPont, Dow, Federal Express, Sterling-Winthrop, Alcan Aluminum, Conoco, and Xerox have reported cost reductions of 30 to 50 percent over one to two years while eliminating certain coverage limits and, therefore, increasing the flexibility of their mental health benefits (Frank & McGuire, 1995).

- In a study of a large West Coast based employer, costs dropped more than 40 percent after the inception of a behavioral health carve-out plan. In the six years after its inception, the number of persons using mental health care increased, however costs continued to decline due to fewer outpatient sessions, reduced likelihood of inpatient admissions and shorter inpatient lengths of stay (Goldman, et al., 1998).

- Black and Decker introduced a managed behavioral healthcare program eliminating all arbitrary benefit limits, and integrating EAP and managed treatment. Between 1993 and 1996, overall behavioral health benefit costs decreased by 60 percent, with the per employee per year costs dropping from $190 to $104, and behavioral health costs as a percentage of total medical costs dropping from 6.6 percent to 3.5 percent (Mercer, 1997).

- IBM reconstructed its managed mental health program in 1998, providing an integrated Employee Assistance Program (EAP) and managed care program with no limits on medically necessary behavioral health benefits (apart from a 60 day lifetime limit on inpatient substance abuse treatment). Results showed a reduction in costs, inpatient stays, and recidivism. Increased outpatient therapy, availability of transition care, and education and satisfaction of beneficiaries were reported (APA, 1999a).

In sum, there is growing evidence that instituting mental health parity in both the public and private sector in Florida as well as other states is feasible under managed care. Cost increases in these examples are minimal, and in some cases nonexistent, while service access and utilization were increased despite some earlier predictions that parity would actually present disincentives to seeking treatment (Hennessy & Stephens, 1997; National Advisory Mental Health Council, 1998; SAMHSA, 1999; Ma & McGuire, 1998; and Sturm et al., 1999). As previously stated, only four benefit-purchasing organizations representing groups of employers have invoked an exemption to the federal Mental Health Parity Act of 1996 (SAMHSA, 1999).

IMPACT ON FLORIDA

A Short History of the Parity Act

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 and/or chemical dependency as they do for physical illnesses.

The concept of parity was introduced in 1992 with the redesign of basic benefits plan for mental health services by the Agency for Healthcare Administration (AHCA) (Levin et al., 1999). The Florida Council for Community Mental Health (FCCMH) presented specific benefit design recommendations. The model benefit plan in the state council report was seen as a first step toward parity between physical, mental, and substance abuse treatment benefits (Florida Council, 1992). A substantiating study showed how providing a "continuum of care" could reduce the costs of psychiatric care (Hay/Huggins, 1992). The subsequent AHCA design incorporated a few of the suggestions into the benefit design, but parity for services was not included.

In 1995, "The Mental Illness Insurance Parity Act" was first introduced in the legislature. An independent report (Milliman & Robertson, 1995) indicated an increase in expenditure (per employee per month) of $2.01 with a change in the mandated offering of benefit that would have affected approximately 35.7 percent of Florida's population (i.e., the non-Medicare population who not covered by Medicaid, was not self-insured, was not uninsured, or was not covered under the federal employees health plan). The bill was introduced again in 1996 and 1997. Although the 1997 session, the bill was unanimously approved by the Senate Banking and Insurance Committee, and had near unanimous approval by the House and Senate, it did not pass.

In 1998, the bill, now known as the "Diane Steele Mental Illness Insurance Parity Act" required HMOs and carriers to provide inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits for mental conditions consistent with annual and lifetime physical coverage. The coverage was limited to those mental illnesses that were biological in origin. It also required treatment for substance abuse associated with mental illness. The *Senate Staff Analysis and Economic Impact Statement* recommended that, at a minimum, the insurance code be amended to conform Florida law to the Federal Mental Health Parity Act (State of Florida, 1998). In 1999, the bill again did not pass.

