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Mental Health Parity: National and State Perspectives 1999

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EXECUTIVE SUMMARY

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

Much of the initial concern over parity centered on the costs of implementation. Earlier information on utilization and costs were inconsistent and inconclusive. Estimation efforts were hampered by reliance on outmoded economic and actuarial models (which used data based on the fee-for-service model) and a lack of empirical information on current practice patterns. Recent empirical studies and economic simulations across diverse populations show that the introduction of parity within a managed care environment resulted in modest cost increases and increased access to services. For example:

- In Maryland, full parity in all state regulated plans raised costs by 0.6 % 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.
- Between 1991, when mental health parity coverage for Texas state and local government employees was implemented, and 1995, there was a 48% decrease in mental health and chemical dependency costs.
- Rhode Island reported a less than one-percent increase in total plan costs under parity.
- New Hampshire insurance providers reported no cost increases as a result of implementing parity.
- A Rand study shows that companies complying with parity by equalizing annual limits increased access to mental health services while increasing costs by $1 per year per enrollee.
- Studies show that small businesses are as likely to offer a managed care plan as larger businesses.
- New actuarial studies from the National Mental Health Advisory Council and Mathematica Policy indicate that predicted cost increases for full mental health parity benefits range from less than one percent to three percent.

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

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

In addition, mental health parity legislation could substantially reduce the degree to which financial responsibility for the treatment of mental illness is shifted to government, especially state and local government. There is also substantial evidence that both mental health and addictions treatment is effective in reducing the utilization and costs of medical services. There appears to be a lack of substantial evidence to discourage Florida from pursuing mental health and substance abuse parity legislation.

MENTAL ILLNESS AND SUBSTANCE ABUSE

Fundamental to any discussion of policy change affecting the health and well-being of a specified population is a clear understanding of epidemiology, the study of factors, which determine the frequency, and distribution of disease in a specific population.

National Studies

The best known and most comprehensive of epidemiologic studies on mental health was the Epidemiological Catchment Area Study (ECA) begun in 1978 (Robins & Regier, 1991; Regier et al, 1988; Regier et al, 1985). The ECA was a very large initiative, with over 20,000 respondents over five catchment areas (New Haven, Durham, Baltimore, Los Angeles, and St. Louis). The study examined prevalence and incidence of mental disorders in the community as well as in institutional settings.

The major objective of the ECA was to obtain prevalence rates of specific mental disorders rather than prevalence rates of global impairment. Overall, 20 percent of the people interviewed had an active mental disorder during a given year, with a lifetime prevalence of 32 percent for a mental illness and/or substance abuse disorder. In addition, the ECA estimated the prevalence rate for severe mental illness at 2.8 percent. This prevalence rate has been determined the standard for all national and state prevalence studies on mental illness.

A second significant study was the National Comorbidity Survey (NCS) (Kessler et al., 1994). Comorbidity refers to anyone with both substance disorder and any psychiatric illness as described in the *Diagnostic and Standards Manual*. The NCS was designed to improve on the ECA efforts by incorporating *DSM-III-R* (*Diagnostic and Standards Manual 3rd revision*) nomenclature and by more extensively examining risk factors that affect particular mental disorders and to determine the comorbidity of psychiatric disorders (Blazer et al, 1994). Results from the NCS indicated higher lifetime prevalence rates for mental disorders than the ECA, particularly for depression, alcohol dependence, and phobia. The NCS reported a prevalence rate of 3.2 percent. The lifetime prevalence was 48 percent for any disorder (mental illness or substance abuse), and 29 percent of the respondents reported at least one mental disorder during the previous 12-month period. Approximately 40 percent of those who reported a lifetime prevalence of at least one mental disorder sought treatment in the mental health specialty sector. This prevalence rate has been used as the standard for all national and state prevalence studies on comorbid disorders.

Comorbidity

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. In their 1988 study, 15.4 percent (25.6 million) of 166 million Americans over the age of 18 met the criteria for at least one alcohol, drug abuse, or mental disorder (Regier, 1988a). Persons who suffered from a mental illness were more likely to abuse drugs and alcohol. Other findings from the NCS and follow-up reports indicate that 83.5 percent of those with lifetime comorbidity say that their first mental disorder preceded their first addictive disorder, and in general, co-occurring disorders tend to be more chronic than pure psychiatric disorders (Special Issue, 1996).

Kessler et al. (1996) used data from NCS to look at the prevalence of co-occurring addictive and mental disorders, the temporal relationship between these disorders, and the extent to which 12-month co-occurrence was associated with the utilization of services. Kessler 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 (Special Issue, 1996).

While space does not permit extensive reviews of the results of epidemiologic studies in special populations, the reader is referred to Friedman et al (1996), Glied & Kofman (1995), Levin et al (1998), Levin & Petrila (1996), Lombardo et al. (1996), and Teplin et al (1996).

Florida

Petrila and Stiles (1996) provided an estimate of the prevalence of mental disorders in Florida based upon national data from the ECA study. Unfortunately, as they pointed out, these prevalence figures did not reflect the unique population characteristics specific to Florida, including seasonal residents, a large Hispanic population from Caribbean descent, as well as year-round migration to the sunshine state. Approximately one-third of Florida's migration is from international movement; the remaining two-thirds is movement from other states. (Office of Economic and Demographic Research of the Florida Legislature, 1999).

In 1998, Florida's estimated population was 15,000,475. Additionally, Florida's Hispanic population grew to an estimated 2,041,681 and the African American population grew to an estimated 2,042,664 (Office of Economic and Demographic Research of the Florida Legislature, 1999). Nevertheless, since no statewide prevalence studies are available regarding rates of individuals with mental disorders, figures extrapolated from national estimates indicated that 2.8 percent of the total population suffers from severe mental illness. Current population estimates for persons in Florida suffering from a mental illness alone is 420,007 persons, for those suffering from co-morbid disorders is estimated to include 480,015 persons.

