

Mental Health Parity:
1998
National and State
Perspectives

The Louis de la Parte Florida Mental Health Institute
University of South Florida
Tampa, Florida
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Mental Health Parity: 1998 National and State Perspectives

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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 parity laws for mental health and/or substance abuse benefits. This report summarizes the essential issues facing the state of Florida in the development of state mental health parity legislation, including an examination of the experiences of other states, a look at potential benefits, and a discussion of the impact of managed care and insurance benefit design on the costs of parity for mental health 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 results in modest cost increases and increased access to services. For example:

- In Maryland, full parity in all state regulated plans raised costs by .6 percent per member per month.
- In Minnesota, Allina Health System reported that operating under the parity law for mental health and chemical dependency added \$0.26 per member per month to the health premium, while Blue Cross/Blue Shield reduced its insurance premium by five percent under parity.
- Between 1991, when mental health parity coverage for Texas state and local government employees was implemented, and 1995, there was a 48 percent decrease in mental health and chemical dependency costs.
- Rhode Island reported a less than one- percent (.33%) increase in total plan costs under parity.
- New Hampshire insurance providers reported no cost increases as a result of implementing parity for severe mental illness.
- A recent study by Rand Corporation 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.
- A Peat Marwick study determined that 75 percent of insured workers receive their care through managed care plans. 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.

Although experience from states with mental health parity legislation is limited, the body of information is continually growing and shows only very modest increases in behavioral health costs. Thus, there appears to be a lack of substantial evidence to discourage Florida from pursuing mental health parity legislation.

BACKGROUND ISSUES

EPIDEMIOLOGY OF MENTAL ILLNESS

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 these epidemiologic studies was the Epidemiological Catchment Area Study (ECA) begun in 1978 (Robins, 1991; Regier, 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). Second, 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.

More than 15 million adult Americans reported symptoms of alcohol abuse or alcoholism. Men between the ages of 18 and 29 had a prevalence rate in excess of 23 percent (Regier, 1988). Approximately 75 percent of individuals in need of alcohol and drug abuse services do not receive treatment, which has potential for an enormous impact upon the health and stability of individuals, families, and communities. (Regier, 1988).

Another significant study on serious mental illness and co-occurring disorders (anyone with both substance disorder and any psychiatric illness as described in DSM) was the National Comorbidity Survey (NCS) (Kessler, 1994). 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, 1994). Over 8,000 persons between 15 and 54 who lived in the continental United States were interviewed between 1990 and 1992.

Results from the NCS indicated higher lifetime prevalence rates for mental disorders than the ECA, particularly for depression, alcohol dependence, and phobia. The NCS reported a prevalence rate of 3.2 percent compared with the ECA report of 2.8 percent for individuals with severe mental illness.

The lifetime prevalence was 48 percent for any disorder (mental illness or substance abuse), and 29 percent of the respondents reported at least one mental disorder during the previous 12-month period. Approximately 40 percent of those who reported a lifetime prevalence of at least one mental disorder sought treatment in the mental health specialty sector.

Comorbidity

The National Institute of Mental Health estimated the number of persons with severe mental illness and a co-occurring substance disorder at 1.8 million. In their 1988 study, 15.4 percent (25.6 million) of 166 million Americans over the age of 18 met the criteria for at least one alcohol, drug

abuse, or mental disorder (Regier, 1988). 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, 1995).

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. 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, 1995).

While space does not permit extensive reviews of the results of epidemiologic studies with regard to special populations (Levin and Petrila, 1996), the paragraphs that follow briefly summarize the epidemiologic rates in selected populations.

Children and adolescents

The prevalence of diagnosable mental disorders in children and adolescents has been estimated by Brandenburg and associates (1990) to be between 14 and 20 percent and has been estimated by Costello (1989) to be between 17 to 22 percent. A report issued in June of 1991 by the U.S. House Select Committee on Children, Youth, and Families (1991) stated at least 75 million children, 12 percent of those under age 18, had a diagnosable mental disorder. A recent estimate, based upon the Center for Mental Health Services definition of serious emotional disturbance, estimated the prevalence rate of serious emotional disturbance in children and adolescents (ages of 9 and 17 years) was between 9 and 13 percent (Friedman et al, 1997).

Elderly

Individuals 65 years of age and older comprise over 13 percent of the population of the United States, and if present patterns continue, will approach one-third of the population in America by 2050 (Myers, 1990). The prevalence of mental disorders in the elderly has been estimated at between 15 to 25 percent (Roybal, 1984). Smyer et al. (1994) reported that nearly 88 percent of all individuals in nursing homes have a mental disorder (including dementia as a mental disorder). Additionally, the prevalence of depression among individuals residing in nursing homes ranged between 12 to 22 percent (Lombardo, 1996).

Women

Patterns of mental illness do vary considerably by gender, with women and men showing vulnerability to different conditions. For example, depression occurs at twice the rate in women as it does in men. According to the Commission on Women's Health (Glied & Kofman, 1995), women use the health care system more than men do, especially for conditions that do not meet the diagnostic thresholds for mental disorder but are associated with significant distress and functional impairment.

Many serious mental health conditions affect women during their childbearing years. Untreated mental illness in mothers may increase the risk that their children will have psychological problems. As for services use and related service costs, women are more likely to use outpatient services and primary care providers while men use inpatient care and specialists (Glied & Kofman, 1995). In

addition, Newmann et al. (in Levin et al, 1998) have found increased costs of mental health care for women with serious mental illness who also have experienced sexual abuse. While space does not permit the elaboration of the critical issues in women's mental health services, readers are referred to Levin, Blanch, and Jennings (1998).

Homeless Persons

Studies have shown that one out of every three individuals who are homeless in the United States suffer from a severe mental illness, such as schizophrenia or bipolar disorder (manic-depression) (Tessler & Dennis, 1989). Persons who are homeless with a serious mental illness can also have an alcohol or drug abuse problem, low socioeconomic status, contact with the criminal justice system, diminished social supports, and be a racial or ethnic minority. Research findings suggest that homelessness is associated with the onset of mental illness an earlier age, co-occurring personality disorders, alcohol or substance abuse disorders, physical illnesses (e.g., AIDS, tuberculosis), and a history of childhood disturbances (NIMH, 1991). The social costs of homelessness include costs from law enforcement and legal services, the use of temporary shelters, and other community services (Fischer & Breakey, 1991).

Nationally, there are over 200,000 persons who are homeless and suffer from a serious mental illness. According to the 1995 Florida Statistical Abstract, there are 60,000 individuals who are homeless in Florida. According to Tessler and Dennis (1989), 33 percent of these homeless individuals have a serious mental illness.

Incarcerated Population

Evidence from Robins and Regier (1991) also emphasize the increased rate of prevalence of mental disorders and substance abuse and dependence in jail and prison populations vis-a-vis prevalence rates of mental disorder and substance abuse and dependence in the general population. For example, the lifetime prevalence rate for schizophrenia from the ECA study was 1.4 percent in the general population and 6.7 percent in prisons. Similarly, the lifetime prevalence rate for drug abuse and dependence from the ECA study was 7.6 percent in the general population and 56 percent in prisons.

More recently, Teplin (1994) and Teplin et al. (1996) found approximately nine percent of men and 18.5 percent of women who were new admissions to a large urban jail had a diagnosable severe mental disorder. Furthermore, over 70 percent of women and over 60 percent of men with mental disorders in jails also had diagnosable substance abuse disorders. In addition, Holden et al. (1993) reported that one-half of female jail detainees in Michigan had been victims of physical or sexual abuse at some point in their lives. Veysey (in Levin, Blanch, Jennings, 1998) has summarized the literature regarding the needs of women diagnosed with mental disorders who reside in U.S. jails.

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. 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 (see Table Two in the Appendix for estimated prevalence rates through the year 2010).