In 2000, the bill has been introduced as S. 1658 by Sen. Myers. The bill states (in part) that the current requirement for group insurers to offer coverage for mental health conditions does not apply to serious mental illness; requires group health insurers and HMOs to provide coverage for serious mental illness; and requires the health benefit plan committee to consider and recommend modifications to standard, basic, and limited health benefit plans. The bill amends Chapters 627 and 641 of the Florida Statutes (sections 0627.6472, 0627.6515, 0627.668, 0627.6681, 0641.31). It has been referred to the Banking and Insurance Committee and the Fiscal Policy Committee (SB1658, 2000).

An Interim Project Summary Report, by the Committee on Children and Families (1999), defines publicly funded mental health and substance abuse services and priority population groups. With this report, as well as past House and Senate staff analyses, parity appears to be a prominent issue for the Legislature. For more information on health insurance laws in the state, please see the interim session report *Review of Florida's Health Insurance Laws Relating to Rates and Access to Coverage* (1999).

Health Benefits and Mandates in Florida

Health insurance regulation is a patchwork of federal and state laws. The rules for a health plan will differ depending on whether the health insurance is self-purchased, employer-purchased or if the insurance is part of a self-funded ERISA plan. If a health plan is part of an ERISA plan, then the health plan has to comply only with a few minimal federal regulations because of a law passed decades ago which exempts self-funded ERISA plans from state regulation. Mid-to-large sized employers will sometimes choose to fund their own health benefits plans for their employees — those are ERISA plans. But if an employer buys health insurance from an insurance company, or if a consumer purchases their own private plan, then additional state regulations apply. State regulations entitle the consumer, private plan or employer, to certain kinds of coverage, the specifics of which vary from state to state. In some places, the plan entitles policyholders to treatment for alcoholism. In other places, the policyholder will have to pay for other types of care.

Florida law does not guarantee that all individuals have access to a health insurance policy (Committee on Banking and Insurance, 1999). Furthermore, there is no statutory requirement that mandates the inclusion of mental health or substance abuse treatment benefits for health insurance coverage. Florida law, however, does require insurers and health maintenance organizations to *offer the option of coverage* for mental illness or nervous disorders to the group policyholder (Florida Statutes, §627.668*).*

In addition, insurers are authorized to charge "an appropriate additional premium." The law also requires the insurer to offer a range of coverage. The number of inpatient days and the amount of outpatient benefits are limited. Insurers may price the coverage separately and may vary the benefits for inpatient or outpatient services for hospitalization. The "standard" and "basic" small group insurance plans currently define "mental and nervous disorder" from the most recently published edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*).

The Impact of Parity Legislation for Florida in Benefits Design

What specific changes would parity legislation mean for Florida?

1. Statutes will be affected, specifically *S.627.688, .6472, .6515, 641.31, F.S.*, relating to optional coverage for mental and nervous disorders. S.627.6681 will be created.

2. Confidentiality of records would be required for those records relating to serious mental illness.

3. Every insurer and HMO in Florida transacting group health insurance or pre-paid health care would be required to provide treatment for serious mental illness.

4. For those who have a co-occurring substance abuse problem, treatment would be included for the substance abuse problem.

5. The health insurance mandate would apply to local government health insurance plans. [1]

1 The State Constitution allows a general law such as this one if the legislature determines the law fulfills an important state interest. Each time Legislature has determined that the bill fulfills a critical state interest.

6. Severe mental illness is defined as any biological disorder of the brain that substantially limits the life activities of the patient.[2]

In House staff analyses of the Florida parity legislation, it was determined that if a parity model similar to the Texas state employee model were enacted, the cost to the state would be $2.50 per member per month or $405,600 (Commiteee, 1997). For the public sector, there ultimately would be reduced costs for health care in that extended coverage would reduce direct and indirect costs of treatment. For the private sector, although there would be initial increase in the utilization costs, there would also be a reduction in total health costs resulting from the more comprehensive treatment of these conditions (Commiteee, 1997; and Levin et al., 1999).