Florida's population is compounded by age distribution that reflects the continuation of an aging trend of the population. In 1980, there were 1,687,573 Floridians aged 65 and older (17.3 percent of the total population). The 1990 census enumerated 2,355,926 elderly (18.2 percent of total) and by April 1, 2010, this age group will number 3,395,208 and constitute 18.9 percent of the total population. These changes represent increases of 39.6 percent between 1980 and 1990 and 19.4 percent between 2000 and 2010. The population aged 85 and older was one of the fastest growing age segments during the 1980's, increasing by 75.1 percent. This group is expected to increase by more than half again during the last decade of this century and number 330,220 by April 1, 2000. High rates of growth will continue for this age group through the first decade of the next century with the age 85 and older population projected at 489,635 by 2010 (Office of Economic and Demographic Research of the Florida Legislature, 1999).

HEALTH CARE EXPENDITURES

United States

Health expenditures in the United States have increased dramatically over the past three decades. National health expenditures were approximately $73 billion in 1970, $247 billion in 1980, and $700 billion in 1990, and $1.1 trillion in 1997. As a percentage of the United States gross domestic product (GDP), national health care expenditures have increased from 7.0 percent in 1970 to 9.0 percent in 1980 to 12.0 percent in 1990. In 1997, national health care expenditures were 13.5% of the GDP (Levit et al, 1998). The total costs to society for mental disorders and substance abuse far exceed the costs of cancer ($104 billion), respiratory disease ($99 billion), AIDS ($66 billion), or coronary heart disease ($43 billion) (Rouse, 1995).

Costs associated with mental disorders and substance abuse have been substantial. A recent study by McKusick et al (1998) reviewed national spending trends during this decade by studying the formal health care services used to diagnose and treat mental health and substance abuse conditions. Their study did not review the indirect costs of mental illness or substance abuse disorders. McKusick et al estimated that in 1996 expenditures for mental health and substance abuse diagnosis and treatment were $79.3 billion. The largest share went to mental illness ($66.7 billion), $5.0 billion went to alcohol abuse, and $7.6 billion went for abuse of other substances. 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 was 13.4 percent and other federal government programs made up 3.8 percent. Private health insurance paid 26.3 percent of the expenditures. Client and other private sources equaled 19.5 percent.

For example, the economic cost of treating depression in the United States in 1995 (the last year for which such figures were available) was $44 billion, more than the costs for treating strokes or osteoporosis (*Cost of Uncured Disease in the U.S*, 1995). The National Institute of Mental Health (NIMH) estimates that 15 percent of persons over 65 suffer life impairing depression and the vast majority of these people never get the help they need to treat the disease. The NIMH also estimates that 17 million Americans suffer from depression annually. In addition, 40-65 percent of heart attack, 10-25 percent of stroke, and 25 percent of cancer survivors are affected with depression. The average depressed patient was found to make approximately two to three times as many general medical visits as non-depressed patients (Fisher, 1997).

Anxiety disorders afflict some 6 percent of men and 13 percent of women in the United States and account for a fifth of the national expenditures for mental illness. Anxiety disorders include phobias and post-traumatic stress to generalized anxiety, obsessive-compulsive and panic disorder. In 1992 (the last year for which such figures were available), anxiety disorders cost an estimated $30 billion in direct treatment costs and lost earnings, decline in productivity and other associated expenses. Anxiety and depression have been found to markedly drive up primary care costs: One HMO calculated the average per patient cost for enrollees with either anxiety or depression was $2,390 for a six-month period, compared to $1,400 for enrollees without the disorders. Much of the additional cost came from higher use of general medical services rather than specialized mental health care (Smith & McGhan, 1997).

In addition, it has been estimated that 16.1 percent of the population in the United States is uninsured

(US Census Bureau, 1999) and mental health coverage is limited for those who are insured (Frank & McGuire, 1994). Furthermore, persons with severe mental illness many times have limited financial resources. As such, they experience significant barriers to access treatment. The financial impact of having a serious mental illness can be catastrophic. Once the insurance benefits are finished, the person is channeled into the public mental health care sector.

Florida

While Florida currently ranks 9th in total state mental health expenditures, it ranks 42nd in per capita state expenditures for mental health services. Petrila and Stiles (1996) have examined estimates of the cost of mental health (not including alcohol and drug abuse services). They used a combination of two 1994 data sources to estimate the mental health costs in Florida: the Alcohol, Drug Abuse, and Mental Health Program Office of the Florida Department of Health and Rehabilitative Services (ADM) and the Agency for Health Care Administration (AHCA). The ADM data source consisted of information collected from organizations that received financial support from ADM, excluding general and private hospitals during 1994. The 1994 AHCA data contained information from all non-state-supported hospitals and was based upon Medicare and insurance revenues reported by the hospitals, which had individuals with mental disorders. However, substance abuse diagnoses were not included in this data set.

The estimated costs of mental health services clearly show that most funds for mental health services in Florida are to supported state hospitals, while community hospitals received funds from entitlement programs and insurance providers. Local government and state ADM expenditures accounted for approximately one third of the total expenditures for mental health services in Florida. Additionally, while hospital mental health services were funded equally by state ADM, Medicaid, third party insurers, and Medicare funding, nearly two-thirds of expenditures for outpatient mental health services in Florida were funded by state ADM and third party insurance.

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

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. This program is administered by the Health Care Financing Administration (HCFA). In 1996, public spending for Medicaid totaled $121 billion.

Approximately 23 percent of all Medicaid recipients are in a managed care program compared to 10 percent in 1991. (HCFA in Freund & Hurley, 1995). The aged, blind, and disabled recipients of Medicaid together consumed the lion's share of Medicaid resources. Fiscal pressures have been the main impetus for states to adopt managed care for their Medicaid populations with the loss of federal "matching dollars" and the move to Medicaid waivers (Ridgley & Goldman, 1996).