STATES' PERSPECTIVES (see Table 1 in Appendix C)

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). Coopers & Lybrand (Seppa, 1997) defined four levels of state parity, (partial, severe mental illness, full, and comprehensive). 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. Of these, only Maryland, Minnesota, North Carolina, and Vermont have passed comprehensive parity legislation for the treatment of both mental illnesses and substance abuse disorders. Thirty-four states introduced mental health parity legislation in 1997.

The following section briefly summarizes mental health parity legislation that has been passed in each of the twenty states (see Table 1 for references). Obviously, parity legislation that has passed in each state has been very heterogeneous and not identical. For example, while Maryland and Minnesota required parity coverage for all mental disorders as well as substance abuse, Maine, New Hampshire, and Rhode Island required parity coverage be restricted specifically to biologically-based mental disorders. Meanwhile, Kansas, Nevada, South Carolina, and Tennessee have passed laws based upon the federal mental health parity law.

Arizona

This 1998 legislation (effective January 1, 1999) requires HMOs, Blue Cross/Blue Shield, group insurers, and individual insurers to offer coverage for the diagnosis and treatment of mental disorders and substance abuse under the same terms and conditions as coverage for physical illnesses. These mental health benefits will be phased in during the initial year (1999).

Arkansas

Arkansas enacted a parity law in 1997 which requires group health plans to provide coverage for the diagnosis and treatment of mental and developmental disorders (defined as listed in ICD and the DSM) as provided for other medical disorders. Benefits for substance abuse are not included in this law. This law does not apply to employers with 50 or fewer employees or to health plans

enrolling state employees. In addition, this law exempts mental health coverage if projected or anticipated cost increase of plan equals or exceeds 1.5 percent.

Colorado

In 1997, Colorado passed parity legislation that required all group health policies to provide coverage for the treatment of “biologically-based mental illness” which is equal in coverage for physical illnesses. Biologically-based mental illness was defined as including bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder, panic disorder, schizoaffective disorder, and schizophrenia.

Connecticut

This 1997 legislation requires group insurance policies to provide equal coverage for biologically-based mental or nervous disorders compared to medical or surgical conditions. Biologically-based mental disorders include bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic disorder, paranoia and other psychotic disorders, pervasive developmental disorder or autism, schizoaffective disorder, and schizophrenia.

Indiana

This 1997 law provides equitable coverage for biologically-based serious mental disorders as provided for other serious illnesses. Coverage includes benefits as defined by contract, policy, plan, or HMO, including prepaid plans for state employees. Treatment for substance abuse or chemical dependency is excluded. Exemptions to this law include ERISA plans, businesses with fewer than 50 employees and businesses whose insurance costs would increase by over one percent as a result of complying with this law. Biologically-based serious mental illnesses include schizophrenia, bipolar disorders, panic disorder, obsessive-compulsive disorder, and attention deficit disorder.

Kansas

In 1997, Kansas passed a limited parity law for mental health benefits only. This legislation mirrors the federal mental health parity benefits, which does not apply to small business employers or to groups whose policies would increase by one percent or more due to compliance with the legislation.

Maine

Maine’s original 1993 parity law provides for requiring parity for specific biologically-based mental disorders. Nevertheless, in 1995, an amendment was passed (effective 1 July, 1996) that mandated health policies (in group contracts covering more than 20 persons) to provide nondiscriminatory coverage for the following mental disorders: schizophrenia; bipolar disorder; pervasive developmental disorder or autism; paranoia; panic disorder; obsessive-compulsive disorder; and major depressive disorder. This legislation also required other (group or individual) policies and nonprofit hospitals and health plans to offer nondiscriminatory mental health coverage. This law does not provide coverage for the treatment of alcoholism or drug dependence.

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

Maryland

After 25 years of debate and three years of intensive discussion, in 1994 Maryland became the first state to enact parity legislation for mental disorders and substance abuse (Stauffer, 1996). The law requires non-discriminatory coverage for any person with a mental illness, emotional disorder, drug abuse, and alcohol abuse. The law also requires companies with 50 or more employees to provide for inpatient coverage for mental health and substance abuse treatment vis-a-vis inpatient coverage for physical illnesses. The law allows various co-payments for out patient services. The Maryland parity law provides for at least 60 days of inpatient care, 60 days for partial hospitalization, outpatient medication management (the number of visits equal to visits for physical illnesses), psychotherapy with no annual limitations, and graduated co-payments based upon the number of outpatient visits. Partial hospitalization is also a required service benefit.

Minnesota

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

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

Missouri

This 1997 mental health parity law covers all mental disorders in DSM-IV (excluding mental retardation and chemical dependency) in managed care plans only, which cover approximately 40 percent of the population. Insurance coverage for mental disorders must be equal to benefits for physical illnesses.

Montana

This 1997 law was passed within the context of managed health care reform. Mental health benefits must be offered and must not be more restrictive than plans offered for general health conditions.

Nevada

This 1997 law applies to mental health benefits only, with alcohol or substance abuse benefits excluded. Health plans must offer equitable benefits for mental health if they offer mental health care. The mental health benefits are intended for large group health plans only and plans are not required to comply with parity provisions if costs increase one percent or more.

New Hampshire

New Hampshire passed parity legislation in 1994 (effective I January, 1995). In New Hampshire, mental illness was defined as "a clinically significant or psychological syndrome or pattern that

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

North Carolina

This 1991 mental health parity law applied only to state and local government employees and covered treatment for mental illness subject to the same deductibles, durational limits, and coinsurance vis-à-vis physical disorders. "Mental Illness" was defined as "an illness which so lessens the capacity of an individual to use self-control, judgment and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control (for adults)." For minors, the definition was "a mental condition, other than mental retardation alone that so impairs the youth's capacity to exercise age adequate self-control, or judgment in the conduct of his activities and social relationships so that he is in need of treatment."

Necessary services included: institutional and professional charges for inpatient psychiatric care; outpatient psychotherapy; intensive outpatient crisis management; partial hospitalization; and residential care. Benefits under this law shall be subject to a managed, individualized care of inpatient utilization review through preadmission and length-of-stay certification for scheduled inpatient admissions and length-of-stay reviews for unscheduled inpatient admissions. Treatment will be provided by a network of mental health practitioners.

A 1997 mental health parity law included the same parity provisions enacted by the United States Congress in 1996. It added treatment for chemical dependency, including inpatient care, outpatient care, intensive outpatient services, partial hospitalization, and residential care. Treatment for chemical dependency is subject to the same deductibles, limitations, and coinsurance as benefits for physical disorders.

Rhode Island

Rhode Island passed parity legislation in 1994 (effective 1 January, 1995). In Rhode Island, serious mental illness was defined as "any mental disorder that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the illness (State of Rhode Island, 1994 p. 2)." The term includes, but is not limited to: schizophrenia; schizo-affective disorder; delusional disorder; bipolar affective disorders; major depression; and obsessive compulsive disorder. The law requires all health insurers, including HMOs and medical service plans, "to provide coverage for the medical treatment of serious mental illness under the same terms and conditions as coverage for other illnesses and diseases". The law also requires that "insurance coverage offered pursuant to this statute must include the same durational limits, amount limits, deductibles, and coinsurance factors for serious mental illness as for other illnesses and diseases (p. 1)." The law applies to inpatient hospitalization and

outpatient medication visits. The law also permits health insurers to seek information from service providers regarding medical necessity and/or the appropriateness of treatment.

South Carolina

This 1997 mental health parity law mirrors the federal mental health parity law enacted in 1996. Group policies must offer same aggregated lifetime and annual limits as offered for medical or surgical benefits. Small employers are exempted, as are plans that do not offer mental health benefits. Mental illness is not specifically defined. Substance abuse and chemical dependency are excluded.

