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Mental health parity: National and state perspectives 2001: A report to the Florida Legislature

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Mental Health Parity

National and State Perspectives 2001

A REPORT TO THE FLORIDA LEGISLATURE

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EXECUTIVE SUMMARY

Limitations in private insurance coverage for serious mental illness often bankrupts covered individuals and their families and often forces an individual to cycle between episodes of acute illness without the ability to use the full range of outpatient services in the community. This cycle affects all ages, all ethnic and cultural groups, and all socio-economic levels.

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. Without parity, the difference between coverage for physical and mental illness is striking. While the typical lifetime cap for mental health treatment is about $500,000 and the annual limit runs about $5,000, insurers routinely provide a $1 million lifetime cap for physical illnesses with no annual limit. Thirty-two states have parity laws for mental health and /or substance abuse. In addition, forty-four states (including the District of Columbia) across the nation have enacted laws for mental health and/ or substance abuse benefits.

The estimated costs of implementation of parity still appear to hamper states' decisions to adopt parity legislation. Earlier information on utilization and costs were inconsistent and inconclusive. Many of these estimation efforts were hampered by reliance on inappropriate 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 and 1999, 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 concluded 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 Research, Inc. indicate that predicted cost increases for full mental health parity benefits range from less than one percent to three percent.
- Only four benefit-purchasing organizations representing groups of employers have invoked exemption, according to U.S. Labor Department statistics.

Benefits from Parity

There has been a fundamental shift in the way behavioral health services are delivered in the United States with a focus on shorter stays, lower costs, and expanded access to care. While more recent cost experiences show modest increases, numerous additional benefits can be realized from implementing parity legislation:

- 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 and/or substance abuse;
- 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 potentially reduce the degree to which financial responsibility for the treatment of mental illness is shifted to government, especially to state and local governments. There is substantial evidence that both mental health and addictions treatment is effective in reducing the utilization and costs of medical services.

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.

> **Mental health is fundamental to a person's overall health, indispensable to personal well-being and instrumental to leading a balanced and productive life.**
>
> David Satcher, Surgeon General, 1999

PREVALENCE OF 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).

Problem Significance

Mental disorders remain significant public health problems in twenty-first century America. The World Bank and the World Health Organization reported findings from 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. A striking finding from the study, *The Global Burden of Disease*, was 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 disorders (Murray & Lopez, 1996).

According to the report from the United States Surgeon General (U.S. Department of Health and Human Services, 1999), mental disorders comprise four of the ten 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. Mental disorders are also significant contributors to the burden of disease, ranking second only to cardiovascular illnesses in disease burden in this country.

The ECA Study and the NCS

The best known and comprehensive epidemiologic study on mental health was the Epidemiologic Catchment Area Study (ECA) begun in 1978 (Regier et al., 1993; Robins & Regier, 1991; Regier, Boyd, et al., 1988; Regier et al., 1985) that examined prevalence and incidence of mental disorders in the community as well as in institutional settings. Results from the ECA study indicated, overall, that twenty percent of the population had an active mental disorder in the past twelve months.

National Comorbidity Study

A second significant study was the National Comorbidity Survey (NCS) (Kessler et al., 1994)*. The NCS incorporated DSM-III-R (Diagnostic and Standards Manual 3rd revision) nomenclature and extensively examined risk factors that affect particular mental disorders to determine the comorbidity of psychiatric disorders (Blazer et al., 1994). Results from the NCS indicated that thirteen percent of the population aged fifteen to fifty-four had both a substance abuse and a mental disorder in their lifetime.

The National Institute of Mental Health (NIMH) estimated the number of persons with severe mental illness and a co-occurring substance disorder at 1.8 million (Regier et al., 1988). 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 (Special Issue, 1996). A second study by Kessler, Nelson, et al. (1996) stated 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.

* Comorbidity refers to the occurrence of both a substance disorder and any psychiatric illness in an individual as described in the *Diagnostic and Standards Manual.*

EXPENDITURES & SERVICES FOR MENTAL HEALTH

Expenditures

Between 1987 and 1997, according to the United States General Accounting Office (2000), the growth in mental health spending in the United States roughly paralleled the growth in overall health care spending. However, federal mental health spending grew at more than twice the rate of state and local spending. Increasingly, Medicaid and Medicare expenditures accounted for a larger federal share, with combined federal and state Medicaid expenditures accounting for 20 percent of all mental health spending in 1997 (United States General Accounting Office, 2001).

Rouse (1995) estimated the total (direct and indirect) costs to society for mental disorders and substance abuse in 1994 far exceeded the costs of cancer ($104 billion), respiratory disease ($99 billion), AIDS ($66 billion), or coronary heart disease ($43 billion). McKusick et al. (1998) reviewed only the direct costs of treatment by analyzing national spending trends during this decade by studying formal health care 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 were $79.3 billion. The largest share went to mental illnesses ($66.7 billion), $5.0 billion went to alcohol abuse, and $7.6 billion went for abuse of other substances. A more recent study by Coffey et al. (2000) estimated that 1997 expenditures for treatment of mental health and substance abuse were $85.3 billion. Of the total, $73.4 billion went to mental illnesses and $11.9 billion went to substance abuse disorders.

Services & Coverage

Historically, trends in health care influence mental health (and substance abuse) services and spending. Factors affecting behavioral health expenditures include managed care constraints, changes in how hospitals are used, increases in outpatient treatment relative to residential care, the rapidity in discoveries and promotion of pharmaceutical therapies.

In 1997, health maintenance organizations, preferred provider organizations, and at-risk contracts accounted for 29.2 percent of inpatient admissions, an increase of 18.2 percent over 1996 (Health Care Financing Review, 1999). Government programs accounted for 40.7 percent of all inpatient admissions in 1997 (Medicare, 22.3 percent and Medicaid, 18.4 percent). Inpatient admissions covered by other payers, commercial insurers (including Blue Cross and Blue Shield) covered 16.2 percent ; CHAMPUS (Civilian Health and Medical Program of the Uniformed Services), 1.2 percent; other government organizations and state health departments, 1.5 percent; employer contracts, 1.7 percent; and self-pay, 4.0 percent. In addition, the proportion of inpatient care covered by health maintenance organizations, preferred provider organizations (PPOs) and other at-risk contracts grew 18.2 percent between 1996 and 1997, covering 24.7 percent of inpatient admissions in 1996 and 29.2 percent by 1997 (Kaplan, 1999).

Recent analyses indicate that over 78 percent of insured Americans (approximately 140.6 million people) are enrolled in some type of managed behav-

ioral health program (Fox et al., 1999). In addition, it has been estimated that 16 percent of the population in the United States is uninsured (US Census Bureau, 2000), and mental health coverage is limited for those who are insured (Frank et al., 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).

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 also 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 (Health Care Financing Administration in Freund & Hurley, 1995). Fiscal pressures, such as the loss of federal "matching dollars" and the move to Medicaid waivers, have been the main impetus for states to adopt managed care for their Medicaid populations (Ridgely & Goldman, 1996). As the U.S. population ages, the proportion of older adults in treatment, including those covered by Medicare, is likely to increase. At the same time, a large number of Medicare beneficiaries, eligible due to psychiatric disability, will need inpatient as well as outpatient services (Kaplan, 1999).

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 (United States General Accounting Office, 1996). 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, neither information on breakdown by type of mental disability nor updated figures were available (United States General Accounting Office, 1996).

Medicaid inpatient admissions rose by 3.3 percent in 1997. The federal Medicaid rule, known as the Institutions for Mental Diseases (IMD) exclusion, prohibits coverage for persons between ages 22 and 64 in private hospitals. Therefore, inpatient admissions from Medicaid are primarily for patients 21 years of age or under and 65 years or older. Nevertheless, in restructuring their Medicaid programs, many states are applying for federal waivers to the IMD exclusion. These waivers could potentially contribute to an increase in Medicaid-covered admissions (Kaplan, 1999).

There are "recurrent concerns regarding the adequacy of resources; the way they are used; and how best to increase the equity, efficiency, and effectiveness of health care."

Manfred Huber, 1999

* In 2001, the name of the Health Care Financing Administration (HCFA) was changed to the Centers for Medicare & Medicaid Services (CMMS). For purposes of this report, the Health Care Financing Administration and/or HCFA will continue to serve as the name of the agency.