Nationally, disabled individuals comprised about 15 percent of the Medicaid population and accounted for 39 percent of the Medicaid expenditures, including long-term care (GAO, 1996). The Medicaid expenditures (per person) for individuals with disabilities averaged $2,072 for inpatient services; $443 for physician, lab, and x-ray services; $773 for outpatient services; $1,183 for prescription drugs, case management, therapy, and other practitioner care, and $3,485 for long-term

care, for a total of $7,956 for all services. Unfortunately, information on breakout by type of mental disability was not available (GAO, 1996).

In Florida, there were 1,597,461 individuals who qualified for Medicaid in the 1997 fiscal (HCFA, 1999). In fiscal year 1996, Florida paid $3,382,000 in Medicaid costs (Florida Statistical Abstract, Table 20.74). Revised projections of Medicaid expenditures for the 1998-99 fiscal year are 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 is expected to average 1.53 million cases this year, or about 10% of the state's population. For next year, Medicaid expenditures are forecasted at $7.47 billion, or $513.1 million greater than this year's appropriation base. (Florida Consensus Estimating Conference, 1999)

Out of the statewide total, 257,265 were blind or disabled persons (HCFA, 1999a). 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 Administration, 1998). 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). Unfortunately, no information was available for just individuals with mental disorders. 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, 1995).

MANAGED CARE

Overview of Managed Care

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

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). Regardless of the organizational structure, behavioral managed care organizations provide (or contract to provide), to a defined population, mental health and substance abuse services which have been shown to be the most effective as well as least costly, (usually) on a prepaid, contractual basis. There often is risk-based contracting, because the managed care (the risk often is "shared" with service providers) entity assumes financial risk of providing services beyond those paid for when necessary. Therefore, there are strong financial incentives for managed care entities to control service utilization, and thus the costs of services. Additionally, managed care organizations may control costs through a variety of mechanisms, including case management, provider profiling, and utilization management.

Managed care organizations have become more active in their expansion into the public sector, where more and more public mental health systems have shifted their priorities from providing mental health and substance abuse services to purchasing these services, and from maintaining institutions and other services to the utilization of a systems of care approach to service delivery (Essock and Goldman, 1995).

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 had obtained 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 Council of State Legislatures, 1999). Among the states (including Florida) with approved or pending Section 1115 waiver requests, the most common approach was to offer acute but limited mental health benefits to all Medicaid recipients but to carve-out persons with more severe mental illness and treatment needs (Ridgley & Goldman, 1996). Florida is also testing the 1915(b) waiver, which requires certain Medicaid recipients to enroll in one of two managed care plans: Medicaid HMOs or MediPass. The 1915(b) program is currently under evaluation.

With the proliferation of state mandated mental health and substance abuse benefits in the 1980s, managed behavioral health care companies were created to manage the behavioral health benefits within health insurance plans as well as to manage mental health and substance abuse benefits which were contracted out or "carved-out" from HMOs and PPOs. By mid 1998, all but four states had implemented some form of managed behavioral health care (National Conference of State Legislatures, 1999).

The number of people receiving mental health benefits through managed care arrangements has grown from 78 million people in 1992 to 162 million people in 1998 (Oss, 1998). Managed care is now the predominant type of health insurance for employed individuals. Approximately three-quarters of employed individuals with health insurance have coverage through a variety of managed care arrangements (Jensen et al., 1997). The rapid growth of separate carve-out contracts has been stimulated by reports of savings in the range of 40 percent or more (Frank et al, 1995).

Health services delivery continues to move towards managed care, where aggressive utilization review, benefit limitations, and benefit management help to control the over utilization of health and mental health services. The use of capitated reimbursement methods for health and mental health services can increase the potential to improve service coordination, promote disease prevention, and reduce institutional care. Two recent studies, one in California (Chandler et al, 1997), the other in Massachusetts (Ma & McGuire, 1998) review, respectively, studies on an integrated service agency and mental health/ substance abuse benefits program for state employees.

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

For example, a study by the Rand Corporation (Sturm, 1997) examined claims from 24 managed care carve-out plans which offered unlimited mental health benefits with minimal copayments. Results of the study indicated that companies which complied with the federal mental health parity law by removing an annual limit of $25,000 for mental health care would incur 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.

Managed care companies have insisted that parity for mental health is feasible. Managed behavioral health care organizations operate on three assumptions: mental illness diagnoses are relatively objective and consistent; medical necessity criteria can be operationally defined; and the benefits for the treatment of mental illness can be managed for appropriateness and effectiveness. Some have suggested that eliminating discriminatory caps on lifetime and annual caps would not have much of an effect on health plans. Studies have indicated only a fraction of one percent of plan enrollees ever exceeds the kinds of mental health caps found in the marketplace (Special Issue, 1996). Others reported that there are clear, measurable diagnoses and treatments for severe mental illness. Diagnoses that were abused in the past to justify extended hospitalizations can be met with focused treatment. Though managed care can limit a patient's choice of providers, after a business adopts managed care, mental health care access increases by 15 percent while the business costs drop (Special Issue, 1996).

Highlights of Benefit/Cost Analysis and Actuarial Studies

It has been argued that limited coverage for mental illness in health insurance policies increases the cost of treatment to the patient and/or the health care provider, and thus provides a disincentive to seeking treatment. Because the primary purpose of parity legislation is to ensure the availability of treatment services, direct treatment costs may potentially increase under a parity bill. However, the increased flexibility and comprehensiveness of treatment allowed by parity plans do hold out the promise of more cost-effective treatment. For example, if under a parity plan individuals have more access to outpatient services, rather than being forced into inpatient treatment due to insurance restrictions, then treatment may become more cost effective as well as less restrictive.