South Dakota

This 1998 law 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

This 1997 law is based upon the federal mental health parity legislative requirements. The law applies to group plans which offer mental health benefits. Alcohol and drug abuse benefits are excluded. Small employers are exempt as well as health plans that experience cost increases of one percent or more due to compliance with this law.

Texas

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

In 1997, Texas provided for mental health coverage in children and adolescence; exempted businesses with fewer than 50 employees; and required 45 inpatient days and 60 outpatient visits per year.

Vermont

This 1997 legislation requires health plans to provide insurance coverage for "mental health conditions" under the same terms and conditions as coverage for physical health conditions. "Mental health conditions" include mental illness or alcohol/substance abuse in the ICD (International Classification of Diseases). Children with mental health conditions are fully covered, as are persons in need of substance abuse treatment. Any policy offered by a health insurer, as well as any policy administered by the state, are subject to the terms of full parity. Managed care organizations are required to comply with standards set by the state insurance commissioner to maintain quality and access in delivery of services.

Other states

At least thirteen states currently have parity legislation under review or are examining mental

health parity issues in committee, including Alaska, California, Delaware, Florida, Georgia, Hawaii, Illinois, Louisiana, New Jersey, New York, Ohio, Pennsylvania, and Washington.

In addition to health care reform activities being addressed at the federal level, legislative efforts have been undertaken in a variety of states with regard to mandated mental health and substance abuse insurance coverage as well as mental health parity issues. While managed behavioral health care legislation has been initiated nationally in various states, 43 states have some type of legislative mandate for mental health and/or substance abuse service coverage. A total of 29 states have both mental health and substance abuse insurance mandates. These complex, confusing benefit and coverage limitations vary considerably from state to state (see Table 1 in Appendix C).

IMPACT OF STATE PARITY LEGISLATION

As the preceding paragraphs (together with Table 1 in Appendix C) suggest, there is considerable variability in how states define, determine eligibility standards, and set service limitations for mental health and substance abuse parity legislation throughout the United States. Thus, while parity in Maryland means coverage for all mental disorders and substance abuse treatment vis-à-vis coverage for physical illnesses, parity in New Hampshire refers to treatment coverage for specific biologically-based severe mental disorders. Furthermore, current exemptions in state insurance regulations potentially further limit the number of companies (thus individuals) forced to comply with state mental health parity laws and other (mental health and substance abuse) insurance coverage mandates. For example, in Maryland, companies with fewer than 50 employees have been exempt from the parity law, along with self-insured companies. Also, for those with individual health policies, parity is optional. Finally, the federal parity law permits states which 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).

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.

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.

Texas

Between the inception of mental health parity coverage for state and local government employees in 1991 to 1995, there was a 48 percent decrease in mental health and chemical dependency costs for 170,000 enrollees.

HEALTH CARE EXPENDITURES

United States

Health expenditures in the United States have increased dramatically over the past three decades. National health expenditures were approximately \$131 billion in 1975, \$428 billion in 1985, and \$949 billion in 1994. As a percentage of the United States gross domestic product, national health care expenditures have increased from 8.0 percent in 1975 to 10.2 percent in 1985 to 13.7 percent in 1994. While both hospital care and physician services as a percentage of national health expenditures have decreased between 1990 and 1994, long term (nursing home) care as a percentage of national health expenditures has increased (US DHHS, 1996).

Costs associated with mental disorders and substance abuse have been substantial. In 1990, the nation spent \$54 billion in direct costs for mental health and substance abuse services. These disorders cost the American economy (in 1990) over \$314 billion a year in total direct and indirect costs (\$150 billion for mental disorders, \$99 billion for alcohol abuse and alcoholism, and \$67 billion for drug abuse), including mental health treatment costs, other treatment costs - related health care costs, housing assistance, law enforcement and public safety, and lost productivity - due to injury, illness, or premature death (Rouse, 1995). These total costs to society for mental disorders and substance abuse far exceed the costs of cancer (\$104 billion), respiratory disease (\$99 billion), AIDS (\$66 billion), or coronary heart disease (\$43 billion).

For example, the economic cost of treating depression in the United States in 1995 was \$44 billion, more than the costs for treating strokes or osteoporosis (Cost, 1995). In 1990, the total direct and indirect costs of treating schizophrenia was \$33 billion (National Advisory, 1993).

The total impact of individuals with mental disorders on the criminal justice and corrections system has been estimated at between \$1.2 billion to \$1.8 billion (1993-1994). Approximately 8 to 20 percent of state prison inmates suffer from a serious mental disorder, resulting in a total state corrections cost of \$245 million to \$619 million (in 1995-1996). About 40 to 65 percent of the prison population are chemically dependent. Additionally, approximately 7 to 15 percent of

county jail inmates have a serious mental disorder, resulting in probation costs ranging from \$59 million to \$118 million. About 10 percent of all arrestees have a serious mental disorder (Izumi et al, 1996).

Additionally, 16 percent of the population in the United States is uninsured and mental health coverage is limited for those who are insured (Frank & McGuire, 1994). Persons with severe mental illness many times have limited financial resources . As such, they experience significant barriers to access treatment. (Kessler et al, 1994; Robins & Regier, 1991). 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 (Ostacher & Dorwart, 1996).

Florida

While Florida currently ranks 9th in total state mental health expenditures, it ranks 42nd in per capita state expenditures for mental health services. Petrila and Stiles (1996) have recently 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 based upon Medicare and insurance revenues reported by the hospitals which had individuals with mental disorders. However, substance abuse diagnoses were not included in this data set.

The estimated costs of mental health services have been provided in Charts 1 through 8 (Petrila and Stiles, 1996) located in the Appendix. Chart 1 contains the total costs of mental health services in Florida by type of service, and Chart 2 shows the percent of expenditures for mental health services by patient care type, with continued emphasis on the treatment of mental disorders in hospital settings. Chart 3 contains the estimated costs of mental health services in Florida by type of service and source of revenue. It is clear from this chart that most funds for mental health services in Florida supported state hospitals, while community hospitals received funds from entitlement programs an insurance providers.

Charts 4 and 5 contain the percentage of total expenditures for mental health services in Florida by source of revenue and by type of service. Local government and state ADM expenditures accounted for approximately one third of the total expenditures for mental health services in Florida. Additionally, while hospital mental health services were funded 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.

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

Entitlement Programs

Established in 1965 as Title XIX of the Social Security Act, Medicaid programs have been re-

quired by law to provide eligible individuals with certain short and long term benefits. This program is administered by the Health Care Financing Administration. In FY 1993-1994, public spending for Medicaid totaled \$142 billion with approximately \$61 billion spent by states. Over 5 million persons were enrolled in Medicaid programs in 1993. Approximately 23 percent of all Medicaid recipients are in a managed care program compared to 10 percent in 1991. (Health Care, 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).

In Florida, there were 1,972,784 individuals who qualified for Medicaid in the 1995-1996 fiscal year, at a cost of \$5.4 billion (State of Florida, 1997a).

Nationally, in fiscal year 1994, disabled individuals comprised about 15 percent of the Medicaid population and accounted for 39 percent of the Medicaid expenditures, including long-term care (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 1995, in Florida, there were 230,502 disabled workers receiving Social Security benefits, at a total cost of \$158 million per month to the state of Florida (Florida Statistical Abstract, 1997b). In 1996, there were 187,160 individuals with disabilities in Florida who received Supplemental Security Income at a total of \$120 million (Florida Statistical Abstract, 1997c). Unfortunately, no information was available for individuals with mental disorders.

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

What Can Be Gained from Parity

Although the signing of the federal amendment was an historic event for the mental health field, the federal employees' health benefits plan had already eliminated lifetime and annual caps for mental health coverage as the result of an executive order signed by President Clinton in 1993. Insurance companies immediately lowered the number of inpatient and outpatient visits for mental illness and raised co-payments.