Further Benefits from the State's Perspective

In addition to the impacts noted above, the passage of a mental illness parity law would benefit the state of Florida by shifting some of the costs of providing treatment for severe mental illness from state (and federal) government to the private sector, specifically to the private business sector (either employer or employee). As previously noted in the discussion of the costs of mental health treatment, the burden of paying for treatment costs that are not covered under private insurance plans often falls on state or federal agencies. McKusick et al. (1998) estimated state and local government expenditures for mental illness and substance abuse treatment to be approximately 22 percent of overall spending, approaching $15 million. The Federal government, namely Medicaid and Medicare programs, accounted for an additional 32 percent. Nationally, 41.3 percent of persons (ages 21 to 64) with a mental disability are employed. Of those with a severe disability, 43.7 percent have private health insurance (US Census Bureau, 1996).

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

In this section we provide a rough estimate of the magnitude of benefits to the state of Florida from a mental illness parity law. In 1998, the population of Florida was 14.92 million persons, with 3.54 million persons under the age of 18 and 11.38 million adults (Statistical Abstract of the United States, 1999, Table 33). If Florida has the same incidence of severe mental illness as exists in the country as a whole, then 319,000 adults (2.8 percent times 11.38 million) and 113,000 children (3.2 percent times 3.54 million) currently suffer from severe mental illness, a total of 432,000 persons in Florida.

Milliman & Robertson (1995) estimated that the proposed parity law would affect 35.7 percent of Florida's population. Certain groups are exempted from the proposed legislation, most importantly the self-insured, those employed by small businesses, 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 154,000 persons with severe mental illness who will fall under the parity law: approximately 114,000 adults and 40,000 children.

2 The latest edition of the relevant manuals of the American Psychiatric Association or the International Classification of Diseases would define severe mental illness.

If treatment utilization rates in Florida are roughly comparable to rates for the rest of the country, then 60 percent of the adults (68,300) and 29 percent of those under the age of 18 (11,700) are currently receiving treatment for severe mental illness (annual average). If the parity law, via its reduced cost of treatment, increases the number of persons who seek treatment by 20 percent, then approximately 13,700 additional adults and 2,300 addition youths will seek treatment if a parity law is enacted, a total of 16,000 additional persons. Treatment efficacy rates for serious mental illness have been estimated to be in the neighborhood of 70 percent. If this rate holds true for Florida, then approximately 11,200 persons (16,000 times .70) will show significant improvement in their condition as a result of the enactment of a parity law.

Nationally, the annual per person social cost (i.e., costs, such as lost productivity, in addition to treatment costs) of serious mental illness were estimated to be approximately $6,700 in 1990. This implies that the benefits resulting from the successful treatment of a person with serious mental illness would be $8,540 in 1999 dollars. Multiplying this figure by the estimated 11,200 persons who would show significant improvement in their serious mental illness as a result of enactment of a parity law yields an estimated annual social benefit for the state of Florida of $95.7 million.

While this is obviously a rough calculation, there are reasons to believe that it represents a lower bound estimate of the benefits to Florida of a parity law. One reason relates to results published by The National Advisory Mental Health Council. The Council estimated that in 1990 a nationwide parity law would yield $7.5 billion in benefits in the form of reduced social costs from serious mental illness (as well as an addition $1.2 billion in reduced health care costs for physical illness).

If these benefits were converted to 1999 dollars and prorated on the basis of 1998 population data, Florida's share of the benefits from reduced social costs would equal $530 million, or more than five times the estimate derived above (Florida's share of the reduced health care costs would equal an additional $83 million).

A second reason to think that the benefit estimate derived above represents a lower bound estimate is that several factors were omitted that should be accounted for in a more complete analysis. Most notable among these are the:

1. increased treatment utilization of those who are currently receiving treatment, which would presumably result in improved mental health, thus increasing benefits;

2. improved cost effectiveness in treatment that should occur as a result of the law, as care providers are no longer constrained by insurance provisions to utilize sub-optimal treatment methods (e.g., in-patient rather than more inexpensive out-patient care);

3. reduction in costs for physical health care (roughly estimated above to equal $83 million); and

4. financial benefit to the state for the transfer of treatment costs to the private sector.