MANAGED CARE

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

(David 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 aggressive and 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 & 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. Carve-out programs are more likely to cover specialty services (i.e., residential, rehabilitation, support, and consumer-run services), while integrated programs are more likely to cover pharmacy services. 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, reduction in the length of mental health treatment, 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, insurers, as well as sub-contracting with HMOs and other models of managed health care plans, a number of studies have reported significant declines in the costs of mental health care under these MBHOs (Cuffel, Goldman, Schlensinger, 1999; Goldman, McCulloch, Sturm, 1998; Grazier et al., 1999; Ma & McGuire, 1998; Congressional Budget Office, 1995; National Advisory Mental Health Council, 1998).

A 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), Rand Corporation (Sturm, 1997; Goldman, McCulloch, Sturm, 1998), and the Lewin Group (1997, 2000) 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 co-payments. 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, cost increased by 20% annually. Post carve-out, costs decreased by 40%. Cost reduction was not due to decreased access.

Public Sector Managed Behavioral Health Care

The number of states with public sector managed behavioral health care programs has tripled in three years (Lewin Group, 2000). In 1996, fourteen states implemented managed care programs. By 1999, forty-two states (including the District of Columbia) operated some form of managed behavioral health care. 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 (http://www.hcfa.gov/medicare/mgdcar.htm, 2001).

Financing

Medicaid is the largest source of funding for public managed behavioral health care programs. Ninety-eight percent of all states with managed behavioral health care programs use Medicaid to either fully or partially fund their programs (Lewin Group, 2000). Medicaid finances integrated programs almost exclusively. In contrast, carve-outs are much more likely to include a combination of Medicaid and non-Medicaid funding. Thirty-seven states (eighty-eight percent of states with managed care) contract with a managed care organization on a capitated basis for at least one of their programs. The next most common payment arrangement consists of fixed fees (twelve states) and FFS (ten states). Administrative service only (ASO) contracts account for seven of the twelve states using fixed fees. In contrast to managed care organizations, providers are predominantly paid on a fee-for-service basis (thirty-four states).

Purchasing and Contracting Arrangements

While Medicaid agencies most often serve as the primary purchaser for managed behavioral health care programs, state mental health and substance abuse authorities work in collaboration with Medicaid agencies, particularly for carve-out programs. The complexity of the contractual arrangements between state and local governments and managed behavioral health care organizations (MBHOs) varies considerably (Findlay, 1999). Some programs are comprehensive, covering multiple populations or areas across the state while others are limited to certain populations or one county or region. Most programs are risk-based, while still others remain fee-for-service through ASO contracts. In 1999, for example, two states (Montana and North Carolina) terminated their managed behavioral health care programs and reverted to fee-for-service systems (Lewin Group, 2000).

Some states contract directly with MBHOs or subcontract 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 subcontract 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. A recent Lewin Group report (2000) described how Medicaid agencies acted as the purchaser in ninety-three percent of states with integrated programs, compared with sixty-nine percent of states with carve-outs. Lewin also noted that integrated programs most often contracted with private sector managed care organizations. Of thirty states with integrated programs, ninety-three percent contracted with private entities, primarily health maintenance organizations. Public sector managed care organizations were more prevalent in carve-out programs. Of the twenty-nine states with carve-outs, fifty-nine percent contracted with a public entity, primarily county, local governments, or community mental health centers. Counties also dominated among all types of public sector contractors, regardless of model. Ten states (twenty-four percent) had ASO contracts with private organizations to operate managed care programs with no clinical responsibilities or financial risk.

"... 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

Populations Covered

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 twenty-six 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 (Ridgely & Goldman, 1996).

Currently, SSI populations are required to enroll in more than half of the managed care programs providing behavioral health services (Lewin Group, 2000). Of the seventy-one Medicaid programs in forty-one states, sixty-six percent have mandatory enrollment for TANF (Temporary Assistance to Needy Families) populations and fifty-one percent have mandatory enrollment for SSI (Lewin Group, 2000).

Medicare funds a much smaller proportion of publicly supported mental health services. The large differences between Medicaid and Medicare reflects the age-specific prevalence of mental health (and substance abuse) problems in the United States. A recent study, which excluded dementia from its study of mental illness, concluded the differences in funding reflected the age-specific prevalence of mental illnesses and may reflect generational attitudes toward the acceptance of mental illnesses as treatable conditions (Coffey et al., 2000).

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 hold the promise of more cost-effective treatment. For example, if under parity, 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.

Despite opposition by those who have claimed that parity would increase expenditures, additional studies (Sing et al., 1998; National Advisory Mental Health Council, 1998; Sturm, 1997; Lewin Group, 1997; Congressional Budget Office, 1996; Goldman, McCulloch, Sturm, 1998; Grazier et al., 1999; Sturm & McCulloch, 1998; 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* (1999) 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 nonexistent. 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 *Survey*, the Mental Health Parity Act had an unintended beneficial effect of also improving coverage for substance abuse benefits in many plans.

A report by the United States General Accounting Office (2000, May) indicated that although most employers are complying with the federal mental health parity

[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.

law, compliance may actually have little effect on employees' access to mental health services. Eighty-six percent of the responding employers in the twenty-six states and the District of Columbia reported, that as of December 1999, their plans were in compliance with the federal parity requirement.

The GAO survey found that fourteen percent of plans were noncompliant, which was a rate similar to the Department of Labor's preliminary estimates based on investigations of employer-sponsored plans. In contrast, in 1996 before the parity law was enacted, approximately fifty-five percent of responding employers reported offering parity in dollar limits. Many responding employers cited the federal Mental Health Parity Act as a significant or primary reason for changing the dollar limits in their health benefit plans.

Although most employers' plans now have parity in dollar limits for mental health coverage, eighty-seven percent of those that comply with the federal law contain at least one other benefits design feature that is more restrictive for mental health benefits than for medical and surgical benefits. The GAO found that sixty-five percent of plans restricted the number of covered outpatient office visits and hospital days for mental health treatment more than those for other health treatment. It also found that many employers may have adopted newly restrictive mental health benefit design features since 1996, specifically to offset the more generous dollar limits they adopted as a result of the federal law. Finally, the GAO reported that about two-thirds of these newly compliant employers changed at least one other mental health benefit design feature to a more restrictive one compared with only about one-fourth of the employers that did not change their dollar limits.

While most employers have not examined changes in their plans' claims costs, the federal parity law appears to have had a negligible effect on these costs. Approximately 3 percent of responding employers reported that compliance with the law increased their claims costs, and virtually no employers have dropped their mental health benefits or health coverage since the law was enacted (United States General Accounting Office, 2000). In addition, published estimates of the cost of federal parity are typically less than one percent. More comprehensive parity laws as enacted by some states are generally estimated to have modest cost increases of about two to four percent compared to earlier estimates ranging from six percent or higher (United States General Accounting Office, 2000).

The GAO (2000) reviewed two agencies that have oversight roles under the parity law: the Department of Labor and the Health Care Financing Administration (HCFA). According to the GAO, the Department of Labor is using a complaint-driven approach used in its oversight of private employer-sponsored health plans as well as randomly selected employer investigations to gauge overall compliance with parity and other federal standards. The HCFA has not yet fully determined the nature and extent of its oversight responsibilities.

Initially HCFA identified seven states that appeared not to have a parity law. By May 2000, HCFA reported that four of these states are enforcing the federal standards through conforming legislation or other means. It is still working with the three other states to assist them in enacting similar protections. Although HCFA determined that laws in 20 states appear to fully conform to the federal standards, it is still evaluating whether laws in the remaining twenty-four states fully conform to the federal standards (United States General Accounting Office, 2000).

COST OF TREATMENT ISSUES

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; Clark et al., 1994; Dickey & Azeni, 1996; Chandler et al., 1997). 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; Teplin, Abram, McClelland, 1996). 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.

The Global Burden of Disease, a publication of the World Bank and the World Health Organization, reported on 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), is 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 (Murray & Lopez, 1996).

Direct Costs

According to Mark et al. (1998), $69 billion was spent 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). A second study by Coffey et al. (2000) estimated that specialty providers accounted for 71.0 percent ($60.6 billion) of the $85.3 billion of the total expenditure on mental health and substance abuse in 1997. General providers received 14.3 percent ($12.2 billion). Public payers funded the majority of mental health and substance abuse spending compared to all health spending, 58 percent to 46 percent respectively. The remaining money, nearly 15 percent, was spent on prescription drugs and administrative expenses of insurance.

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 parity 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.