There are a number of different aspects of the parity issue. The first has been the struggle with American business interests who were resistant to any change. However, the passage of the Health Insurance Reform Act bans insurance companies from excluding people with pre-existing conditions and allows insurance portability. The second was the struggle to keep the language inclusive. The third was the cost of implementing parity, i.e., the impact of managed care; the cost of insuring the uninsured; and offset effects (services that, when used, reduce costs in other areas of insurance plans).

There are social and economic benefits to be gained as a result of insurance parity for mental ill-

ness. Children and adults can be successfully treated and integrated back into communities (US House, 1991). Employers who offer comprehensive mental health benefits find that employee productivity increases, health improves, and health care costs decrease (Bazelon, 1995). When people are denied mental health coverage under private insurance, these costs have the potential to shift over to the public sector. Untreated mental illness can result in physical illness, the inability to work, and impaired relationships.

MANAGED CARE

The concept of "managing" health care can be traced to the early part of the twentieth century and the evolution of prepaid health plans in the United States (Levin in Manderscheid and Sonnenschein, 1992). While the growth of managed care has gone through a number of major evolutionary stages, particularly over the last thirty years, managed care strategies have remained an evolving array of health care review and service coordination mechanisms which ultimately attempt to control or reduce the utilization and costs of health and mental health services. While there are a multitude of hybrid models of managed care organizations, e.g., managed behavioral health care organizations, the predominant managed care systems include health maintenance organizations (HMOs) and preferred provider organizations (PPOs). 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).

With the proliferation of state mandated mental health and substance abuse benefits in the 1980s, managed behavioral health care companies were created to manage the behavioral health benefits within health insurance plans as well as to manage mental health and substance abuse benefits which were contracted out or "carved-out" from HMOs and PPOs. The number of people receiving mental health benefits through managed care arrangements has grown from 78 million people in 1992 to 149 million people in 1997 (Open Minds, May 1997). (Shore in Shore, 1994), establishing managed care as 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).

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.

The health care reform proposals put forth over the last three years focus on certain fundamental characteristics of a system of care, emphasizing prevention, primary care, treatment effectiveness, treatment guidelines, and low-cost treatment. These elements are seen as crucial for controlling inflationary trends and for significant cost savings.

In recent years, managed care arrangements have proven successful in managing service utilization and plan expense (CBO, 1995; National Advisory, 1998). New studies from Peat Marwick (Jensen et al., 1997), William M. Mercer (1997), and the Rand Corporation (Sturm, 1997) have provided support regarding the success of these arrangements.

For example, a recently published 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 inpatient 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.

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. On an individual level, three out of four persons are enrolled in some form of managed medical care (Jensen et al, 1997) and managed care penetration in mental health has always been higher (Sturm, 1997). In 1995, managed care plans (defined as HMOs, PPOs, and point-of-service plans) enrolled 73 percent of all Americans who received their insurance through an employer (Jensen et al, 1997). 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. In addition, there is evidence that state health care delivery systems are also moving more towards managed care, e.g., a recent national survey by the Bazelon Center found that 43 states had obtained Medicaid waivers to provide innovative approaches to organize and finance mental health services through various behavioral health carve-out strategies. Among the sixteen states with approved or pending Section 1115 waiver requests in 1996, 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).

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. E. Clarke Ross, executive director of the American Managed Behavioral Healthcare Association, 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 exceed the kinds of mental health caps found in the marketplace (Special Issue, 1996).

Ian Schaffer, chief medical officer at Value Behavioral Health (Special Issue, 1996), 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). There clearly has been an absence of definitive studies measuring the impact of man-

aged care on the costs of health and mental health services in states with and without parity legislation. Nevertheless, as managed care continues to evolve, there is a growing convergence in the use of managed behavioral health care strategies and mental health parity reforms to control these spiraling health care costs. The key issue in terms of further research involves the investigation of the impact managed behavioral health care will have in states with mental health parity laws versus states without mental health parity laws.

COST OF TREATMENT ISSUES

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. The 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.

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. 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 1996). Furthermore, it is possible that a parity proposal will alter the mix of service providers.

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 (Mechanic et al. 1995; Pallak et al, 1994). One report estimated that the treatment of mental disorders can reduce general health care costs by approximately 10 percent (National Advisory, 1993) as a result of improved physical condition of the individual. 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).

Improved treatment can reduce the burden of care imposed on families of persons with mental illness. A national study estimated the cost of family care-giving in 1990 at \$2.5 billion (National Advisory, 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).

A system of care, emphasizing prevention, primary care, treatment effectiveness, treatment guidelines, and low-cost treatment are crucial elements in controlling inflationary trends and can provide significant cost savings. Managed care arrangements have proven successful in managing plan expense in recent years according to a recent CBO Memorandum (1995). Treatment effectiveness for major mental disorders yielded success rates of 60 to 80 percent (National Advisory, 1993). 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.

Using the classification developed by Clarke et al (1994), the costs associated with mental illness also include indirect costs, such as maintenance costs (housing assistance, administrative costs of transfer payments), law enforcement and public safety, and lost productivity and productive capacity. The latter directly involves the cost to employers of increased absenteeism and less effective work performance by persons with mental illness (and their families) as well as reduction in the labor force.

Persons with mental illness often face problems at work, either due to decreased effectiveness while working or due to increased absenteeism. Furthermore, the increased morbidity and mortality rates associated with mental illness lowers the productive capability of the economy. In 1990, the costs of lost productivity to the economy from mental illness was estimated to be \$44 billion (National Advisory, 1993). A more recent report by the Massachusetts Institute of Technology reported lost productivity solely from clinical depression at \$28.8 billion in 1995 (Greenberg, 1995).

The National Advisory Mental Health Council (1993) attempted to estimate the annual benefits from mental illness parity. They estimated that the annual savings in indirect costs would be \$7.5 billion, and the annual saving in general health care costs would be an additional \$1.2 billion. It is worth noting that these benefits would be gained at an additional cost to society of \$6.5 billion, thus yielding a net gain to society from mental illness parity of \$2.2 billion annually.

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 passage of a mental illness parity law would 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, 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).

CONCLUSION Florida, together with at least 12 other states in America, 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.

Parity for mental illnesses could also yield economic and societal benefits. Many Americans will be able to participate more productively at home, at work, and in the community. Substantial numbers will no longer need to impoverish themselves to obtain coverage under Medicaid or marginally subsist on supplemental security benefits, such as SSI/SSDI. According to the NMHAC (1993), parity for severe mental illness alone can produce a 10 percent decrease in the use and cost of medical services for these individuals. The report predicts that annual savings in indirect costs and general medical services could amount to approximately \$8.7 billion. Thus, with the anticipated expense of adding parity coverage at \$6.5 billion, the net savings would be approximately \$2.2 billion.

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. Rhetorically, 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. 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).

As consumers, payers, and providers of mental health services increasingly become focused on outcomes-oriented data, states will need to reorganize epidemiologic, financing, and service delivery data and link databases in order to monitor mental health care and assess outcomes associated with that care.

APPENDIX A

Overview of National Parity Legislation

Background

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

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

Legislative History - brief review of the past five years

The issue of parity for mental health services was introduced in 1993 with President Clinton's *Health Security Act* (HR 3600). In this plan, mental health and addiction benefits included a combined benefit of thirty days of inpatient care, sixty days of partial care and/or 120 days of outpatient care. Over the next three years, a number of health care reform plans which included parity were *American Health Security Act* (Wellstone and McDermott), the *Managed Competition Act*, (Breaux and Cooper), *Senate Health Care Task Force* (Chaffee), *Consumer Choice Health Security Plan* (Nickles), and the *Stark Plan* (Stark). The last two plans, *House Republican Plan* (Michel) and the *Reform Proposal* (Gramm) offered no mental health benefits.