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

Despite opposition by those who have claimed that parity would increase expenditures, additional studies (Sing et al., 1998; NAMHC, 1998; Sturm, 1997; Lewin Group, 1997; CBO, 1996; Goldman et al., 1998; Grazier, 1998; Sturm & McCulloch, 1998; Ma & McGuire 1998) have shown this to be inaccurate. A study released in March by the Substance Abuse and Mental Health Services Administration provides additional support for the adoption of parity.

The report, *Effects of the Mental Health Parity Act of 1996* (1999), was based on data from the Mercer/Foster Higgins *National Survey of Employer-Sponsored Health Plans*. The data indicates that the effects of the federal Mental Health Parity Act have been positive. 86 percent of plans surveyed indicated that they had made no compensatory changes to their benefit because they expected the cost increases to be minimal or non-existent. The remainder did make some type of compensatory changes in benefits or administration; most commonly increasing limits on inpatient days and/or outpatient visits. According to the *Survey*, the Mental Health Parity Act had an unintended beneficial effect of also improving coverage for substance abuse benefits in many plans.

In summary, based on new knowledge derived from empirical case studies and updated actuarial cost-prediction models, the costs of parity are controllable.

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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 including day, dollar, and visit limits. The standardized benefits value is equivalent to the average premium for healthcare for medium and large employers in the United States.

COST OF TREATMENT ISSUES

Overview

The costs of mental health services can be partitioned into budgeted costs (or actual costs) and social costs (the cost of mental disorders due to lost productivity, etc.) (Dickey et al 1986; Clarke et al 1994; Dickey et al 1996). McKusick et al (1998) estimated that in 1996 expenditures for mental health and substance abuse diagnosis and treatment were $79.3 billion. The largest share went to mental illness ($66.7 billion), $5.0 billion went to alcohol abuse, and $7.6 billion went for abuse of other substances. Rouse (1995) estimated percentage breakouts of expenditures included 34 percent of the costs were from loss of productivity, 26 percent of the costs were due to the somatic health consequences of mental disorders, and 22 percent of the costs were 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 they can become involved with the criminal justice system due to inconsistent and occasionally violent behavior (Teplin, 1990).

This figure does not include the actual transfer of payments made by social service agencies. Such payments, from society's perspective, either represent a transfer payment, a resource cost, or are already included in direct treatment costs.

Direct Costs

The limited coverage for severe mental illness in many current health insurance policies increases the cost of treatment to the patient and/or the health care provider, and thus provides a disincentive to seeking treatment. The state of Massachusetts reported a 5 percent increase in the number of persons using services after implementing a more comprehensive, flexible plan for dealing with the treatment of mental illness (Coalition, May 1996a).

In addition to this "pent-up" demand, the more comprehensive coverage provided under a parity plan can also increase the utilization of services by persons who currently seek treatment, e.g. the 30-day limit on inpatient care is a characteristic of some current insurance plans which is alleged to restrict treatment to those who run up against this constraint. Milliman and Robertson (1995) estimated that, for the state of Florida, the parity law would increase the total number of days for inpatient mental health service stays for those currently utilizing the system by 4.7 percent.

Direct Treatment Costs Because the primary purpose of parity legislation was to increase utilization of treatment services, direct treatment costs would presumably increase under a parity bill. Indeed, such increases would be considered a cost associated with the legislation, rather than a benefit. No attempt was made here to estimate those costs, but other studies have indicated that such costs, in the form of increased premium payments, would be relatively small. However, the increased flexibility and comprehensiveness of treatment allowed by parity plans do hold out the promise of more cost-effective treatment. For example, if under a parity plan patients have more access to outpatient services, rather than being forced into inpatient treatment due to insurance restrictions, then treatment may become more cost effective as well as medically effective. Massachusetts, for example, contracted in 1992 for a Medicaid managed mental health program that includes the disabled in the covered population. A study of the first year of the Massachusetts program claimed a 22 percent saving to Medicaid. The savings came from 37 percent reductions among the disabled and 16 percent reductions among the non-disabled. Clearly some of these savings 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 a parity proposal will alter the mix of service providers. A parity proposal will shift some of the costs of caring for persons with severe mental illness from the public sector to the private sector. Private sector coverage has in the past relied more heavily on community outpatient service than has publicly funded insurance. State expenditures in particular are highly weighted toward state hospital inpatient treatment. This potential shift in service providers should prove to be cost effective.

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

There is substantial evidence in the literature that both mental health and addictions treatment are effective in reducing the utilization and cost of medical services (Borus, 1985; Holder & Blose, 1987; Massad et al. 1990, Pallak et al 1994, Mechanic et al. 1995, Olfson, 1999). Cummings et al (1993) showed that, depending upon the subgroup of users, the costs of providing managed mental health services were recovered in terms of reduced medical offset within 5-21 months. Shemo (1985) 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 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).

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

Treatment of severe mental illnesses can be effective. The National Institute of Mental Health reports the following treatment efficacy rates (Hyman, 1996): schizophrenia -60 percent, major depression - 65 percent; bipolar disorder - 80 percent; and panic disorder - 70 to 90 percent. Furthermore, the availability of more comprehensive coverage can result in more effective treatment methods being utilized, thus improving the probability of success as well as reducing costs. These are fully comparable to efficacy rates of treatment in many areas of medicine (Goodwin, 1993). Furthermore, the availability of more comprehensive coverage can result in more effective treatment methods being utilized, thus improving the probability of success as well as reducing costs.

For example, the NIMH, recognizing that the total costs of depression are skewed to various indirect cost categories, has stated that "the shift in even a small portion of the … indirect costs into direct treatment costs could produce a profound improvement in the lives of those currently untreated and undertreated" (Regier et al, 1988b).