In 1997, fifty-three percent of money spent on mental health and substance abuse treatment nationally was based in non-hospital based care (Coffey et al., 2000). Using the state of Massachusetts as an example, the state contracted in 1992 for a Medicaid managed mental health program, which includes the disabled in the covered population. 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 are attributable to lower reimbursement rates for the same services, but some are 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 state parity legislation will alter the mix of service providers. Such legislation would 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.

In 1997, the United States spent an estimated $21,714,000 on hospital-based care, $37,136,000 on other outpatient and residential treatment, and $9,038,000 on retail prescription drugs for outpatient care (Coffey et al., 2000). Insurance administration, which included the administrative expense of all third-party payers and profit and reserve adjustment for private insurers, totaled $2,870,000. One item of interest from Coffey et al. is that the growth rate for insurance administration during 1992-1997 was 2.3 percent compared to a growth rate of 8.6 percent during 1987-1992.

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 is also true for those with other forms of disabilities, which 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; Olfson & Pincus, 1999; Moran, 1999). Cummings et al. (1993) and Cummings (1996) 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) suggests 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; Pallak et al., 1993). In addition, 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 (Langenbucher, 1994; 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, Hirschfield, et al., 1988).

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 (Clark et al., 1994; Rupp et al., 1998; Greenberg, 1995; Greenberg et al., 1999). 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 proceedings.

Public and Private Sector Issues

Funding for mental health 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) were from private insurance (Regier et al., 1993; Kessler, Berglund, 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).

Coffey et al. (2000) also reviewed out-of-pocket expenses in 1997. When viewing aggregate dollars (combined public and private spending), public dollars often more than compensate for private co-payments that come directly from patients or their families. However, public-private trade-offs are not made for the same individuals. For individuals with mental illnesses receiving private care, patients paid 85 percent to psychiatrists or other mental health professionals and 18 percent to non-specialist physicians. Out-of-pocket expenses indicate that private insurance for mental illnesses has higher cost sharing, co-insurance rates, and deductibles than private insurance for somatic illnesses. It is also possible that many people seeking treatment for mental illnesses do not have insurance to cover the cost of private practitioners (Coffey et al., 2000; Levit et al., 1998). For example, in 1993 only 34 percent of HMO enrollees had co-payments of $10 or more per physician visit while four years later, 70 percent of enrollees were required to pay at least $10, with similar trends occurring in point-of-service (POS) plans. In 1997 these two plan types covered about half of all private health insurance enrollees in medium and large private firms (Levit et al., 1998).

Key demographic factors as well as economic status affect health insurance coverage. According to the United States Census Bureau (2000), persons 18-24 years of age were less likely to have health insurance coverage in 1999 (71.0 percent). Most persons 65 years and older had health insurance due to Medicare coverage (98.7 percent). The likelihood of being covered by health insurance rose with income. Among persons living in poverty, adults ages 18 to 64 had markedly lower health insurance coverage (55.8 percent) than either children (76.7 percent) or persons 65 years of age and older (96.6 percent). For the working poor, 52.5 percent were insured in 1999 compared to 59.2 percent of poor non-workers covered in 1999. For the near poor (those with a family income greater than the poverty level but less than 125% of the poverty level), 25.7 percent (3.1 million people) had no health insurance coverage. Although approximately 33.4 of the foreign-born population was uninsured, coverage increases with length of residence and citizenship.*

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, 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, co-occurring mental illnesses 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).

* Natives are persons born in the United States, Puerto Rico, Guam, the U.S. Virgin Islands, or who had a parent who was a United States citizen.

The passage of a 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).

"High bad debt numbers reflect discriminatory benefit restrictions that continue to plague behavioral health. Despite limited progress to full parity, many benefit plans place arbitrary caps or treatment limits on behavioral benefits that do not apply to general health care. When patients with severe behavioral disorders find their benefits exhausted, hospitals continue to provide medically necessary care, which is often written off as bad debt."

NAPHS, 2000
Annual Survey Report, p.19.

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 national policy very difficult (Ridgely & Goldman, 1996; Drake et al., 1998).

Due to many reasons, the estimated savings for private sector plans are larger than have been reported for most, but not all, Medicaid managed care programs. 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 could vary from 1.3 percent to 9 percent, depending on the definition used for a mental health outpatient service. Further, over the past ten years, most Medicaid managed care programs have first enrolled the TANF and "TANF-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).

The National Advisory Mental Health Council (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 (National Advisory Mental Health Council, 1997).

While there have been two recent 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 mental health parity legislation must include the impact of specific managed behavioral health care on mental health costs (National Advisory Mental Health Council , 1997).

In summary, based on new knowledge derived from empirical case studies and updated actuarial models, the cost increases due to parity are modest compared to previous

Summary of Selected States and Impact

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

EXPERIENCES OF STATES AND THE PUBLIC/PRIVATE SECTORS

As of March 1, 2000, laws in effect in 43 states and the District of Columbia address mental health coverage in employer-sponsored group plans and to a lesser extent coverage sold in the individual market (US General Accounting Office, 2000). Further, with regard to group plans, twenty-nine states have laws more comprehensive than the parity law in that they require parity in dollar amounts and in service limits or cost-sharing provisions. Many of these twenty-nine states also mandate that mental health benefits be included in all plans sold. Six states have laws that essentially mirror the federal law. Eight states and the District of Columbia have laws that are more limited and may not conform to federal law, while seven states have no laws addressing mental health benefits. Finally, forty-one states and the District of Columbia either address substance abuse within the scope of their mental health laws or have separate statutes addressing coverage for substance abuse. However, thirteen states address only alcoholism. (United States General Accounting Office, 2000).

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 and recent activity 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.

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 most state parity laws have been enacted for a short time, relatively few states have sufficient experience to evaluate the impact parity has on service costs. Nevertheless, increasing cases have been documented in the literature that highlight the

experience of selected public and private sector organizational health costs since parity has been implemented. (Shore, 1994; National Mental Health Advisory Council, 1997).

Public Sector Experiences with Nondiscriminatory Benefits

Selected States

California A recent RAND study found removing annual benefit limitations of $10,000 on substance abuse treatment increased expenditures by 6 cents per member per year. Furthermore, annual costs for behavioral health plans in the study were 43 cents per member per month (Sturm et al, 1999a).

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 (Hausman, Wallace & Bloom, 1998).

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 percentage 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 institution of full parity.

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. 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 one to two percent premium increase in the cost of health insurance for all state employees.

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. (National Advisory Mental Health Council, 1998; United States General Accounting Office, 2000).

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 (National Advisory Mental Health Council, 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.

Vermont In 1999 the Vermont Health Care Administration testified before the Vermont legislature that the cost of implementing their substance abuse and mental health parity (as reported by the managed care companies) has been less than the projected 3.4 percent. (Note: Vermont is considered to have the most comprehensive state parity legislation—defining "mental health" to include any condition/disorder involving mental illness/substance abuse falling under any category in the mental disorders section of the International Classification of Diseases) (Bateman, 2000).

Private Sector Experiences with Nondiscriminatory Benefits

Washington Business Group on Health A review of eight large employers that insure more than 2.4 million Americans through managed care programs for mental illnesses reported an across-the- board elimination of most of the day and lifetime limits and significantly decreased co-payments. Although there has been an increase overall in the use of benefits, it has been accompanied by a corresponding use of outpatient and alternative treatment settings with a decrease in inpatient care. Factors contributing to the success of these programs include a full continuum of treatment settings in a managed care network and strong referral systems to connect employees to appropriate services (Apgar, 2000).

Grazier et al. 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 (NIMH funded study prepared by Grazier and associates, 1999).

RAND 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 (Sturm & McCulloch, 1998).

RAND 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, McCulloch, Sturm, 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 (William M. Mercer, 1997).

IBM IBM reconstructed its managed mental health program in 1998, providing an integrated 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 indicated (Barbara Brickmeier, IBM to January 22, 1998 IBH Conference).

Robert Wood Johnson Foundation Study A study funded by the Changes in Health Care Financing and Organization (HCFO) of The Robert Wood Johnson Foundation compared the health care costs and utilization for employees at small firms and individual health plan subscribers with employees at large firms. It found that employees at small firms use health care services at a rate similar to employees at large firms. Mid-sized firms (50 to 500 employees) actually had lower per-subscriber health care costs than either small or large firms. These findings suggest that community pricing* would actually decrease insurance costs for many large firms and small firms. Mid-sized firms, on average, would see their premiums rise slightly. (Young & McLinden, 2001).