1996 included more debate on health care reform. Mental health parity did not exist in SB 1171, The Health Insurance Reform Act sponsored by Senators Kassebaum and Kennedy. They introduced, as an amendment to SB 1171, full parity coverage for all mental illnesses, and as free-standing legislation, the Mental Health Parity Act of 1996, S. 2031. Neither measure made it out of committee. Senators Domenici and Wellstone then drafted a compromise amendment that prohibited insurers from setting lifetime and annual caps for mental illnesses. The amendment was attached to HR 3666, the Veterans Administration and Housing and Urban Development appropriations bill. The amendment was passed by the House and by the Senate. Another amendment, sponsored by Senator Gramm, allowed businesses to drop mental health parity if their insurance costs rose more than one percent.

On September 26, 1996, President Clinton signed a compromise parity amendment attached to the VA/HUD- appropriations bill for fiscal year 1997. The amendment took effect January 1, 1998 and sunsets in the year 2002.

Current issues

The Parity Act set a precedent in terms of congressional lawmaker willingness to impose benefit mandates on ERISA plans. It requires health insurance issuers and group health plans, including self-insured plans with more than 50 employees, to adopt the same annual and lifetime dollar limits for mental health benefits that apply to medical benefits. Most health plans, financed by both public and private sources, still rely on benefit design to control utilization of mental health and substance abuse services. These design elements often include annual and lifetime dollar caps, annual visit limits, and higher co-payments and deductibles than those applied to medical care. In many cases, the limits on substance abuse care are more strict than those imposed on mental health.

Common issues from business and insurance are 1) the importance of allowing the marketplace to determine the type of benefits offered; 2) freedom of choice for insurance purchasers; 3) the cumulative costs of mandated benefits; 4) the increased financial burden placed on small businesses and individuals; 5) the negative impact of mandates on competitiveness; and 6) an increase in cost-sharing responsibilities by employees.

Questions concerning the implementation of the parity act include: how the one percent premium cap exemption was going to be calculated; what are the societal costs of mental illness; what are the experiences of other states with mental health parity laws; what is the average cost of an insurance policy; what are the differences between actuarial estimates; who is affected by mental health parity laws; what are the various types of mental illness; and what level of mental health benefits is currently offered by employers.

The one percent exemption was added to the law by Sen. Phil Gramm, R.-Texas. The regulations were jointly issued by the Departments of Health and Human Services, Labor and Treasury in the 22 December 1997 *Federal Register*. Summarizing the regulations: Employers must first comply with the law for at least 6 months before being able to use the exemption. Firms seeking the exemption must use retrospective data based upon actual experience with equal lifetime and annual limits. Costs must be directly attributable due to compliance with the Mental Health Parity Act or the administrative costs associated with compliance, i.e. actual claims and administrative costs, *not* premium costs.

For firms seeking to use the exemption, they must first notify the appropriate government enforcement agency and all plan participants of their intent to waive the law. Although the government or plan participants will not be able to see the proprietary data upon which the exemption is based, they can see a summary of the data upon which the one percent cost increase claim is based. This summary must include overall plan expenditures, the dollar value of claims that would have been denied if parity were not in place, and administrative costs attributable to compliance with the Mental Health Parity Act. Plan sponsors are specifically barred from including any individually identifiable information in a data summary. Once an employer submits a notice under the one percent exemption, they will have to wait 30 days before the exemption becomes effective. However, this notice is not a formal application and employers do not have to wait for approval from the government before proceeding. The regulations also allow third parties to obtain the names of these employers. A limited number of employers will be allowed a 3-month "grace period" in 1998 if they reasonably believed that the one percent cost increase would have been available to them on a prospective basis.

The regulations also estimate that approximately 30,000 health plans, or about 10 percent of all health plans that must comply with the law, will seek an exemption under the one percent provision (nearly 113 million covered individuals). However, because of the costs associated with seeking an exemption, and the expected deterrent effect that will result from disclosure of the plan sponsor's name, the regulations estimate that less than a quarter (22 percent) of the eligible plans will pursue it (Federal Register, 1997).

Despite the limitations of the mental health parity provision, clearly the law will benefit a substantial number of people suffering from mental illnesses who are covered by affected health care plans. Perhaps most significantly, during the closing months of the 104th Congress, a new consensus emerged in support of mental health parity. The House voted 392 to 17 to instruct conferees to adopt language that would mandate parity, and parity received a supportive vote in the Senate of 85 to 15. What are the results of this majority opinion?

The Senate Finance Committee approved an amendment in its Medicaid reform which included mental health parity, a more flexible definition of community-based services, and an easing of the Institution of Mental Diseases (IMD) exclusion which prevents facilities using more than 50 percent of their available psychiatric beds from receiving Medicaid reimbursement for adults.

The Substance Abuse Treatment Parity Act (S.11470) calls for insurance coverage for substance abuse treatment that is equal to that provided for physical ailments. It bars limitations on the number of visits or dollar amounts. This bill, unlike the Mental Health Parity Act, extends parity to co-pay and deductibles, not just lifetime and annual spending limits. The provision would only affect those insurance plans which currently cover substance abuse treatment, including both insurers and employers maintaining ERISA (Employee Retirement Income Security Act of 1974) plans.

S.525, the Child Health Insurance and Lower Deficit Act, would require all affected plans comply with the Domenici-Wellstone Amendment and provide parity mental health benefits for low-income children who have serious emotional disturbances. In 1994, the *Stark Plan* had a broad benefits package and gave states the option to create managed mental health programs for adults with severe mental illness and children with serious emotional disturbances. Although the bill was seriously revised by the House Ways and Means Committee, the revision included an "organized system of care" provision for the delivery of mental health and addictions services. This system of care ensured that education, child welfare, juvenile justice and other appropriate, related agencies were involved when people under the age of 22 received services.

Limitations of the Mental Health Parity Act

Beginning January 1, 1998, statutory requirements of the Mental Health Parity Act of 1996 took effect, resulting in greater equity between medical and mental health benefits for applicable health coverage. To recap the main points of this new legislation, the Mental Health Parity Act requires an applicable health plan with mental health coverage to provide the same lifetime and annual maximum dollar limits for mental health benefits as it does for medical benefits. Additionally, if such a plan does not impose dollar limits on medical or surgical services, it may not place them on mental health services. However, if a plan currently does not have mental health coverage, the Mental Health Parity Act does not mandate coverage. Therefore, group plans without mental

health provisions are not subject to compliance under the Mental Health Parity Act.

Just as the Mental Health Parity Act is restricted to the governance of health plans containing mental health provisions, there are other limitations. Benefits for substance abuse and chemical dependency are specifically excluded from the parity requirement (the definition of substance abuse includes treatment for alcohol dependency and abuse). The Act does not prohibit insurers from setting day or visit limits on mental health services. Since no restrictions are placed on the use of different deductibles, coinsurance or co-pays, managed care cost controls may continue to be used. There are no restrictions on the use of medical necessity as a condition of coverage, nor does it limit the use of utilization review requirements. Carve-out plans and separate managed behavioral health care programs are still allowed, as well as special contracting arrangements with mental health providers, even if no comparable arrangements exist for medical or surgical providers. The Mental Health Parity Act does not replace state mandated mental health coverage. The Act does not extend coverage to long-term chronic or convalescent care. This type of care is not generally covered under medical plans and continues to be ineligible under plans covering mental health care.

The Mental Health Parity Act legislation applies to groups of 50 or more employees, both self-insured ERISA plans and fully-insured plans, coverage provided to federal employees under the Federal Employee Health Benefits Act (FEHBA), and collectively bargained plans. Collectively bargained plans ratified before the law was enacted on Sept. 26, 1996, are required to comply with the provisions of the act for plan years beginning after Jan. 1, 1998, or at the end of the collectively bargained agreement, whichever is later. The Act does not apply to those with individual health insurance policies, employer policies covering fewer than 50 employees, Medicare risk contracts, Medicare Select or any privatized versions of Medicaid.