Indirect Costs

Persons with severe mental illness often face problems at work, either due to decreased effectiveness while working or due to increased absenteeism, Furthermore, the increased mortality rates associated with severe mental illness lowers the productive capability of the economy (Glied, 1996). A report by the Massachusetts Institute of Technology Sloan School of Management reported lost productivity from clinical depression was $28.8 billion in 1995 (Greenberg, 1995).

As we learn more about the costs of mental illness, it will be easier to prioritize resources. Learning patterns of resource use is an important part of measuring costs. Certain events, such as involuntary hospitalization or arrests, have predictable sequences of resource use, such as psychiatric and medical evaluation, transportation by law enforcement officers from point of contact to hospital or jail, preliminary hearing, and court proceeding.

Public and Private Sector Issues

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

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

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

The passage of a mental illness parity law could shift some of the costs of providing treatment for mental illness from the state (and federal) government to the private sector, specifically to the private business sector (either employer or employee). Currently, the burden of paying for treatment costs not covered

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

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

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

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

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

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 is 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 (NAMHC 1997).

IMPACT ON THE STATES

Parity legislation, in its purest form, would include insurance coverage for mental health, alcohol, and drug abuse services that would be equal to insurance coverage for any physical disorder in terms of annual or lifetime limitations (service and/or dollar maximums, co-payments, and deductibles. For the purposes of this report, we have defined three levels of parity:

1) *Partial parity* does not allow different limits on physical health or mental health visits. Additionally, partial parity also specifies the benefits structure, defines which diagnoses fall under the umbrella of severe mental illness, and the populations which are covered.
2) *Full parity* is defined as 'separate but equal' coverage for both physical and mental health services.
3) *Comprehensive parity* combines medical and mental health care, including substance abuse treatment, into one plan, with a single deductible and percentage paid.

Twenty states (Arizona, Arkansas, Colorado, Connecticut, Indiana, Kansas, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New Hampshire, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, and Vermont) currently have parity laws for mental health and/or substance abuse services. A table of these twenty states is found in the Appendix of this report.

Impact of State Parity Legislation

There is considerable variability in how states define, determine eligibility standards, and set service limitations for mental health and substance abuse parity legislation throughout the United States. Thus, while parity in Maryland means coverage for all mental disorders and substance abuse treatment vis-a-vis coverage for physical illnesses, parity in New Hampshire refers to treatment coverage for specific biologically-based severe mental disorders. Furthermore, current exemptions in state insurance regulations potentially further 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 exempt themselves from federal law.

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

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, 1999).

Maryland

The Maryland Health Resources Planning Commission has reported continued decreases of inpatient stays in psychiatric units of general hospitals one year after passage of Maryland's parity law. Only

11 individuals were hospitalized for more than 60 days in 1995, compared to 21 people in 1993. In 1993, the number of individuals staying longer than 20 days in private psychiatric hospitals was 24 percent, while in 1995, one year after passage of the parity law, it was less than 18 percent. In Maryland, full parity in all state regulated plans upped costs by .6 percent per member per month.

Massachusetts

In a study of 40,000 people in Massachusetts, the total mental health costs per member per month decreased from $18 before parity legislation to $8 after parity legislation (Ma & McGuire, 1998).

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 percent - 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 percent - 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 $4.06 in 1996 (NAMHC, 1998).

Texas

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

IMPACT ON FLORIDA

A Short Legislative History of Parity Act 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. Parity, in this paper, refers to parity for coverage of mental illnesses and substance abuse disorders to be the same as those offered for physical illnesses.

In 1992, the Agency for Healthcare Administration (AHCA) was reviewing a redesign of the basic benefit plan for mental health services. The Florida Council for Community Mental Health (FCCMH) presented specific benefit design recommendations. The model benefit plan in their report was seen as a first step toward parity between physical, mental, and substance abuse treatment benefits (Florida Council, 1992). A Hay/Huggins study showed how providing a "continuum of care" could reduce 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, a House bill entitled "The Mental Illness Insurance Parity Act" was introduced with a companion Senate bill. An independent report by the actuarial firm of Milliman & Robertson (Milliman & Robertson, 1995) to the Legislature indicated an increase in expenditure (per employee per month) of $2.01 with a change in the mandated offering of benefit. This change would affect approximately 35.7% of Florida's population. This percentage represented the portion of 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 (Milliman & Robertson, 1995). The bill did not pass.

In 1996, House and Senate bills were reintroduced. However, once again both died during session. 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. Nevertheless, the bill did not become state law.

Over the past three years, the bill, now known as the "Diane Steele Mental Illness Insurance Parity Act", has gone through several iterations. The 1998 version 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.

Although the "Diane Steele Mental Illness Insurance Parity Act" has nearly unanimous approval by House and Senate Committees, it has also had serious opposition. On one hand, the Senate Banking and Insurance Commission voted to require that insurance coverage for mental health conditions be comparable to those for physical conditions and acknowledged that such problems affect "significant portions of the state's population." However, the Committee adopted an amendment that exempted employers with fewer than 50 employees from the bill. An estimated 90% of Florida's employers

have less than 50 employees. Three additional amendments included a treatment limit, the ability for HMOs to enter into capitated contracts with providers to provide mental health services, and a nullification option if its application resulted in a more than two percent increase in cost to a health plan (Florida Healthtrac, 1998). The bill died in committee, although the *Senate Staff Analysis and Economic Impact Statement* recommended that, at a minimum, the Insurance code be amended to conform Florida law to the Federal Mental Health Parity Act (State of Florida, 1998).

Health Benefits and Mandates in Florida

Health insurance regulation is a patchwork of federal and state laws. The rules for a health plan will differ depending on whether the health insurance is self-purchased, employer - purchased or if the insurance is part of something called a self-funded ERISA plan.