In summary, 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 seek treatment (Hennessy & Stephens, 1997; National Advisory Mental Health Council, 1998; Ma & McGuire, 1998; Substance Abuse and Mental Health Services Administration, 1999a; Sturm et al., 1999b). As stated earlier, only four benefit-purchasing organizations representing groups of employers have invoked exemption (Substance Abuse and Mental Health Services Administration, 1999b).

* The name of the practice used when insurers charge firms of all sizes a uniform premium rate based on community use of health care instead of the firm's employees' use of health care rating.

IMPACT ON FLORIDA

Florida's service systems for mental illnesses and addictive disorders have changed significantly over the last thirty years. According to a 2001 report by the Florida Commission on Mental Health and Sustance Abuse, Florida's service delivery systems have evolved into a complex hybrid of traditional and non-traditional service providers and treatment milieus. Mental illnesses and addictions disorders are treated by a patchwork of community-based settings comprising both public and private sector care and general health and specialty mental health providers. The traditional services provided under the auspices of Florida's Department of Children and Families programs are augmented by a number of other state agencies that provide or finance services for persons with mental illnesses or addictions disorders. [1] Further, law enforcement and the judicial system have assumed a gatekeeper role to the dual treatment systems for mental illnesses and addictions disorders.

Mental Health and Substance Abuse

A 1999 report by the Committee on Children and Families estimated the prevalence of serious mental disorders in Florida. For persons residing in a private household, the Committee estimated that 5.4 percent (approximately 544,798 persons) would experience a serious mental disorders 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 7.07 percent of Floridians (approximately 1,074,439) would experience a substance abuse disorder in a twelve-month period.

Unfortunately, the prevalence figures in the Committee's study did not reflect 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 movement from other states (Office of Economic and Demographic Research, 2000).

Florida's Office of Economic and Demographic Research (2000) estimated 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. In addition, Florida's Hispanic population grew to an estimated 2,304,515 persons and its 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 disorders.

Florida's population profile is also compounded by the continuation of an aging state 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

[1] These include the Departments of Education, Corrections, Juvenile Justice, Health, and the Agency for Health Care Administration.

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 groups during the 1980s, increasing by 75.1 percent. This group was expected to double once again, numbering 330,220 by April 1, 2000. High rates of growth will continue for this age group through the first decade of this century, with the age 85 and older population projected at 489,635 by 2010 (Office of Economic and Demographic Research, 2000).

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 was 3,877,483 persons age 19 and younger, still representing 25 percent of the total state population (Office of Economic and Demographic Research, 2000).

Healthcare Expenditures

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 showed that most funds for mental health services in Florida support state hospitals, while community hospitals received funds from entitlement programs and insurance providers. However, the Florida Commission on Mental Health and Substance Abuse (2000) estimated that in 1998, twenty-three percent of estimated public and private mental health expenditures were for hospital-based services.

Fifty-one percent of expenditures for outpatient mental health services in the public sector were funded by Medicaid, Medicare, and other federal, state, and local government. For more detailed information on 1998 estimated prevalence as well as mental illnesses and substance abuse expenditures, the reader is referred to Kip (2000).

Entitlement Programs in Florida

The federal Medicaid program, administered by the Agency for Health Care Administration, is a major source of funding for behavioral health services, including substance abuse services in Florida.

In 1998, there were 1,440,331 persons enrolled in Medicaid of which 865,358 were enrolled in a managed care plan (60.08%) (Health Care Financing Administration, 1999b). Out of the statewide total, 257,265 were blind or disabled persons (Health Care Financing Administration, 1999a).[2] In fiscal year 1996, Florida paid $3,382,000 in Medicaid costs (Florida Statistical Abstract, 1998a, Table 20.74). 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%. The Medicaid program was expected to average 1.53 million cases this year, or about 10% 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 that year's appropriation base. (Florida Consensus Estimating Conference, 1999). In 1998, in Florida, there were 257,265 disabled workers receiving Social Security benefits, at a total cost of $92 million per month to the state of Florida (Social Security Adminis-

[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.

tration, 1998b). In 1998, there were 263,163 individuals with disabilities in Florida who received Supplemental Security Income at a total of $103 million (Social Security Administration, 1998). As with the data for the Health Care Financing Administration, there was no further breakout of the data. However, in fiscal year 1996-1997, Florida paid $2,645,191 in disability insurance payments (Florida Statistical Abstract, 1998). 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, 1998).

In 1999, Florida[3] ranked fourth out of the fifty states (fifty-one with Washington, DC) in total population, eighth out of 51 as to total number of persons uninsured (United States Census Bureau, 2000); twenty-eighth out of 51 as to total number of persons on Medicaid, and twenty-fifth out of 51 as to number of persons in Medicaid MCOs (Health Care Financing Administration, 1999). Fourteen percent of Florida's population lives below poverty level (15th out of 51) (United States Census Bureau, 2000).

In 1997, Florida spent $637, 878,797 on mental health expenditures and $270,485,154 on substance abuse expenditures (ranking 6th out of 51 and 3rd out of 51 respectively) (Lutterman, Hirad, & Poindexter, 1999) . The number of children and adolescents estimated to have a severe emotional disturbance[1] was 81,185 (50th out of 51) (Lewin Group, 2000). The number of persons estimated to have a serious mental illness was 543,871 (29th out of 51) . The number of persons estimated to have chronic substance abuse problems was 186,106 (13th out of 26 states for which data was available) (Lewin Group, 2000).

Health Benefits and Mandates

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 something called a self-funded ERISA plan. The Employee Retirement Income Security Act (ERISA) created national standards for employee benefit plans and limits state efforts to expand health care coverage and regulate insurance markets. ERISA essentially prevents states from requiring self-insured employee plans to participate in purchasing pools or even to report data. If a health plan is part of ERISA plan, then the health plan has to comply with minimal federal regulations due to a law passed over two decades ago which exempts self-funded ERISA plans from state regulation.[3] Mid-to-larger sized employers will often 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 individual or employer) to certain kinds of coverage, the specifics of which vary from state to state. In some places, the plan entitles policyholders 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 autho-

[1] Ranks go from largest to smallest percent, most to least expenditures.

[2] Although *Mental Health: A Report of the Surgeon General* (1999) reported an SED prevalence of 5 percent for all states.

[3] For more information, the reader is referred to ERISA Preemption Manual for State Health Policymakers authored by the Alpha Center and the National Academy for State Health Policy [http://statecoverage.net/erisa2-2000.pdf]

rized 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*).

Managed Care

Florida provides access to Medicaid managed care through four programs: a statewide primary care case management plan, a statewide voluntary HMO, a prepaid mental health plan (PMHP) stand-alone program in the Tampa Bay area, and Behavioral Health Care Utilization Management Service for inpatient behavioral health services (Lewin Group, 2000). While all four managed care programs offer behavioral health services, three offer it under a fee-for-service basis. The exception, the Prepaid Mental Health Plan (PMHP), operates within five counties in the Tampa Bay area (Hillsborough, Hardee, Highlands, Manatee, and Polk). Eligible recipients receive aid through the Temporary Aid to Needy Families (TANF), Sixth Omnibus Budget Reconciliation Act (SOBRA), and Supplemental Security Insurance (SSI) with no Medicare categories. Eligible foster care children receive federal foster care or adoption assistance under Title IV-E of the Social Security Act or state adoption assistance. Additionally foster care children, who without medical assistance could not be adopted or who are involved with child welfare services and qualify on the basis of poverty or disability, are also eligible. Florida's State Mental Health Authority contracts with local providers, comprehensive community health centers, and non-limited purpose organizations for community-based public sector mental health services that are excluded from managed care. These organizations then pay a cost-based rate per service unit (Lewin Group, 2000).

The resources and services provided through the Department of Children and Families as well as the programs funded by Medicaid in the Agency for Health Care Administration represent just a fraction of the service system for individuals with mental illnesses and addictions disorders. Services are also provided in emergency rooms and hospitals, crisis centers, jails, prisons, juvenile detention centers, nursing homes, assisted living facilities, residential programs, detoxification facilities, physicians' offices, and schools as well as in individual homes. Thus, there are a variety of credentialed/non-credentialed providers within the mental health delivery systems.

A Short Legislative History of Parity in Florida

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.

