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Mental Health Parity Issue Briefs

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The cost of paying for health insurance parity for mental illness has been one of the most hotly debated issues at the national and state levels. There have been many attempts to provide national estimates of the effect of parity on the cost of mental health care. These estimates vary widely in their assumptions, methodologies, data sources, and projected costs. No studies had used the actual data from states that have enacted parity legislation. Rather, by using actuarial data on benefit use and cost data from large insurance plans that do not operate under parity conditions, the different studies have tried to model the possible consequences of changing one part of the benefit structure, i.e., increasing benefits for mental disorders. While these estimates may make some adjustments for the effects of managed care on costs, the actuarial models generally do not directly incorporate the recent experience of managed behavioral carve-outs and other forms of managed care in greatly reducing mental health costs.

The limited coverage for 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. 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 National Advisory Mental Health Council Parity Workgroup 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. 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 vehement opposition by special interests who have claimed that parity would break the back of business, multiple studies continue to show minimal cost impact and that businesses are going ahead with plans to provide parity to their employees. In summary, based on new knowledge derived from empirical case studies and updated actuarial cost-prediction models, the costs of parity are controllable.

In 1992, the Agency for Healthcare Administration (AHCA) was reviewing a re-design 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 (1). A Hay/Huggins study showed how providing a “continuum of care” could reduce psychiatric care (2). The subsequent AHCA design incorporated a few of the suggestions into the 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 (3) 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 (3). 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” (4), 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 (5). 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 (6).

The Impact of Parity Legislation in Florida

What specific changes would parity legislation mean for Florida?

- S.627.688, F.S., relating to optional coverage for mental and nervous disorders, will be amended.
- Confidentiality of records would be required for those records relating to serious mental illness.
- 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.
- For those who have a co-occurring substance abuse problem, treatment would be included for the substance abuse problem.
- The health insurance mandate of this bill would also apply to local government health insurance plans. (1)
- 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 (3). 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 (3), (4).

While Florida currently ranks 9th in total state mental health expenditures, it ranks 42nd in per capita state expenditures for mental health services. Most funds were for mental health services in Florida supported state hospitals, while community hospitals received funds from entitlement programs and insurance providers. Local government and state Alcohol, Drug Abuse, and Mental Health (ADM) expenditures accounted for approximately one-third of the total expenditures for mental health services in Florida (5). 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 (6).

1. 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.
2. 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.
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 will 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 Statistical Manual of Mental Disorders.

**Florida mandatory health benefits**

*(References are to the Florida Statutes)*

**Application of law**

State laws mandating health benefits require either that insurance companies include certain health benefits in insurance policies offered or that insurance companies make certain optional health benefits available upon request. Therefore, these laws affect only those employers with insured health benefit plans and not employers with self-funded plans or those with no health benefit plans.

Alcoholism and drug abuse treatment (§ 627.669)
Child health services (§§ 627.6416, 627.6579)
Disability (§ 627.4233, §627.6561)
Disclosure of plan terms (§ 627.6141)
Handicapped persons (§§ 627.644, 627.6576)
Mental health (§ 627.668)

Insurers must make available to group policyholders coverage under terms not less favorable than for physical illness generally that includes 30 days of inpatient or partial hospitalization treatment per year and up to $1,000 in outpatient treatment per year.

Policies for small employers (§§ 627.6691, 627.6699, § 627.6699, § 627.6699, § 627.6699)

*Source: Bureau for National Affairs. Last modified Jan. 28, 1999*
An Overview of Parity Legislation

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 .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 in 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 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.

Additionally, 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 parity legislation.
Current Legislative Session Bills on Parity

**H 81** GENERAL BILL by Hafner; (CO-SPONSORS) Wiles; Fasano; Brown; Betancourt; Cosgrove; Ritter; L. Miller; Turnbull; Frankel; Morroni; Chestnut; Wasserman Schultz; Eggelletion (Similar H 0399, S 0302)

Mental Illness Health Insurance; creates “Dianne Steele Mental Illness Insurance Parity Act”; provides that current requirement for group insurers to offer coverage for mental health conditions does not apply to serious mental illness; requires group health insurers & HMOs to provide coverage for serious mental illness; requires benefits to be same as for physical illness generally; provides applicability, etc. Amends 627.668,.6472,.6515, 641.31; creates 627.6681. APPROPRIATION: $38,288. EFFECTIVE DATE: 10/01/1999.

-11/30/98 HOUSE Prefiled; -12/08/98 HOUSE Referred to Health Care Services (HFC); Insurance (CAC); Elder Affairs & Long-Term Care (HFC); General Government Appropriations (FRC) -01/08/99 HOUSE On Committee agenda—Health Care Services (HFC), 01/19/99, 2:00 pm, Reed Hall —Discussion; -01/22/99 HOUSE On Committee agenda—Health Care Services (HFC), 02/03/99, 9:00 am, Reed Hall —Not considered

**H 399** GENERAL BILL by Frankel (Similar H 0081, S 0302) Mental Illness Health Insurance; names “Dianne Steele Mental Illness Insurance Parity Act”; provides that current requirement for group insurers to offer coverage for mental health conditions does not apply to serious mental illness; requires group health insurers & HMOs to provide coverage for serious mental illness; exempts group health plans or coverage for small employer, as defined; provides applicability, etc. Amends Ch. 627, 641.31. APPROPRIATION: $38,288. EFFECTIVE DATE: 01/01/2000.

-01/26/99 HOUSE Prefiled - 02/01/99 HOUSE Withdrawn prior to introduction

**S 302** GENERAL BILL by Campbell (D); (CO-SPONSORS) Latvala (R) (Similar H 0081, H 0399): Mental Illness Health Insurance; creates “Dianne Steele Mental Illness Insurance Parity Act”; provides that current requirement for group insurers to offer coverage for mental health conditions does not apply to serious mental illness; requires group health insurers & HMOs to provide coverage for serious mental illness; requires benefits to be same as for physical illness generally; provides applicability, etc. Amends 627.668,.6472,.6515, 641.31; creates 627.6681. APPROPRIATION: $38,288. EFFECTIVE DATE: 10/01/1999.

-12/30/98 SENATE Prefiled; - 01/20/99 SENATE Referred to Banking and Insurance; Fiscal Policy

**Players**

**House Sponsors:** Wiles; Fasano; Brown; Betancourt; Cosgrove; Ritter; L. Miller; Turnbull; Frankel; Morroni; Chestnut; Wasserman Schultz; Eggelletion

**Senate Sponsors:** Campbell; Latvala

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