State policymakers charged with budgeting expenditures for welfare, Medicaid, corrections, and education should be aware that estimating the costs of any major change in insurance benefits is difficult. Policymakers should bear in mind that the effects of specific forms of managed care on behavioral health will be of great value in making accurate cost estimates. The UCLA/Rand (Sturm, 1997), William M. Mercer (1997), and MIT/Sloan (Greenberg, 1995) studies are evidence of the effectiveness of managed behavioral health care. Finally, policymakers should also be aware of the implications of shifting boundaries between publicly and privately insured mental health care systems when separating cost shifts from new use (Frank & Lave, 1984; and Rupp et al., 1984).

CONCLUSION

The benefits to be achieved from parity in health insurance coverage for mental illness can be viewed from a number of levels. From the societal perspective, the purpose of the mental health parity proposal is to expand and improve the treatment of persons with mental illness. Additional benefits of such legislation will be a function of increased treatment, treatment efficacy rates and the lowering of social costs that mental illness imposes on society, including the individual in treatment, the family, the employer; federal, state, and local governments, and ultimately the taxpayer.

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. Nevertheless, Florida has the opportunity to establish a policy for mental health parity vis-a-vis somatic health services. Based upon the experiences of other states, this initiative will provide availability to mental health insurance coverage as well as reduce the total costs to residents who live in Florida.

Conceptually, parity began as the idea that mental health should be treated the same as physical health. To move beyond rhetoric to actual implementation, parity should be operationalized. Implementing parity would mean that decisions about benefit coverage would be made according to the same set of rules that govern physical health treatment. "Fairness" to beneficiaries, as opposed to strictly identical benefits, would be the guiding principle. All medical services that show similar price responsiveness should be treated the same (Ridgley & Goldman, 1996).

Consumers, payers, and providers of mental health services focus increasingly on outcomes-oriented data aimed at improving the well being of the citizens of the state of Florida. States will need to reorganize epidemiologic, financing, and service delivery data, and link databases in order to reduce waste, improve efficiency, contain costs, and provide services for persons with severe mental illnesses.

A public health focus on the well-being of entire populations, including enrollees in commercial health care plans and Medicaid beneficiaries, can help Florida provide needed mental health services, as well as limit the demands for new resources from financially strapped public and private purchasers.

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Appendix: Summary of State Parity Legislation

State	Bills
Alabama	No specific mental health parity legislation passed.
Alaska 1998	Provides for study of parity.
Arizona Enacted: 1997 Effective: 7/21/97 Enacted: 2/98 Effective: 1/1/99	Mirrors 1996 federal law, excludes substance abuse. HB 26651: HMO's, group and individual insurers must offer coverage for mental illness and substance abuse under same terms as for mental illness. From 7/1/99-6/30/00 insurers will offer at least 60 days of inpatient and outpatient care for mental illness a nd substance abuse. From 6/1/00, insurers must offer at least the same number of days that are offered for physical illness.
Arkansas Enacted: 4/97 Effective: 8/1/97	HB 1525: Provides equal coverage of mental illness & developmental disorders (not substance abuse); exempts state employees, companies of less than 50 employees, and those that anticipate cost increases of over 1.5%.
California Enacted: 1999 Effective: 7/1/00	AB 306: Provides for persons of any age equal coverage for specific biologically-based severe mental illness and serious emotional disturbance in children with one or more mental disorders other than a primary substance abuse disorder. No small business exemption.
Colorado Enacted: 1997 Effective: 1/1/98	HB 1192: Provides for coverage of specific biologically based major mental illness that is no less extensive than that provided for other physical illness.
Connecticut Enacted: 1997 Effective: 10/1/97 Enacted: 1999 Effective: 10/1/99	Two bills enacted. HB 6883: Provides for coverage of biologically based major mental illness and nervous conditions. Defines "biologically-based mental illness." HB 7032:Part of omnibus managed care bill. Requires full parity for mental health and substance abuse benefits.
Delaware Enacted: 1998 Effective: 1/1/99	HB 156: Provides for coverage of severe biologically based mental illness under the same terms and conditions of coverage offered for physical illness.
District of Columbia	No mental health parity legislation activity.
Florida	No mental health parity legislation passed