The concept of "parity" was first introduced in 1992 with the redesign of basic benefits plan for mental health services for the Agency for Health Care 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 for Community Mental Health, 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 was not covered by Medicaid, was not self-insured, was not uninsured, or was not covered under the federal employees health plan). The bill didn't pass. It was introduced again in 1996 and 1997, still with no legislation enacted. In the 1997 session, "The Mental Illness Insurance Parity Act" was unanimously approved by the Senate Banking and Insurance Committee and had near unanimous approval by the House and Senate, however, it still didn't 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 Legislative Staff, 1998). The bill did not pass. In 1999, the bill was again introduced. However, as the session ended, parity legislation did not pass. In 2000, a bill was introduced as S 1658 by State Senator Myers. The bill stated, in part, that the current requirement for group insurers to offer coverage for mental health conditions did not apply to serious mental illness; required group health insurers and HMOs to provide coverage for serious mental illness; and required the health benefit plan committee to consider and recommend modifications to standard, basic, and limited health benefit plans. The bill amended Chapters 627 and 641 of the Florida Statutes. It was referred to the Banking and Insurance Committee and the Fiscal Policy Committee with no further action taken in the 2000 legislative session (SB1658, 2000). In the 2001 legislative session, mental health parity legislation was not introduced in either the House or the Senate.

Both House and Senate staff analyses stated that mental health parity is an affordable benefit for the people of the state of Florida.

Two Interim Project Summary reports, by the Committee on Children and Families (1999) and Government Appropriations, defined publicly funded mental health and substance abuse services and priority population groups. These two reports, when viewed with previous House and Senate staff analyses, indicate that treatment for persons with mental illnesses and/or addictions disorders is affordable and of overall benefit to the state of Florida.

Impact of Parity Legislation on Benefits Design

What specific changes would parity legislation mean for Florida? First, statutes would be affected, specifically *S.627.688, .6472, .6515, 641.31, F.S.,* relating to optional coverage for mental and nervous disorders and a new section, S.627.6681, would be created. Second, confidentiality of records would be required for those records relating to serious mental illness. Third, every insurer

and HMO in Florida transacting group health insurance or prepaid health care would be required to provide treatment for serious mental illness. Fourth, for those who have a co-occurring substance abuse disorder, treatment would be included for the substance abuse disorder. Fifth, the health insurance mandate would apply to local government health insurance plans. [1] Finally, 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 on General Government Appropriations, 1997). For the public sector, there ultimately would be reduced costs for health care and extended coverage would reduce direct and indirect costs of treatment. For the private sector, although there would be an initial increase in utilization and costs, there would also be a reduction in total health costs resulting from the more comprehensive treatment of these conditions (Commiteee on General Government Appropriations, 1997; Levin et al., 1999).

Opponents of parity in Florida insist that by mandating coverage, premium costs will increase. In Kansas (Praeger, 2001), the negative connotations of the term *mandate* made it difficult for legislators to overcome cost concerns of implementing parity, even though actuarial data from other states and business organizations demonstrate that those fears are overstated. Burnam and Escarce (1999) argue, that in an era of managed care, "full benefit parity" is an important step toward a broader goal of ensuring that persons with mental illnesses or addiction disorders have the same opportunites for seeking and receiving care as those persons with somatic illnesses.

A Preliminary Estimate of Benefits for Florida

A Scenario Based on Persons with Severe Mental Illness

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: 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) 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 35.7 percent of Florida's population would be affected by the proposed parity law. 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.

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

[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.

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

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. In 1990, the National Advisory Mental Health Council estimated that 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 additional $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, more than five times the estimate derived above (Florida's share of the reduced health care costs would equal an additional $83 million). Ten years later, the Council (2000) postulated a 1.4 percent cost increase in total health insurance coverage with the caveat that forecasting models do not account adequately for the impact on and response of managed care systems on benefit changes in the behavioral health delivery systems and may actually overestimate the true cost of parity. 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:

1. the increased treatment utilization of those who are currently receiving treatment, which would presumably result in improved mental health, thus increasing benefits;
2. the 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. the reduction in costs for physical health care (roughly estimated to equal $83 million); and
4. the financial benefit to the state of the transfer of treatment costs to the private sector.

State policymakers, charged with budgeting expenditures should be aware that estimating the costs of any major change in insurance benefits is difficult. Understanding the effects of specific forms of managed care on behavioral health will be of great value in making accurate cost estimates. Studies cited within this report 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; Rupp et al., 1984).

CONCLUSION

Efforts to amend the federal parity legislation for the treatment of mental illnesses and substance abuse disorders has continued to evolve. On a federal level, Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN), have introduced new legislation to eliminate the discrimination between mental health and somatic health care. Notably, The Mental Health Equitable Treatment Act of 2001 (S. 543), introduced in March 2001, would prohibit the practice of providing unequal benefits and financial requirements. The legislation builds on the existing 1996 Parity Act (P.L. 104-204), which bans different lifetime and annual spending caps for mental and general health care. It would extend full parity to all individuals with a condition listed in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV). Specifically, S. 543 would prohibit health insurance plans from imposing inpatient hospital day and outpatient visit limits and from applying different deductibles, co-payments, out-of-network charges and other financial requirements for mental health treatment, practices discussed in the recent GAO report (2001).

Among other key provisions, the bill would amend the 1996 Parity Act to eliminate the sunset provision, under which the 1996 parity law would terminate on September 30, 2001; increase the scope of its coverage so as to include small businesses with 25 or more employees; and eliminate the exemption from the 1996 law currently permitted for employers who show that their health insurance premiums rose more than one percent as a result of complying with the Parity Act. S. 543 would only apply to plans that already provide mental health benefits; it would not require plans to offer such benefits. Over thirty senators have signed the bill as co-sponsors. As of June 12, 2001, there was no representation from Florida.

Benefits of such legislation will be a function of increased treatment, increased treatment efficacy rates, and decreased social costs that mental illnesses and addictions impose on society. These decreased costs would affect not only the individuals in treatment and their families but also employers, federal, state, and local governments, and ultimately the taxpayer.

Florida has the opportunity to establish a policy for mental health parity vìs -a-vìs 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. Implementing parity would mean that decisions about benefit coverage would be made according to the same that govern the treatment coverage of physical disorders. “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.

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. Florida 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 disorders.

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 A:
Summary of State Parity Legislation

State	Bills
Alabama	No specific mental health parity legislation passed.
Alaska 1998	Provides for study of parity.
Arizona	Mirrors 1996 federal law, excludes substance abuse.
Enacted: 1997 Effective: 7/21/97	HB 26651: HMO's, group and individual insurers must offer coverage for mental illness and substance abuse under same terms as for mental illness.
Enacted: 2/98 Effective: 1/1/99	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.
Failed: 3/8/01 Senate Banking & Insurance Comm.	H 2173: S 1088 amends the current law to require insurers to provide mental health coverage. Requires insurers that issue group plans that provide coverage for physical health conditions to a group of at least 25 also provide coverage for the treatment of mental health conditions. Defines mental health condition as any condition or disorder that involves mental illness or substance abuse and that falls under any of the diagnostic categories listed in the mental disorders section of the ICD. Further requires that policies cannot contain co-pays, coinsurance or cost sharing requirements that place a greater financial burden on the policyholder.
Passed Senate Comms March 01	S 1463 amends the current state employee health plan to require that it include benefits for mental health conditions. The requirements of this bill are the same as S 1088.
Arkansas	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%.
Enacted: 4/97 Effective: 8/1/97	
Enacted: 3/13/01	H 1562: provides parity mental health benefits under the CHIPS program called ARKids First Program.
Enacted: 3/25/01	S176: amends existing law by requiring health plans offered by employers with 50 or fewer employees will not impose limits on coverage for mental health treatment. This law allows insurers in groups of 51 or more employees to impose an annual maximum of 8 inpatient/partial hospitalization days together with 40 outpatient days.
California	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.
Enacted: 1999 Effective: 7/1/00	
6/4/2001 Passed Senate referred to Assembly	SB 599: Amends existing law & requires health care plans by 1/1/2002 to provide coverage for substance abuse disorders at parity. Coverage & funding for outpatient visits, residential/inpatient treatment days, payments, lifetime benefits, & catastrophic coverage offered at parity with physical illness.