Any group subject to the new legislation must be in compliance by its plan issue or renewal date beginning on or after January 1, 1998. Employers who can provide documenting evidence that the provisions of the Act would result in a one percent or greater increase in the cost of their group health plan, can claim an exemption from the Act. Milliman & Robertson (Melek, 1997) estimated the White House was trying to satisfy both advocates and business/insurance interests. A limited use of the one percent exemption has been urged by mental health advocates and professionals by requiring plans to prove that their costs in fact have increased before they are granted an exemption for a later year. Employer groups, insurers, and managed care companies believe the application of the exemption should be flexible, allowing for exemptions based on projections for an upcoming year.

Other Issues Emanating from the Mental Health Parity Act

In general, the federal law benefits more persons, but provides them with fewer benefits than most state laws. Specifically, it does not limit the legislation to those with biologically-based mental illness. It also applies to a broader group of plans, i.e. state-licensed and ERISA self-insured. However, it limits its application to those plans with 50 or more persons and only affects annual and lifetime limits.

Although a handful of states have passed parity provisions, their full impact on the insurance market cannot be assessed since a majority of the plans are preempted from compliance with

many state insurance mandates by ERISA (Employee Retirement Income Security Act of 1974). Self-insured plans, including both risk retention plans sponsored by employers and multi-employer trusts developed by unions through collective bargaining, have grown significantly since the passage of ERISA. States are prevented from regulating self-insured employee benefit plans through ERISA's "preemption", "savings" and "deemer" clauses. (Ridgley & Goldman, 1996). Preemption was prompted by the recognition that it is much easier to oversee complex benefit programs by ensuring that all administrative practices of a benefit plan is governed by a single set of regulations (Simmons, 1997). State experimentation with large scale health reform within their own states will be limited because ERISA hinders state governments' ability to regulate all employers. Although Congress can grant state-by-state exemptions, it has not been inclined to do so (Ridgley & Goldman, 1996). Any legislation or sponsors of legislation supporting funding of mental health or substance abuse services should make the case of the state's role in providing the behavioral health safety net and demonstrate the extensive public need (Ridgley & Goldman, 1996). For a full discussion of ERISA and its impact on health care reform, see Stio (1994).

The broader state mandates for biologically-based diseases are considered more stringent than the federal law. An increasing number of states have adopted or discussed parity legislation. If states simply adopt the federal provisions, the ultimate effect of the law could be the adoption of more limited state legislation than would have passed in the absence of federal standards.

Overview of Reports Discussing National Parity Legislation

A number of studies have claimed to provide a definitive measure of the cost and impact of mental health parity. The studies predicted potential increases in health care premiums that ranged from .4 percent to 2.5 percent. Virtually no empirical research studies are cited in support of key assumptions in most of the major reports making cost projections for mental health or substance abuse coverage. Furthermore many of the assumptions from previous reports regarding the Health Security Act were simply promulgated and utilized for the assessment reports on the house and senate bills on parity. In addition, each of the studies based their conclusions upon different preliminary assumptions about definitions, coverage, cost, and service utilization.

An analysis of the reports showed that definitions and terms were not consistently used by the estimators. Coopers & Lybrand and the American Academy of Actuaries (AAA) used "managed indemnity" as an unmanaged benefit; the AMBHA and the American Psychiatric Association studies (both by Milliman & Robertson) allowed for some form of management savings in almost all plans (Frank & McGuire, 1995). The studies and the bills also varied in their definitions of parity. The Congressional Budget Office (CBO) defined parity in terms of services and spending limits rather than in how care is provided. It also defined mental health services to include treatment for alcoholism and substance abuse. Price Waterhouse defined substance abuse treatment as a mental health benefit as did Watson Wyatt; Coopers & Lybrand defined it in terms of mental illness only.

The Congressional Budget Office (CBO) study projected approximately 800,000 would lose benefits due to the effects of the Parity Act provision. The CBO, immediately after projecting this figure, stated "...those estimates are highly uncertain because of the large margins of error in the study on which they are based. (Indeed, the possibility that the parity amendment would have no effects at all on the number of covered workers is within the margin of error.)" (CBO, 1996). The

CBO study also states that "Employers not affected by state [health benefit] mandates could choose to drop all mental health coverage in order to avoid the parity requirements, although it seems unlikely that many employers, other than small firms, would choose that option" (CBO, 1996).

According to the U.S. Bureau of Labor Statistics, almost all employment-based health plans offered some mental health benefits in 1991, but less than 2 percent of them had parity for outpatient coverage of mental health services (United States Bureau of Labor, 1992). Coopers & Lybrand (1996) estimated that more than 80 percent of all health plans limit inpatient care for mental disorders, forcing individuals needing mental health treatment into public healthcare programs. They also estimated that implementing the parity amendment would reduce public sector mental health spending by \$16.6 billion a year, representing a 4.4 percent reduction in total public health care costs. Their analysis predicted that mental health spending as a percentage of all healthcare spending would actually drop from 7.0 percent to 6.5 percent under the amendment, resulting in a nationwide savings of \$2.2 billion annually.

Each of the studies used different models for pricing the cost of implementing parity. The estimating of costs for service utilization also varied widely. The choice of databases to make baseline estimates of current use, assumptions made about management of care, and assumptions about how use would change after the uninsured acquired coverage contributed to the widely differing estimates. For example, a commonly used estimate in some of the reports was based on data from private sector indemnity health plans in the 1980s. These plans maintained that up to 10-15 percent of total health benefit costs would go to mental health or substance abuse if a liberal benefit package was included.

The AAA study, for example, used 1986 data based on aggregate distribution of diagnoses from state mental hospitals and Veterans Affairs specialty psychiatric admissions and estimated the costs for the same distribution of diagnoses from a large insurer. This became the 'uninsured psychiatric inpatients' data. The diagnosis-specific cost was then increased by a factor of 1.98 to adjust for the severity of illness within each diagnosis of the currently uninsured with the currently insured. There was no reference to other data or justification for this 'adjustment'. Frank and McGuire (1997) suggested that this unsubstantiated adjustment increased and overstated the cost of extending care to the uninsured.

Only the CBO study used data from the National Comorbidity Study (NCS) and the Patient Sample Survey (Center for Mental Health Statistics). The other estimators used data from proprietary data or based assumptions on comparative epidemiologic data. The National Comorbidity Study shows the prevalence of mental illness is higher among the uninsured population. Approximately 23 percent of uninsured persons have a thirty-day psychiatric diagnosis compared with 17 percent of the insured population. Analysis of the NCS data suggests that if coverage were extended to the currently uninsured population, their utilization rate would be 0-5 percent higher than the currently insured population (Frank et al, 1994).

Another source of differences emerged from the projected costs of persons who are uninsured. Different data sources were used to make baseline estimates of current use and different assumptions were made on how use would change after these persons obtained coverage. An example of this was the use of state mental health expenditures which were not broken into the uninsured, the

underinsured, and Medicaid populations. For insured populations, AMBHA and the Milliman & Robertson studies estimated that only 20 percent of the insured population would be in a managed indemnity plan while HCFA, AAA, and Coopers & Lybrand assumed that 50 percent would be in a managed indemnity or no management plan, 30 percent in a PPO or point-of-service plan, and 20 percent in an HMO or exclusive provider plan (Frank & McGuire, 1995). The enrollment patterns used by AAA, and Coopers & Lybrand mirror very closely the enrollment patterns seen in the marketplace in January, 1994 (Oss, 1994).

Watson and Wyatt (1996) based its estimates for utilization on estimates from the RAND health experiment which was based on largely fee-for-service health insurance from the 1970s (Manning et al, 1989). Both Milliman & Robertson studies (1996) used proprietary data from their *Health Cost Guidelines*.