Georgia Enacted: 1998 Effective: 4/6/98	SB 620: Requires employers that choose to provide mental health benefits to provide equal lifetime and annual caps for mental health benefits. "Mental Illness" covers all brain disorders in DSM-IV.
Hawaii	Three bills passed.
Enacted: 1999 Effective: 7/1/99	SB 844: Makes health insurance coverage for mental illness no less extensive than that for other medical illnesses. Does not include coverage for substance abuse or disorders other than schizo phrenia, schizoaffective disorder or bipolar mood disorder. Exempts small businesses with 25 or fewer employees. Established mental health parity task force.
Intro. & Passed: 1/26/00	SB 2973: Requires parity for in insurance coverage for mental health benefits; defines serious mental illness as mental disorders as defined in the Diagnostic and Statistical Manual, except for specified conditions; deletes exception for employers with 25 or fewer employees; clarifies duties of the Hawaii mental health insurance task force.
Intro. & Passed: 1/25/00 & 1/26/00	SB 2891: Requires health insurers to equitably reimburse providers for mental health treatment.
Illinois	No mental health parity legislation passed.
Indiana	
Enacted: 5/13/97 Effective: 67/1/97 Sunsets: 9/29/01	HB 1400: Mirrors federal law with full parity for state employees; no provisions for substance abuse.
Enacted 1999 Effective: 7/1/99 & 1/2/00	HB 1108:Amends 1997 parity law to cover "services for mental illness" as defined by contract, policy or plan for health services. No provisions for substance abuse. Exempts businesses with 50 or fewer employees and provides for a four & cost-increase exemption. Removes sunset provision.
Enacted: 1/10/00 Effective: 7/1/2000	SB 0392: Includes parity for substance abuse treatment.
Enacted: 1/10/00 Effective: 7/1/2000	SB 0395: Amends 1999 law to provide exemption for businesses with 25 or fewer employees.
Idaho	No specific mental health parity legislation passed
Iowa	No specific mental health parity legislation passed
Kansas Enacted: 5/15/97 Effective: 1/1/98	S 204: Limited parity for mental health benefits mirroring 1996 federal law, referring to mental health services as defined under terms of the policy. Substance abuse and chemical dependency specifically excluded. Does not extend to small businesses or groups whose policy increases more than 1%.
Kentucky	**No mental health parity legislative activity.
Louisiana	Enacts law mirroring 1996 federal law (1997)
Enacted: 1999 Effective: 1/1/00	HB 1300: Insurer's group plans must include equitable coverage for severe mental illness. Coverage for mental illness must be under the same terms as coverage for other illnesses. No small business exemption. Policies must offer optional coverage for other disorders at the expense of the policyholder. Set minimum benefits: 45 in-patient days & 52 outpatient visits/year.