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.
Referred: 3/7/01 House Approp Comm	H 1273: Requires health plans that provide coverage for substance abuse treatment provide coverage regardless whether it occurs as a result of contact with the legal system. Substance abuse services added as an optional service under Medicaid. Establishes a study committee comprised of legislators and members of the general public to study substance abuse and report any potential cost savings to the state general fund.
Referred:3/26/01 Senate Comm. on Health, Environ., Children, & Family	S 153: Makes current mandatory health insurance coverage for mental illnesses & biologically basedmental illness optional provisions at the discretion of consumer. Exempts plans issued by valid multi-state association from requirements to issue a health benefit plan that includes coverage for mental illness, biologically based mental illness, or alcoholism &coverage for business groups of one. Effective after 01/01/2002.
5/29/01 Governor's desk	H 1236: Amends existing parity law- requires insurance carrier to use preauthorization or utilization review that is the same as, or no more restrictive than, used to provide coverage for 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.
5/9/01 Amended by House	H 100: Provides complete parity for health plans issued for mental disorders. Deletes "serious mental illness" from existing law and adds the words "mental disorder" (described as any mental illness that falls under the diagnostic categories listed in the most recent edition of the DSM, including, but not limited to, schizophrenia, bipolar disorder, OCD, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, delusional disorder, ADHD, autism, alcoholism & drug dependence).
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.
5/14/01 carried to 2002 session	S 825 (H 841): Adds major depression to list of illnesses covered under existing law. Deletes language from existing law that creates unique limits by episode in the treatment of addictions.
Idaho	No specific mental health parity legislation passed
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.
Enacted: 5/3/01	H 112: Adds pervasive developmental disorder to list of mental disorders covered under existing law.
Iowa	
5/31/01 amended & on Gov's desk	S 1341: Creates parity for coverage of serious mental illness and minimum mandated benefits for other mental illnesses and substance abuse. Includes study of mental health benefit coverage. Contains small business exemption. "Serious mental illness" defined as: schizophrenia, paranoid and other psychotic disorders, bipolar disorders, major depressive disorders, schizoaffective disor ders, PDD OCD, childhood depression and panic disorders. Provides medical necessity language. Sunsets 12/31/2005.
4/6/01 Failed in Commitee. Parity in Gov's Approp Bill	H 72: Policies must provide coverage at parity for mental conditions. Mental health conditions defined conditions or disorders involving mental illness or alcohol or substance abuse that fall under any of the diagnostic categories found in the ICD.

Kansas Enacted: 5/15/97 Effective: 1/1/98	S 204: Limited parity for mental health benefits mirrors 1996 federal law, refers to mental health services as defined under terms of the policy. Substance abuse &chemical dependency specifically excluded. Does not extend to small businesses/groups whose policy increases more than 1%.
	HR 5005: resolves that the Kansas Legislature enact legislation to provide health insurance parity for persons with mental illness. No detail was provided in the resolution.
Enacted: 5/21/01 Effective: 1/1/02	H 2033: Amends current law to require parity for any group health plan providing MH benefits. Annual coverage - 45 days each inpatient care/ outpatient care. Includes access, use & cost study. Defines MI as schizophrenia, schizoaffective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis, major affective disorder, cyclothymic/ dysthymic disorders, OCD, panic disorder, PDD including autism, ADD and ADHD as defined in DSM IV,. Does not include conditions not attributable to a mental disorder that are a focus of attention or treatment. Applies to state employee plan. Requires parity in coverage of prescription drugs used outside a physician's office or hospital.
Kentucky	**No mental health parity legislative activity.
Louisiana Enacted: 1999 Effective: 1/1/00	Enacts law mirroring 1996 federal law (1997) 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.
Enacted: 5/24/01	H 859: Prohibits different aggregate lifetime/annual limits on MH benefits on other medical benefits under certain large employer group health plans as of 09/30/2001. Existing law will not require group plan to provide mental health benefits. Includes 1% cap & small business exemption.
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	Administrative order(state employees only): Requires parity coverage for outpatient/intermediate/ inpatient mental health/substance abuse care that state plan determines to be medically necessary. The order defines mental illnesses as the categories listed in the current version of the DSM-IV, excluding certain disorders.
4/2/01 In committee	S 763: Adds the treatment and diagnosis of alcoholism and chemical dependency to the existing parity law. Effective: 01/01/02

Massachusetts (continued)	
In committee 4/2/01	H 3120: Adds addiction treatment to the existing parity law. Health plans required to cover clinically effective and appropriate services. Outlines qualifications of treatment staff.
In committee 4/26/01	S 1433: Requires state employee health plan/private health plans cover at parity treatment & diagnosis of specific pervasive developmental disorders: 1) autistic disorders, 2) Asperger's disorder, 3) PDD, 4) Rett's disorder, and 5) childhood disintegrative disorder. Bill requires minimum of 60 days of inpatient & 24 outpatient visits.
Michigan	S 101: Requires parity for cost-sharing requirements and benefits or service limitations found in health plans for outpatient/inpatient mental health/substance abuse services. (S 102- mirrors bill for health care corporations writing plans after 1/1/2002)
In committee 2/6/01	
Minnesota	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."
Enacted: 8/1/95 Effective: 8/1/95	
Mississippi	H 667: Requires (some exceptions) policies covering mental illness provide minimum of 30 days inpatient services, minimum 60 days partial hospitalization, & minimum 52 outpatient visits/year. Requires individual and group health insurance policies (includes plans offered by small employers) that currently do not offer mental illness benefits, offer benefits. Includes 100 employee small business exemption. Specifies that this coverage will be offered on an optional basis. Includes a 1% opt-out clause for businesses. Allows for parity for rate payments for inpatient services and partial hospitalization. Rate payment for outpatient visits would be capped at a maximum payment of fifty dollars per visit.
Enacted: 4/6/01	
Missouri	Two bills.
Enacted: 6/25/97 Effective: 9/1/97	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.
Enacted: 7/13/99 Effective: 1/1/00 Expires: 1/1/05	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	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.
Enacted: 4/97 Effective: 1/1/98	
Enacted: 1999 Effective: 1/1/00	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.
Effective: 4/01	S 310: Revises certain requirements of Montana's high-risk pool. Adds severe mental illness to the pool. Raises the maximum pharmacy benefit to an annual maximum of $2000.
Effective: 4/01	H 504: Amends existing law & removes the inpatient limit for alcoholism and drug addiction only.

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.
Adopted by Comm. 3/20/01	L 563 requires parity for co-payments, coinsurance, or out of pocket limits.
Introduced: 5/7/01	LR 88 creates study of 1999 health insurance parity law with review of costs and utilization.
Nevada	
Enacted: 1997 Effective: (Sec 88) 1/1/98 Expires 9/30/01	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%.
Enacted 5/30/99 Effective: 1/1/00	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.
In House commitee 5/5/01	H 672: Creates parity for health plans covering the assessment, diagnosis & treatment of mental/nervous conditions by psychiatrists, psychiatric/mental health advanced nurse practitioners, & mental health practitioners. Substance abuse is covered under the definition of mental disorder. Previous definition of "biologically-based mental illnesses" repealed. Now defined as any mental or nervous conditions or mental disorders as defined in the most recent editions of ICD or DSM.
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	
In Senate commitee	S 1744 and A 733 require parity for group plans.
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.

New Mexico (continued)	HB 452: Provides equal coverage for mental illness in health insurance plans that are new or
Enacted: 2/15/00	renewed starting Oct. 1, 2000. Allows companies with up to 49 workers to opt out of the
Effective: 10/1/00	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.
Enacted: 4/5/01	HR 81: Requests the legislative finance committee study & make recommendations related to the programs of the publicly funded health care agency created by the Health Care Purchasing Act. Mental health parity statutes will be studied as part of this process.
North Carolina	Three bills.
Enacted: 1991	HB 279: Provides for employees of local and state government to have treatment of mental illness
Effective: 1/1/92	subject to the same deductibles, durational limits and coinsurance factors as for physical illness.
Enacted: 7/3/97	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.
Enacted 8/28/97	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	Provides for study of parity.
1994	
Ohio	H 33: Creates parity in health plans for the coverage of mental illness and substance abuse.
In House commitee 3/26/01	Both mental health & substance are defined as any condition or disorder as defined in most recent edition of DSM or ICD.
Oklahoma	SB 2 Provides equitable coverage for severe mental illness. Exempts employers with 50 or fewer
Enacted: 5/13/99	employees and those who experience a premium increase of 2% or more. The law is repealed in
Effective: 11/1/99?	2003 if an Oklahoma Insurance Department study shows a premium increase of 6% over three years.
Oregon	S 112: Creates parity in insurance coverage for mental illness/substance abuse with other medical condi
In Senate committee 1/12/01	tions. Schools, halfway houses, psychoanalysis or psychotherapy for educational or training purposes excluded from coverage at parity. Managed care & cost sharing requirements are outlined. Would take effect on 1/01/2003.
In Senate committee 2/10/01	S 624 creates parity in group health plans for the treatment of mental conditions and addictions. Contains same service exclusions as S 112.
In House committee 1/24/01	H 2472 requires group health plans cover expenses arising from treatment of severe mental illnesses/ serious emotional disturbances in children/adolescents. Eliminates monetary limits on treatment for children/adolescents. Limits for minimum total payouts for all treatments of chemical dependency listed.