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

In Florida there is no statutory requirement that mandates the inclusion of mental health or substance abuse treatment benefits for health insurance coverage. Florida law, however, does require insurers and health maintenance organizations to offer *the option of coverage* for mental illness or nervous disorders to the group policyholder (*Florida Statutes,* §627.668*).* In addition, insurers are authorized to charge "an appropriate additional premium". The law also requires the insurer to offer a range of coverage. The number of inpatient days and the amount of outpatient benefits are limited. Insurers may price the coverage separately and may vary the benefits for inpatient or outpatient services for hospitalization. The "standard" and "basic" small group insurance plans currently define "mental and nervous disorder" from the most recently published edition of the *Diagnostic and Statistic Manual of Mental Disorders*.

The Impact of Parity Legislation for Florida in Benefits Design

What specific changes would parity legislation mean for Florida?

1. Statutes will be affected, specifically *S.627.688, .6472,.6515, 641.31, F.S.,* relating to optional coverage for mental and nervous disorders, will be amended. S.627.6681 will be created.
2. Confidentiality of records would be required for those records relating to serious mental illness.
3. It would also require that every insurer and HMO in Florida transacting group health insurance or pre-paid health care must provide treatment for serious mental illness.
4. For those who have a co-occurring substance abuse problem, treatment would be included for the substance abuse problem.
5. The health insurance mandate would apply to local government health insurance plans. [2]

2 The State Constitution allows a general law such as this one if the legislature determines the law fulfills an important state interest. In each presentation of the parity bill, the Legislature has determined that the bill fulfills a critical state interest.

6. Severe mental illness is defined as any biological disorder of the brain that substantially limits the life activities of the patient.[3]

In House staff analyses of the Florida parity legislation, it was determined that if a parity model similar to the Texas state employee model were enacted, the cost to the state would be $2.50 per member per month or $405,600 (Commiteee, 1997). For the public sector, there ultimately would be reduced costs for health care in that extended coverage would reduce direct and indirect costs of treatment. For the private sector, although there would be initial increase in the utilization costs, there would also be a reduction in total health costs resulting from the more comprehensive treatment of these conditions (Commiteee, 1997; Levin et al, 1998).

Further Benefits from the State's perspective

The passage of a mental illness parity law would benefit the state of Florida in a manner not noted above. Such legislation would shift some of the costs of providing treatment for severe mental illness from the state (and federal) government to the private sector, specifically to the private business sector (either employer or employee). As previously noted in the discussion of the costs of mental health treatment, the burden of paying for treatment costs that are not covered under private insurance plans often falls on state or federal agencies. McKusick et al (1998) estimated state and local government expenditures for mental illness and substance abuse treatment to be approximately 22% of overall spending, approaching $15 million. The Federal government, namely Medicaid and Medicare programs, accounted for an additional 32 percent. Nationally, 41.3 percent of persons (ages 21-64) with a mental disability are employed. Of those with a severe disability, 43.7% have private health insurance. (US Census Bureau, 1996). The increased coverage under private plans should result in some of these costs being transferred to private insurance coverage, and thus indirectly to the businesses that provide such coverage. These increased costs upon the private sector will be reflected either in increased premiums (paid for by either the employer or employee) or reduced coverage for other covered illnesses, which in effect passes the increased costs onto the employee.

A Preliminary Estimate of Benefits for Florida

A Scenario Based on Persons with Severe Mental Illness

An idea of the magnitude of the benefits to the state of Florida from a mental illness parity law can be acquired by applying the information above to the relevant data from Florida. In 1995 the population of the Florida was 14.16 million persons, 3.37 million persons under the age of 18 and 10.79 million adults (Florida Statistical Abstract, 1996). If Florida has the same incidence of severe mental illness as exists in the country as a whole, then 302,000 adults (2.8 percent times 10.79 million) and 108,000 (3.2 percent times 3.37 million) persons under the age of 18 currently suffer from severe mental illness, a total of 410,000 persons in Florida.

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3 Severe mental illness would be defined by the latest edition of the relevant manuals of the American Psychiatric Association or the International Classification of Diseases.

Milliman & Robertson, Inc. (1995) estimated that the proposed parity law would affect 35.7 percent of Florida's population. Certain groups are exempted from the proposed legislation, most importantly the self-insured and those covered by Medicare and Medicaid. Applying this percentage to the number of persons in Florida with severe mental illness results in an estimate of 146,300 persons with severe mental illness who will fall under the parity law: approximately 107,800 adults and 38,500 persons under the age of 18.

If treatment utilization rates in Florida are roughly comparable to rates for the rest of the country, then 60 percent of these adults (64,700) and 29 percent of those under age 18 (11,200) are currently receiving treatment for severe mental illness (annual average). If the parity law, via its reduced price of treatment, increases the number of persons with severe mental illness who seek treatment by 120 percent, then approximately 13,000 additional adults and 2,200 additional youths will seek treatment, a total of approximately 156,000 persons. If treatment efficacy rates average around 70 percent, then approximately 10,500 of these persons will show substantial improvement in their SMI. Nationwide, the annual per person social costs of severe mental illness has been estimated to be approximately $6,700. (Note: This figure was derived by dividing the estimated $47 billion "indirect and related costs" from the NMHAC report of severe mental illness in 1990 by the 7 million persons -- 5 million adults and 2 million persons under age 18 -- who suffered from severe mental illness. Multiplying this figure by the estimated 10,500 persons who will show significant improvement from treatment for severe mental illness they will now seek because of parity legislation yields an estimated annual social benefit for the state of Florida of $70.5 million).