Finally, the Watson Wyatt and the Milliman & Robertson studies did not include estimates of off-set effects or the effect of “SMI creep” (where health care providers reclassify non-severe mental conditions as severe mental illness). Both studies used the same estimates for a “typical PPO” (Fronstin, 1997). Further, the Watson Wyatt study did not include the effect of the elimination of lifetime limits for mental health care services.

The studies of Watson Wyatt (1996), the Congressional Budget Office(1996), and Price Waterhouse (1996) assumed that providing insurance coverage would increase the use of behavioral health care dramatically, while both of Milliman & Robertson's studies (1996), assumed that behavioral health benefits could be managed appropriately and effectively (see the table following this discussion for a more thorough breakdown of the reports).

None of the national studies factored other delivery of care models into their estimates. The Center for Health Policy (1996) estimated that non-mental health providers deliver at least half of the mental health care services used in the United States. 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 fee-for-service 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).

Highlights of Reports Discussing National Parity Legislation

Watson Wyatt (1996)

(The Costs of Uniform Plan Provisions for Medical and Mental Health Services...)

- Assumed behavioral health diagnoses are subjective.
- Assumed employers would not want to manage behavioral health benefits, except in PPOs.
- Assumed persons with behavioral health benefits would utilize the maximum number of benefits.
- Use of the RAND demand response data for outpatient mental health services.
- Assumed both mental illness and substance abuse.
- 1970 data based on primarily fee-for-service indemnity plans.
- Extrapolated from RAND outpatient data that utilization might also increase for inpatient care.
- Analyzed S. 298 "Equitable Health Care for Severe Mental Illness Act."

Coopers Lybrand (1996)

(An Actuarial Analysis of the Domenici-Wellstone Amendment...)

- Assumed public costs for mental health benefit would decline under parity.
- Assumed private plans would pick up expenses for services currently provided by the public sector.
- Assumed medically necessary benefits would be unchanged.
- Assumed mental illness only.
- Assumed managed care cost control would not be affected by this legislation.
- Does not apply to Medicaid or Medicare populations.
- Assumed to cover self-insured groups including ERISA groups.
- Used a matrix of 20 plan options to determine impact of S.203 I - five plan designs with four delivery systems of varied managed care models.
- Analyzed S. 2031 "Mental Health Parity Act of 1996."

Milliman & Robertson (1996)

(The Cost of Non-discriminatory Health Insurance Coverage)

- Assumed behavioral health diagnoses are relatively objective and consistent.
- Assumed medical necessity criteria can be operationally defined.
- Assumed behavioral health benefits can be managed appropriately and effectively.
- Deductibles, co-pays, and coinsurance adjustments appropriate to various benefits
- An administrative expense load of 15percent of claims costs.
- Used Milliman & Robertson *Health Cost Guidelines* (1996 proprietary information) that shows components of per-capita claims cost.
- Did not include medical, employment or social cost-offset.
- Did not include individuals covered by Medicaid or Medicare.
- Estimated per capita costs using a typical PPO plan with managed care delivery.
- Assumed the maximum number of days and visits for treatment for mental illness and substance abuse disorders.
- Analyzed S.298 An Equitable Health Care for Severe Mental Illness Act.

Milliman & Robertson (1996)

(Premium Rate Estimates for a Mental Illness and Substance Abuse Parity...)

- Assumed behavioral health diagnoses are relatively objective and consistent.
- Assumed medical necessity criteria can be operationally defined.
- Assumed behavioral health benefits can be managed appropriately and effectively.
- Used Milliman & Robertson *Health Cost Guidelines* (1996 proprietary information).
- Did not include medical, employment or social cost-offset.
- Did not include individuals covered by Medicaid or Medicare.
- Estimated per capita costs using a mix of "typical" benefit plans, ranging from fee-for-service.
- PPOs/POS plans, and HMO/EPO plans.
- Assumed the maximum number of days and visits for treatment for mental illness only.
- Analyzed S. 1028 "Health Insurance Reform Act of 1995."

CBO Study (1996)

(CBO's Estimates of the Impact on Employers of the Mental Health Parity Amendment...)

- Assumed outpatient visits would be unlimited under parity.
- Assumed unlimited behavioral health benefits (no lifetime costs/caps).
- Assumed treatment for all mental health conditions including substance abuse.
- Defined parity in terms of services and spending limits rather than in how care is provided.
- Used Congressional Research Service's (CRS) estimate which was confined to impact on indemnity plans.
- Analyzed Mental Health Parity Amendment in HR 3103.
- Federal cost estimate projected a 0.4 percent increase in premiums and a 0.16 percent increase in employer contributions for parity in annual and lifetime limits.

Price Waterhouse LLP (1996)

(Analysis of the Mental Health Parity Provision in S. 1028...)

- Assumed behavioral benefits would not be carved out under parity.
- Assumed utilization of behavioral health services would be well above utilization for other health services.
- Expected parity to lead to the end of indemnity-type coverage.
- Used Bureau of Labor Statistics Employee Benefits Survey on health plan characteristics.
- Assumed a shift from the public sector to a private sector provision.
- Analyzed S. 1028 "Health Insurance Reform Act of 1996" Section 305.

Corporate Studies

Rand Corporation Study (1997)

(How Does Risk Sharing Between Employers And Managed Behavioral Health Organizations Affect Mental Health Care) (Sturm,1997)

- Equalizing annual limits (typically \$25,000) – a key provision of the Mental Health Parity Act of 1996 – will increase costs by only about \$1 per employee per year under managed care.
- An even more comprehensive change required by some state laws (i.e., removing limits on inpatient days and outpatient visits) will increase costs by less than \$7 per enrollee

per year.

- The main beneficiaries of parity will be families with children who, under current conditions, are more likely than adult users to exceed their annual benefit limits and go uninsured for the remainder of the year.
- Most health maintenance organizations (HMOs) are expecting cost increases of less than 0.5 percent, with only rare cases exceeding one percent.

Mercer Study

(The Costs of Uniform Plan Provisions for Medical and Mental Health Services)

- 85 percent of American companies are either in compliance or plan to make changes to comply with the Mental Health Parity Act of 1996 by January 1, 1998.
- Seven out of ten of those same employers agree that mental health parity is a reasonable national policy goal and that parity important to their employees.

State Studies

National Advisory Mental Health Council

(National Advisory Mental Health Council Interim Report on Parity Costs)

- The introduction of parity in combination with managed care results in, at worst, very modest cost increases. In fact, lowered costs and lower premiums were reported within the first year of parity.
- Maryland reported a 0.2 percent decrease after the implementation of full parity at the state level.
- Rhode Island reported a less than 1 percent (0.33 percent) increase of total plan costs under state parity.
- Texas experienced a 47.9 percent decrease in costs for state employees enrolled in its managed care plan under parity.

The Lewin Group, Inc. (Lewin, 1997)

(Insurance Carrier/Health Plan Views On Impact Of New Hampshire Parity Legislation)

[available online at <http://www.nami.org/update/lewinst9704.html>]

- In a survey of New Hampshire insurance providers, no cost increases were reported as a result of a state law requiring health insurance parity for severe mental illnesses.

APPENDIX B

Evaluating Benefits Of Mental Health Parity

An Economic Analysis for Persons with Severe Mental Illness

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

From the societal perspective, the purpose of the mental health parity proposal is to expand and improve the treatment of persons with severe mental illness (SMIs). The benefits of such legislation will be a function of the following variables: 1) increased treatment, 2) treatment efficacy rates, and 3) social costs of severe mental illnesses.