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.
5/29/01 Passed House & Senate committees. Amended by Lt Gov	H 5478: Requires health insurance on provided at parity for mental illness and addictions on or after 01/01/2002. Significantly broadens existing law redefines SMI & adds addiction coverage at parity. MI coverage includes inpatient, partial hospitalization, intensive outpatient services and community residential care for addictions only. Continues medical necessity guidelines. Limits placed on outpatient services, community residential coverage, detoxification & addictions outpatient services.
Held for study 3/27/01	S 406 amends the existing parity law to deletes the definition of serious mental illness and mandate the insurers provide equal coverage for the medical treatment of all mental illness and substance abuse.
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	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.
Enacted: 1998 Effective: 1/1/00	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	HB 2: Covers all public state and local employees including teachers and university system employees for schizophrenia, schizoaffective disorder, bipolar disorder, and major depression.
Enacted: 1997 Effective: 1997	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 & co-insurance for serious mental illness as for physical illness. Does not include chemical dependency.
In House committee 3/6/01	H 189: Creates parity in delivery of disability insurance policies written in Texas. Disability plans/policies cannot exclude or reduce the payment of benefits to or on behalf an enrollee because of MI unless the limitation consistent across all physical disabilities. Effective on 09/01/200.

Texas (continued)	
In House committee 2/27/01	H 2099: Expands existing law with coverage for children with SED, list of serious mental illness to be covered, removes limits for inpatient days & outpatient visits, deletes the small employer exemption. Serious mental illness defined as "schizophrenia, paranoid and other psychotic disorders, bipolar disorders, major depressive disorders, schizo-affective disorder, PDD, OCD, anorexia nervosa, bulimia nervosa and depression in childhood and adolescence".
Utah	Utah passed full parity for mental health, excluding substance abuse coverage. Mirrors federal Mental Health Parity Act of 1996. Annual and lifetime limits on mental health benefits must be equal to physical health benefits (NCSL, 2000).
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
Effective: 3/20/01	H 2095 allows for additional category for certification of substance abuse counseling assistants. Outlines the scope of practice between a substance abuse counselor and an assistant.
Washington	
1998	Provided for study of parity
Failed in committee 4/25/01	H 1080 (S 5211): Provide parity for coverage under health plans for public employees, disability insurance contracts providing health care coverage to groups 50 or more, health care contracts & HMO plans for groups 50 or more and for groups with at least 25 persons but fewer than 50 issued or renewed after July 1, 2003. Requires single annual maximum for out of pocket limits. Allows for separate mental health deductible that must be offered at parity. Plans serving adults allowed to have differential co-pays/coinsurance requirements. Wellness/preventive services for children reimbursable at 100%. Mental health services include outpatient and inpatient services to treat any mental disorder found in the DSM and prescription drugs. Amended to focus on access for children to mental health services by making co-pays comparable to medical/surgical services, and providing for a single deduct ible for all health care services. Managed care language dropped. Includes minimum standards for health plans of 30 outpatient visits, and 15 inpatient days. Includes a small business exemption of less than 25 employees. Effective date 01/01/ 2002.
West Virginia	
1997	Provided for study of parity

West Virginia	Both bills failed on floor 5/15/01 S 390: Provides coverage at parity in private group health plans & state employees health plan for SMI-defined as schizophrenia & other psychotic disorders, bipolar illness, depressive disorders, substance abuse & anxiety disorders. Provides benefit for children (18 years and younger) for ADHD, attachment disorder, disruptive behavior disorder, eating disorder & oppositional defiance disorder. 2% cost increase exclusion cap. Requires a study by commissioner of insurance. H 2601: Health plans will provide coverage to individual/group members for expenses arising from the treatment of mental illness. SMI defined as schizophrenia & other psychotic disorders, bipolar disorder, depressive disorder, substance abuse & anxiety disorders. Includes children to the age of nineteen years ADHD, attachment disorder, disruptive behavior disorder, eating disorder and ODD. Contains a 2% increase cap. Removes visit limits found in existing law. Requires insurance commissioner conduct an impact study of bill with report to Legislature. Impact on state employee plan reported separately. Sunsets 2006.
Wisconsin In Senate committee 4/25/01	S 157: Parity in group policies written for mental health & addictions. Includes rates, deductibles, co-pays, coinsurance, annual & lifetime limits, out of pocket & out of network limits, visits limits & medical necessity definitions. Individual policies required to offer coverage at parity if they offer MH/addictions coverage. Contains language describing parity coverage under collective bargaining agreements.
Wyoming Failed in committee 1/29/01	H 59: Parity for coverage provided in individual/group plans for treatment of biologically based mental illness - defined as schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, OCD and panic disorder. Effective 07/01/2001.

REFERENCE SOURCES: The Health Policy Tracking Service, National Conference of State Legislatures, the American Psychiatric Association's State of the States: Parity Laws [http://www.psych.org/pub_pol_adv/paritysos0401_5201.cfm], and the following legislative web sites:

Alabama [http://www.legislature.state.al.us]
Alaska [http://www.legis.state.ak.us]
Arizona [http://www.azleg.state.az.us]
Arkansas [http://www.arkleg.state.ar.us]
California [http://www.leginfo.ca.gov]
Colorado [http://www.state.co.us/gov_dir/stateleg.html]
Connecticut [http://www.cga.state.ct.us/]
Delaware [http://www.state.de.us/research/assembly.htm]
Florida [http://www.leg.state.fl.us/]
Georgia [http://www2.state.ga.us/Legis/]
Hawai'i [http://www.capitol.hawaii.gov/]
Idaho [http://www2.state.id.us/legislat/legislat.html]
Illinois [http://www.state.il.us/state/legis/]
Indiana [http://www.state.in.us/legislative/]
Iowa [http://www.legis.state.ia.us/]
Kansas [http://www.state.ks.us/public/legislative/]
Kentucky [http://www.lrc.state.ky.us/home.htm]
Louisiana [http://www.legis.state.la.us/]
Maine [http://janus.state.me.us/legis/]
Maryland [http://mlis.state.md.us/]
Massachusetts [http://www.magnet.state.ma.us/legis/legis.htm]
Michigan [http://michiganlegislature.org/]
Minnesota [http://www.leg.state.mn.us/]
Mississippi [http://www.ls.state.ms.us/]
Missouri [http://www.moga.state.mo.us/]
Montana [http://www.mt.gov/leg/branch/branch.htm]
Nebraska [http://www.unicam.state.ne.us/index.htm]
Nevada [http://www.leg.state.nv.us/]
New Hampshire [http://www.state.nh.us/gencourt/gencourt.htm]
New Jersey [http://www.njleg.state.nj.us/]
New Mexico [http://legis.state.nm.us/]
New York [http://assembly.state.ny.us]
North Carolina [http://www.ncga.state.nc.us/]
North Dakota [http://www.state.nd.us/lr/]
Ohio [http://www.state.oh.us/ohio/legislat.htm]
Oklahoma [http://www.lsb.state.ok.us/]
Oregon [http://www.leg.state.or.us/]
Pennsylvania [http://www.legis.state.pa.us]
Rhode Island [http://www.rilin.state.ri.us/]
South Carolina [http://www.leginfo.state.sc.us/]
South Dakota [http://www.state.sd.us/state/legis/lrc.htm]
Tennessee [http://www.legislature.state.tn.us/]
Texas [http://www.capitol.state.tx.us/]
Utah [http://www.le.state.ut.us]
Vermont [http://www.leg.state.vt.us/]
Virginia [http://legis.state.va.us/]
Washington [http://www.leg.wa.gov/]
West Virginia [http://www.legis.state.wv.us/]
Wisconsin [http://www.legis.state.wi.us/]
Wyoming [http://legisweb.state.wy.us]

Appendix B: Statistics

TABLE 1 **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			
BY YEAR	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

TABLE 2. Estimates of the Number of Persons in Florida 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%

Source: Petrila & Stiles, 1995

Notes:

(a) *Prevalence rates for individuals in the youngest end of the distribution are higher than for individuals in the older ages.*

(b) *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.*

During any twelve-month period, 5.4 % of Floridians will experience a mental illness and 7 % of Floridians will experience a substance abuse disorder.