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

Most notable among these are:

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

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

CONCLUSION

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

Parity efforts in the individual states vary dramatically, due to the changing definitions of mental disorders, the scope of the parity provision (total provision of mental health and substance abuse service coverage or partial provision of only mental health services), the existence of managed mental health initiatives within the state, and existing insurance mandates. Nevertheless, Florida has the opportunity to establish a policy for mental health parity vis-a-vis somatic health services. Based upon the experiences of other states, this initiative will provide availability to mental health insurance coverage as well as reduce the total costs to residents who live in Florida.

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

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

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

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Appendix
Summary of State Parity Legislation

LEGISLATION	COVERAGE
ARIZONA[1] HB 2580 enacted 2/98. Effective 1/1/99.	HMOs, BC/BS, group and individual insurers are to offer coverage for the dx and tx MI and SA, under the same terms and conditions as for physical illness. From 7/1/99-6/30/00, insurers will offer at least 60 days IP and OP for dx and tx of MI or SA. Beginning 6/1/00, IP/OP tx for MI or SA will be offered for at least the same number days equitable to physical illness, under the same terms and conditions as for physical illness.
ARKANSAS.[2] HB 1525 enacted 4/97, Effective 8/1/97.[7]	Health benefit plans must provide benefits for dx and tx of MI and DD (as defined in the ICD and DSM), under the same terms and conditions (including duration, frequency , and dollar amount for coverage), as well as financial requirements.[7] Benefits for SA not included in this bill. HB 1525 exempts employers with 50 or fewer employees; the bill is not applicable if *projected* cost increase of plan equals or exceeds 1.5%.
CALIFORNIA[3,4] AB 1100 originated 2/97 "to the Senate in 1998.	Provides benefits for dx and medically necessary tx of MI, including specific biologically-based SMI and serious emotional disturbances of children (these categories include, but are not limited to, schizophrenia, schizo-affective disorder, bipolar disorder, depressive disorder, panic disorder, OCD, and PDD or autism). Coverage for these disorders shall be same as for treatment of other brain disorders; dx may be confirmed by insurer, and tx plans may be reviewed for medical necessity.
COLORADO enacted 1997, takes effect 1/1/98[5]	Provides for coverage of schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder that is no less extensive than the coverage provided for other physical illnesses.
CONNECTICUT H.B. 6883, 1997 [6,7]	Requires group policies to provide coverage for biologically-based mental or nervous conditions at parity with medical or surgical conditions. "Biologically-based mental illness" is defined as "any mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia & other psychotic disorders, obsessive-compulsive disorder, panic disorder, pervasive developmental disorder or autism."
GEORGIA.[8] SB 245 introduced 2/10/97.	Requires that group contracts (e.g., accident and sickness insurance; medical service corporations; health plans; HMOs) offer same tx limits or financial requirements on tx for mental disorders as for other medical illnesses without subjecting plans for tx of mental disorders to exclusions, reductions or co-insurance provisions dissimilar to plans for other medical illnesses. Substance abuse is excluded unless co-morbid with mental disorder.
INDIANA [9] HB 1400 enacted 5/13/97. HB 1400 effective 6/30/97. The law sunsets 9/29/01.	Provides equitable coverage for "biologically-based" SMI: schizophrenia; bipolar disorder; panic disorder; OCD; ADD; and any other disorder that is a "biologically-based" SMI, as provided for other physical health conditions. Coverage for services for mental illness include benefits with respect to mental health services as defined by the health services contract, policy, plan or HMO; applicable contracts include prepaid plans for state employees. By way of amendment, the bill was extended to provide mental health benefits parity to a broader range of MI, in private contracts. Treatment for substance abuse or chemical dependency is excluded. Exemptions to the law include: ERISA plans, small businesses (fewer than 50 employees) and any business whose insurance rates would increase by over 1% as a result of compliance with the law.
KANSAS [10] S 204 enacted 5/15/97. Effective 1/1/98.	Limited parity for MH benefits, refers to MH services, as defined under the terms of the policy. Treatment of substance abuse or chemical dependency is specifically excluded. Describes provisions for general health care, including long-term coverage, chronic and pre-existing conditions. MH benefits shall be on par with medical and surgical expense benefits. The law does not apply to small business employers or to groups whose policy will increase by at least 1% due to compliance.