Maine Enacted 1995 Effective: 7/1/96	PL 407/HB 432- LD 595: Provides for coverage for specific major mental and nervous disorders to be no less than that of physical illness. Does not include substance abuse and excludes groups of 20 or fewer employees.
Maryland Enacted: 1993 & 1994 Effective: 8/1/94	HB 1359, HB 1197, HB756: Establishes full parity. Prohibits insurers and HMOs from discriminating against any person with mental illness, emotional disorder or substance abuse by failing to provide treatment or diagnosis equal to that of physical illnesses. Does not define "mental health" or " mental illness."
Massachusetts	No mental health parity legislation passed.
Michigan	No mental health parity legislation passed.
Minnesota Enacted: 8/1/95 Effective: 8/1/95	SB845: Establishes full parity. Requires cost of inpatient and outpatient mental health and chemical dependency services to be not greater or more restrictive than for similar medical services. Does not define "mental illness" or "substance abuse."
Mississippi	No mental health parity legislative activity.
Missouri Enacted: 6/25/97 Effective: 9/1/97 Enacted: 7/13/99 Effective: 1/1/00 Expires: 1/1/05	Two bills. HB 335: As part of larger managed care regulatory measure, covers all disorders in the DSM-IV in managed care plans only, equal to that of physical illness. HB 191: specifies that coverage for mental illness benefits shall not place greater financial burdens on the insured than that of physical illnesses. Substance abuse only covered if co-morbid with other mental illness and coverage can be limited to one detox session not to exceed 4 days. Insurer may apply different deductibles, co-pays and co-insurance terms. Business can apply for exemption if cost increase exceeds 2%. Provides for impact study.
Montana Enacted: 4/97 Effective: 1/1/98 Enacted: 1999 Effective: 1/1/00	SB 378 Sec 9: Addresses mental health parity in the context of managed care reform. Mirrors 1996 federal law. States mental health benefits must be offered and must not be more restrictive than plans for general health conditions. SB 219: Provides equitable health insurance and disability insurance for severe biologically based mental illnesses that is no less than that provided for other physical illnesses.
Nebraska Enacted: 5/25/99 Effective: 1/1/00	LB 355: Prior to January 1, 2002 plans to provide coverage for schizophrenia, schizoaffective disorder, delusional disorder, bipolar affective disorder, bipolar disorder, major depression and obsessive-compulsive disorder shall not place financial burden for treatment than for physical health conditions. Parity must be provided for annual and lifetime limits and the number of inpatient and outpatient visits. Parity is not required in co-pays, co-insurance and deductibles. After January 1, 2002 the law applies to any mental health condition that current medical science affirms is caused by a biological disorder of the brain and substantially limits the life activities of the person with the illness. Exempts business of fewer than 15 employees. Not a mandate.

Nevada Enacted: 1997 Effective: (Sec 88) 1/1/98 Expires 9/30/01 Enacted 5/30/99 Effective: 1/1/00	AB 521: Broad health care reform bill with specific reference to mental health parity in section 88. Mirrors 1996 federal law. Health plans must offer equitable benefits for mental health care if they do offer such care. Intended for large group health plans and plans are exempt if their cost increases more than 1%. AB 557: Mandates coverage for those with severe mental illness. Annual, lifetime, and out-of-pocket limits must be equal to that of other medical/surgical benefits. Minimum 30 inpatient and 27 outpatient visits annually. Outpatient visits for medication management come out of standard medical coverage. Co-pays are maximum of $18 for outpatient visits and $180 per inpatient visit. Businesses of 25 or fewer employees are exempt from mandate.
New Hampshire Enacted: 1994 Effective: 1/1/95	SB 767: Provides parity for biologically based severe mental illness. Applies to groups and HMOs only regardless of size.
New Jersey Enacted: 5/13/99 Effective: 8/99	S 86: An Act concerning Health Insurance Benefits of Mental Health covers biologically based mental illness.
New York	No mental health parity legislation passed.
New Mexico Enacted: 2/15/00 Effective: 10/1/00	HB 452: Provides equal coverage for mental illness in health insurance plans that are new or renewed starting Oct. 1, 2000. Allows companies with up to 49 workers to opt out of the coverage if premiums increase more than 1.5 percent. Companies with 50 or more to opt out if the increase exceeds 2 percent. Businesses can negotiate some reduction in coverage or develop a cost-sharing arrangement with employees. Self-insured businesses are not included.
North Carolina Enacted: 1991 Effective: 1/1/92 Enacted: 7/3/97 Enacted 8/28/97	Three bills. HB 279: Provides for employees of local and state government to have treatment of mental illness subject to the same deductibles, durational limits and coinsurance factors as for physical illness. HB 434: Established full parity by amending North Carolina's insurance laws to comply with federal legislation. Does not require mental health coverage to be provided, but if it is it must be equal to that of physical illness. Now known as CH SL 97-0259. HB 435: Amends state employees' health plan to include benefits for treatment of chemical dependency subject to the same deductibles, durational limits and coinsurance factors as for physical illness. Now known as CH SL 97-0512
North Dakota 1994	Provides for study of parity.
Ohio	No mental health parity legislation passed.