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TABLE 3. **Estimated Public Mental Health and Substance Abuse Expenditures in Florida in 1998**

Payer and Provider Type	MH Costs (thousands)	% of public MH Costs	% of all MH Costs*	SA Costs (thousands)	% of public SA Costs	% of all SA Costs*	MHSA Costs (thousands)	% of all Costs*
Medicare	**$1,026,965**	**41.7%**	**23.9%**	**$91,587**	**20.5%**	**13.2%**	**$1,118,552**	**22.4%**
Hospital-based[a]	$491,076	19.9%	11.4%	$23,073	5.2%	3.3%	$514,149	10.3%
Other Outpatient/Residental[b]	$314,901	12.8%	7.3%	$67,886	15.2%	9.8%	$382,787	7.7%
Retail Prescription Drugs[c]	$196,396	8.0%	4.6%	$252	0.1%	0.0%	$196,648	3.9%
Insurance Administration[d]	$24,592	1.0%	0.6%	$376	0.1%	0.1%	$24,968	0.5%
Medicaid	**$725,825**	**29.4%**	**16.9%**	**$132,286**	**29.6%**	**19.1%**	**$858,111**	**17.2%**
Hospital-based[a]	$140,705	5.7%	3.3%	$4,614	1.0%	0.7%	$145,319	2.9%
Other Outpatient/Residental[b]	$372,077	15.1%	8.6%	$126,345	28.3%	18.2%	$498,422	10.0%
Retail Prescription Drugs[c]	$183,986	7.5%	4.3%	$627	0.1%	0.1%	$184,613	3.7%
Insurance Administration[d]	$29,057	1.2%	0.7%	$699	0.2%	0.1%	$29,757	0.6%
Other Federal	**$121,213**	**4.9%**	**2.8%**	**$95,580**	**21.4%**	**13.8%**	**$216,793**	**4.3%**
Hospital-based[a]	$12,823	0.5%	0.3%	$767	0.2%	0.1%	$13,590	0.3%
Other Outpatient/Residental[b]	$92,537	3.8%	2.2%	$93,784	21.0%	13.5%	$186,320	3.7%
Retail Prescription Drugs[c]	$8,626	0.3%	0.2%	$511	0.1%	0.1%	$9,137	0.2%
Insurance Administration[d]	$7,227	0.3%	0.2%	$519	0.1%	0.1%	$7,746	0.2%
Other State and Local	**$591,281**	**24.0%**	**13.7%**	**$126,994**	**28.4%**	**18.3%**	**$718,275**	**14.4%**
Hospital-based[a]	$25,582	1.0%	0.6%	$7,031	1.6%	1.0%	$32,613	0.7%
Other Outpatient/Residental[b]	$485,689	19.7%	11.3%	$118,667	26.6%	17.1%	$604,356	12.1%
Retail Prescription Drugs[c]	$42,080	1.7%	1.0%	$640	0.1%	0.1%	$42,719	0.9%
Insurance Administration[d]	$37,930	1.5%	0.9%	$657	0.1%	0.1%	$38,587	0.8%
Total – All Public Payers	**$2,465,284**	**100.0%**	**57.3%**	**$446,447**	**100.0%**	**64.3%**	**$2,911,730**	**58.3%**
Hospital-based[a]	$670,186	27.2%	15.6%	$35,485	7.9%	5.1%	$705,671	14.1%
Other Outpatient/Residental[b]	$1,265,203	51.3%	29.4%	$406,681	91.1%	58.6%	$1,671,885	33.5%
Retail Prescription Drugs[c]	$431,088	17.5%	10.0%	$2,030	0.5%	0.3%	$433,117	8.7%
Insurance Administration[d]	$98,806	4.0%	2.3%	$2,251	0.5%	0.3%	$101,057	2.0%

SOURCE: Kip, K.E. (2000).

See page 52 for all footnoted citations (*, a-d).

TABLE 4. **Estimated Private Mental Health and Substance Abuse Expenditures in Florida in 1998**

Payer and Provider Type	MH Costs			SA Costs			MHSA Costs	
	Costs (thousands)	**% of private MH Costs**	**% of all MH Costs***	Costs **(thousands)**	**% of private SA Costs***	**% of all SA Costs**	Costs **(thousands)**	**% of all Costs***
Out-of-Pocket	**$681,768**	**37.1%**	**15.8%**	**$67,581**	**27.3%**	**9.7%**	**$749,348**	**15.0%**
Hospital-based[a]	$50,944	2.8%	1.2%	$18,823	7.6%	2.7%	$69,767	1.4%
Other Outpatient/ Residental[b]	$467,469	25.4%	10.9%	$48,201	19.4%	6.9%	$515,670	10.3%
Retail Prescription Drugs[c]	$126,848	6.9%	2.9%	$290	0.1%	0.0%	$127,138	2.5%
Insurance Administration[d]	$36,507	2.0%	0.8%	$267	0.1%	0.0%	$36,774	0.7%
Insurance	**$1,051,986**	**57.3%**	**24.5%**	**$160,793**	**64.9%**	**23.2%**	**$1,212,779**	**24.3%**
Hospital-based[a]	$243,837	13.3%	5.7%	$26,054	10.5%	3.8%	$269,891	5.4%
Other Outpatient/Residental[b]	$583,215	31.7%	13.6%	$133,256	53.8%	19.2%	$716,471	14.3%
Retail Prescription Drugs[c]	$179,388	9.8%	4.2%	$745	0.3%	0.1%	$180,133	3.6%
Insurance Administration[d]	$45,546	2.5%	1.1%	$738	0.3%	0.1%	$46,284	0.9%
Other Private	**$103,378**	**5.6%**	**2.4%**	**$19,498**	**7.9%**	**2.8%**	**$122,876**	**2.5%**
Hospital-based[a]	$14,621	0.8%	0.3%	$5,296	2.1%	0.8%	$19,917	0.4%
Other Outpatient/ Residental[b]	$68,403	3.7%	1.6%	$14,033	5.7%	2.0%	$82,436	1.6%
Retail Prescription Drugs[c]	$15,012	0.8%	0.3%	$92	0.0%	0.0%	$15,103	0.3%
Insurance Administration[d]	$5,342	0.3%	0.1%	$78	0.0%	0.0%	$5,420	0.1%
Total – All Private Payers	**$1,837,131**	**100.0%**	**42.7%**	**$247,872**	**100.0%**	**35.7%**	**$2,085,003**	**41.7%**
Hospital-based[a]	$309,402	16.8%	7.2%	$50,173	20.2%	7.2%	$359,575	7.2%
Other Outpatient/ Residental[b]	$1,119,087	60.9%	26.0%	$195,490	78.9%	28.2%	$1,314,577	26.3%
Retail Prescription Drugs[c]	$321,247	17.5%	7.5%	$1,127	0.5%	0.2%	$322,374	6.5%
Insurance Administration[d]	$87,395	4.8%	2.0%	$1,082	0.4%	0.2%	$88,477	1.8%

*Public and private costs combined.

SOURCE: Kip, K.E. (2000)

[a]"Hospital-based" services include all services owned and operated by hospitals – inpatient, outpatient (including clinics and home health), and residential facilities (including nursing homes).

[b]"Other out-patient and residential care" includes all providers except hospital-based services, retail prescription drugs, and insurance administration. Note: hospital-based services include outpatient services, which are thus excluded from the "other out-patient and residential care" category. This latter category captures most out-patient and non-hospital based services to MH/SA clients.

[c]"Retail prescription drugs" includes prescriptions obtained through retail (pharmacy or mail order) distribution. Inpatient drug treatment and facilities which dispense drugs through public programs, such as methadone clinics, are not included in this category, but rather as part of the specific facility expenditure.

[d]"Insurance administration" includes the administrative expenses of all third-party payers and profit and reserve adjustment for private insurers.