MAINE [11] PL 407 enacted 1995. PL 407 effective 7/1/96.	The law specifies certain mental illnesses: schizophrenia; bipolar disorder; pervasive developmental disorder or autism; paranoia; panic disorder; obsessive-compulsive disorder; or major depressive disorder, and defines *a person suffering from a mental or nervous condition* as 'a person whose psycho-biological processes are impaired severely enough to manifest problems in ... social, psychological or biological functioning.'[11] Excludes coverage for alcohol/drug abuse. Mandates that tx for these MI are of no less coverage than benefits provided for tx of other physical disorders.
MARYLAND [12] **Full Parity:** HB 1359 enacted 1993; H 756 enacted 1994 Effective 7/1/94.	The law does not define "mental illness" or "mental health" and therefore, requires parity coverage for all mental illnesses/substance abuse/chemical dependency. The law also prohibits discrimination in health care coverage against any person with a drug or alcohol abuse disorder.
MASSACHUSETTS [13] S 1877 "An Act Relative to Certain Health Care Benefits" passed 4/6/98	Covers adults with severe mental illness (but not limited to SMI) and children with severe emotional disturbances
MINNESOTA [14] **Full Parity:** SB 845 enacted 8/1/95.[11]	Broad-based parity–the state does not define "mental illness" and "substance abuse" and therefore, requires parity for both. The law specifies that cost-sharing or service limitations for IP and OP MH/SA Tx not place a greater financial burden or be more restrictive on the insured or enrollee than that for other medical services.
MISSOURI [15] HB 335 introduced 1/20/97 HB 335 signed by the Governor 6/25/97.	In the context of a bill supporting consumer-rights and regulation of health care organizations (including HMOs), offers parity for mental disorders listed in the DSM, excluding mental retardation and chemical dependency, and specifies minimum mental health benefits (diagnostic visits, equitable co-payments and extent of coverage), in addition to other specified general health benefits and insurance proceedings.
MONTANA [16] SB 378 introduced 2/97. SB 378 effective 7/1/97; Section 9 effective 1/1/98.	SB 378, Section 9, addressed mental health parity in the context of managed health care health reform. The bill states that mental health benefits must be offered and must not be more restrictive than plans offered for general health conditions.
NEVADA [17] AB 521 introduced 5/22/97. Section 88 not effective until 1/1/98 and expires 9/30/01	Broad health care reform bill with specific reference to mental health parity in Section 88. Applies to mental health benefits only; health plans must offer equitable benefits for mental health care, if they do offer such care (this bill does not require insurance companies to offer such services); the bill is intended for large group health plans only; and plans are not required to comply with parity provisions if cost increases 1% or more.
NEW HAMPSHIRE [18] parity: SB 767 introduced 1994. SB 767 effective 1/1/95.	The law provides parity for "biologically-based" SMI (schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, OCD, panic disorder, and PDD or autism).[18] All health plans must provide equitable coverage for dx and tx of these disorders, under the same terms and conditions as for other physical disorders.
NEW JERSEY [19] parity: A 249 and A 660 were both introduced 1/13/98. S 86 passed 4/2/98	A 249 requires health insurers to offer coverage for MI tx; A 660 requires health insurers to provide mental health benefits under the same terms and conditions as for other illnesses. Definition of 'mental illness' is referred to DSM. A 249 specifies minimum standards of benefits (including stated minimal IP and OP benefits, in days and dollars) and requires benefits. A 660 is more general and requires insurers to offer benefits as for other illnesses, without specifying minimum standards.[24] S 86, "An Act Concerning Health Insurance Benefits of Mental Health", covers biologically-based mental illnesses.

NORTH CAROLINA [20] **Full parity**: HB 434 introduced 3/16/97. SB 400/ H563) introduced 3/97. HB 434 enacted 7/1/97; now known as CH. SL 97-0259. SB 400 assigned to Insurance-Health Committee 5/97.	HB 434 amends North Carolina's insurance laws to comply with recent federal legislation concerning health insurance underwriting and portability, maternity coverage, and coverage for MI Tx. Includes both MI and SA. Does not require insurers to provide MH coverage, but if coverage is provided, must have equal benefits, no greater restrictions than coverage for other illnesses. Special regulations for group contracts; small employers (less than 50 employees) and plans which result in projected cost increase of at least 1% due to compliance with law, are exempt. SB 400 (and H 563) are statements of non-discrimination in insurance for MI and specify parity requirements.[27]
RHODE ISLAND [21] took effect January 1, 1995	Applies to those illnesses that current medical science affirms are caused by biological disorders of the brain and that substantially limit life activities. The term "serious mental illness" includes, but is not limited to: schizophrenia, schizoaffective disorder, delusional disorder, bipolar affective disorder, major depression, and obsessive-compulsive disorder.
SOUTH CAROLINA [22] S 288 introduced 1/30/97. Approved 3/31/97	Broad-based parity in insurance contracts which offer mental health benefits. Group policies must offer same aggregated lifetime and annual limits as are offered for medical or surgical benefits. Small employers are exempt, as are plans that do not offer mental health benefits. Mental illness is not specifically defined; substance abuse or chemical dependency is excluded.[31] Effective for group plans on or after 11/1/98 and does not apply to services furnished on or after 9/30/01.
SOUTH DAKOTA [23] HB 1262 Approved into law 3/13/98	Requires insurance companies to offer coverage for biologically-based mental disorders, including bipolar disorder, major depression, and schizophrenia, equal to that of serious somatic illnesses.
TENNESSEE [24] SB 1699/HB 1825 introduced 2/97 Approved 4/30/97). Public Chapter Number 157; effective 1/1/98.	This bill features a section (17) with language for parity (broad-based MI, no benefits for alcohol/drug abuse) based on federal parity requirements, in the context of broad HIPAA compliance legislation. The law applies to group health plans that offer mental health benefits. Small employers, and plans that experience a cost increase of 1% due to compliance with the law, are exempt.
TEXAS [25] HB1173 introduced 1997, effective 9/1/97.	Specifies requirements for group insurance coverage for tx SMI: IP 45 days/yr; 60 OP visits (does not include medication review/management sessions); no lifetime limit on IP/OP benefits. Managed care acceptable; law requires insurers to have same amount limits, deductibles, co-insurance for SMI as for any other illness. Does not include services for chemical dependency.
VERMONT [26] **Full Parity**: HB 57 enacted 5/28/97. Effective 1/1/98.	Broadest parity bill enacted to date: Defines mental health conditions as 'any condition or disorder involving mental illness or alcohol or substance abuse that falls under any of the diagnostic categories listed in the mental disorders section of the international classification of disease, as periodically revised.'[34] Children with MH conditions are fully covered, as are persons in need of substance abuse tx. Any policy offered by a health insurer, as well as any policy administered by the state, in any capacity, is subject to full parity. MCOs must comply with standards set by the state insurance commissioner to maintain quality and access in delivery of services.

Abbreviations: ADD = attention deficit disorder; BC/BS = Blue Cross/Blue Shield insurance; DSM = *Diagnostic and Statistical Manual of Mental Disorders*; Dx = diagnosis; ICD = *International Classification of Disorders*; IP = inpatient treatment; HMO = Health Maintenance Organization; MI = mental illness; OCD = obsessive-compulsive disorder; OP = outpatient treatment; P = partial hospitalization; PDD = pervasive developmental disorder; R = residential treatment; SA = substance abuse; SMI = serious mental illness; Tx = treatment

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