Oklahoma Enacted: 5/13/99 Effective: 11/1/99?	SB 2 Provides equitable coverage for severe mental illness. Exempts employers with 50 or fewer employees and those who experience a premium increase of 2% or more. The law is repealed in 2003 if an Oklahoma Insurance Department study shows a premium increase of 6% over three years.
Oregon	No mental health parity legislative activity
Pennsylvania Enacted: 1998	Health plans required to cover 30 days of inpatient mental health treatment and 60 outpatient visits. Plans must cover emergency screenings and stabilization for plan members.
Rhode Island Enacted: 1994 Effective: 1/1/95	S 2017: Provides coverage for serious mental illness that current medical science affirms is caused by a biological disorder of the brain and substantially limits life activities.
South Carolina Enacted: 3/31/97 Effective: group plans 11/1/98 Expires 9/30/01	S 288: Broad based parity in insurance contracts offering mental health benefits. Group policies must offer same lifetime and annual benefits as offered for medical/surgical benefits. Small employers exempt as are plans not offering mental health benefits. Substance abuse excluded and mental illness not specifically defined.
South Dakota Enacted: 3/13/98 Effective: 7/1/98 Enacted: 1999 Affective: 1999	Two bills. HB 1262: Requires insurance companies to offer coverage for biologically based severe mental disorders that is equal to that offered for severe somatic illnesses. HB 1264: Clarifies definition of “biologically-based mental illness”
Tennessee Enacted: 4/30/97 Effective: 1/1/98 Enacted: 1998 Effective: 1/1/00	SB 1699/HB 1825: Features a section (17) with language for parity based on federal parity requirements in the context of broad HIPAA compliance legislation. Applies to group health plans that offer mental health benefits. Small businesses and those that experience more than a 1% increase in premiums are exempt. HB 3177: Provides mental health coverage mirroring 1996 federal law but does not cover substance abuse. Lifetime and annual limits must be equal to other medical and surgical benefits. Businesses with 25 or fewer employees or an increase of more than 1% in premiums are exempt.
Texas Enacted & Effective: 1991 Enacted: 1997 Effective: 1997	Two bills. HB 2: Covers all public state and local employees including teachers and university system employees for schizophrenia, schizoaffective disorder, bipolar disorder, and major depression. HB 1173: Specifies requirements for group insurance coverage for serious mental illness, no lifetime limit on inpatient/outpatient benefits. Requires same deductibles, limits, co-pays and co-insurance for serious mental illness as for physical illness. Does not include chemical depen dency.
Utah	No mental health parity legislation passed

Vermont Enacted: 5/28/97 Effective: 1/1/98	HB 57: Full parity. Broad definition of mental illness and substance abuse, covering any conditions within the diagnostic categories in the international classification of disease. Children and substance abuse fully covered. Applies to any policy offered by any health insurer or administered by the state. Managed care organizations must comply with state insurance commissioner.
Virginia Enacted: 9/25/99 Effective: 1/1/00	HB 430: Requires that insured plans offer the same level of coverage for biologically based mental illness as for physical conditions including ADD, autism, drug and alcohol addiction
Washington 1998	Provides for study of parity
West Virginia 1997	Provides for study of parity
Wisconsin	No mental health parity legislative activity.
Wyoming	No mental health parity legislative activity

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