Increased Treatment

Approximately 2.8 percent of the adult population in the United States and 3.2 percent of the under 17 population suffer from a severe mental illness (National Advisory, 1993). It has been estimated that in a given year approximately 60 percent of these adults receive outpatient and 17 percent receive inpatient care. For children, the respective figures are 29 percent and 10 percent (National Advisory, 1993)

The limited coverage for SMIs in many current health insurance policies increases the cost of treatment to the patient and/or the health care provider, and thus provides a disincentive to seeking treatment. The National Advisory Mental Health Council (1993) relying on results from a Rand study, estimates that the outpatient utilization rate would increase to 80 percent under parity. However, this calculation appears to be in error. The Rand study stated a 20 percent increase in utilization, not a twenty percentage point increase. If the service utilization rate was 60 percent, this indicates a percentage increase to 72 percent. An increase to 80 percent utilization indicates a 33 percent increase. The state of Massachusetts reported a 5 percent increase in the number of persons using services after implementing a more comprehensive, flexible plan for dealing with the treatment of mental illness (Coalition, May 1996).

In addition to this "pent-up" demand, the more comprehensive coverage provided under a parity plan can also increase the utilization of services by persons who currently seek treatment, e.g. the 30-day limit on inpatient care is a characteristic of some current insurance plans which is alleged to restrict treatment to those who run up against this constraint. A report by Milliman and Robertson (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.

Treatment Efficacy Rate

Treatment of severe mental illnesses (SMIs) 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.

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, 1988).

Social Costs

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; Dickey et al, 1996). In 1990, the total costs of mental disorders and substance abuse were estimated at \$314 billion (Rouse, 1995). Of this total amount, 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.

Using the classification developed by Clarke et al (1994), the costs associated with severe mental illness can be classed as follows:

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

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

Direct Treatment Costs

It has been estimated that in 1990 the direct costs for severe mental illnesses for the country equaled \$20 billion (National Advisory, 1993). 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, as noted, the increased flexibility and comprehensiveness of treatment allowed by parity plans do hold out the promise of more cost-effective treatment. For example, if under a

parity plan patients have more access to outpatient services, rather than being forced into inpatient treatment due to insurance restrictions, then treatment may become more cost effective as well as medically effective. Massachusetts, for example, contracted in 1992 for a Medicaid managed mental health program which 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 SMIs from the public sector to the private sector. Private sector coverage has in the past relied more heavily on community outpatient service than has publicly funded insurance. State expenditures in particular are highly weighted toward state hospital inpatient treatment. This potential shift in service providers should prove to be cost effective.

Related Medical Treatment or Assistance Costs

It has been estimated that the treatment of mental disorders can reduce general health care costs by approximately 10 percent (National Advisory, 1993) as a result of improved physical condition of the patient. Furthermore, improved treatment can reduce the burden of care imposed on the families of persons suffering from severe mental illnesses (Franks, 1990). A recent study estimated the cost of family care giving in 1990 at \$2.5 billion (National Advisory, 1993). Another study found that families of persons with severe mental illness spend over \$300 per month on support and over 40 hours of informal care (Clark et al, 1994). While direct monetary treatment costs would presumably be included in the direct treatment of cost figures given above, the 40 hours of time, along with any supplemental care (costs), would represent additional costs to society which improved treatment should reduce.

There is also 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). In other words, the reduction in medical costs would offset the cost of providing mental health (or substance abuse) services (Pallak, 1993; Mumford, 1984). In addition, cost 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).

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

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).

Indirect Costs

Persons with SMIs often require assistance in funding, if not outright provision of, housing. They are also likely to utilize the services of state and federal social services agencies, and they can become involved with the criminal justice system due to inconsistent and occasionally violent behavior (Teplin, 1990). These costs were estimated to total approximately \$1.0 billion in 1990 (National Advisory, 1993). 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.

Persons with SMIs often face problems at work, either due to decreased effectiveness while working or due to increased absenteeism. Furthermore, the increased mortality rates associated with SMIs lowers the productive capability of the economy (Glied, 1996). In 1990, the costs of lost productivity to the economy from SMIs was estimated to be \$44 billion (National Advisory, 1993). A more recent report by the Massachusetts Institute of Technology Sloan School of Management reported lost productivity from clinical depression was \$28.8 billion in 1995 (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.

An Overall Estimate

The National Mental Health Advisory Council (1993) has attempted to estimate for the United States the annual benefits from mental illness parity. They estimated that the annual savings in indirect costs would be \$7.5 billion, and the annual savings in general health care costs would be additional \$1.2 billion. It is worth noting that these benefits would be gained at an additional to society of \$6.5 billion, thus yielding a net gain to society from mental illness parity of \$2.2 billion annually.

Further Benefits from the State's Perspective

The passage of a mental illness parity law would also benefit the state of Florida in a manner not noted above. Such legislation would shift some of the costs of providing treatment for SMIs from the state (and federal) government to the private sector, specifically to the private business sector (either employer or employee). 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. For the country as a whole, state and local governmental sources accounted for 31 percent of the funding for treatment of SMIs in 1990. The Federal government, namely Medicaid and Medicare programs, accounted for an additional 26 percent. Nationally, 64 percent of persons with SMIs have private insurance (National Advisory,

1993). 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 SMIs, a total of 410,000 persons in Florida. Milliman & Robertson, Inc. (1995) estimated that 35.7 percent of Florida's population would be affected by the proposed parity law. Certain groups are exempted from the proposed legislation, most importantly the self-insured and those covered by Medicare and Medicaid. Applying this percentage to the number of persons in Florida with SMIs results in an estimate of 146,300 persons with severe mental illness who will fall under the parity law: approximately 107,800 adults and 38,500 persons under the age of 18.

If treatment utilization rates in Florida are roughly comparable to rates for the rest of the country, then 60 percent of these adults (64,700) and 29 percent of 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 NIMHAC 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), 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, 1985; Rupp et al, 1984).

APPENDIX C

Tables and Charts

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

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

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

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

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

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

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

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

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

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

Table 1
Summary of State Parity Legislation and State Benefit Mandates

PARITY/MANDATE LEGISLATION	COVERAGE	STATUS
ALABAMA parity: None.	parity: None.	parity: None.
mandate: Alcohol abuse: 27-20A-1 to 27-20A-4 (group) ¹	mandate: Alcohol abuse only; IP 30 days or formula: 3 OP = 1 IP day; 1 IP day = 2 days P/R. ²	mandate: Alcohol abuse only; mandated offering to group policies. ²
ALASKA parity: CSSCR 14 (Health, Education, and Social Services Committee), 2/17/98, amended from SCR 14, 4/30/97. ³	parity: Study of mental health parity benefits. ³	parity: Referred to fi- nance committee, to be reviewed 3/4/98. ³
mandate: Alcohol/drug abuse: 21.42.365 (group) ¹	mandate: Alcohol/drug abuse: group contract coverage: IP/R \$7,000/2-year period; \$14,000 lifetime maximum; ⁴ payments, deductible, co-payments equal to other ill- nesses. ⁵	mandate: Alcohol/drug abuse: mandated cover- age in group contracts. ¹
ARIZONA parity: HB 2580 enacted 2/98. ⁶	parity: 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. ⁶	parity: Effective 1/1/99. ⁶
mandate: None. ¹	mandate: None. ¹	mandate: None. ¹
ARKANSAS parity: HB 1525 enacted 4/97. ⁷	parity: 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 <i>projected</i> cost increase of plan equals or exceeds 1.5%. ⁷	parity: Effective 8/1/97. ⁷
mandate: Mental illness: 23-86-113 ⁵ Alcohol/drug abuse: 23-79-139 (group) ¹		mandate: Mental illness : mandated offering of coverage. ¹ Alcohol/drug abuse: mandated offering of coverage, in group contracts.

PARITY/MANDATE LEGISLATION	COVERAGE	STATUS
CALIFORNIA parity: AB 1100 originated 2/97 ⁸	parity: 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. ⁹	parity: AB 1100 to the Senate in 1998. ⁸
mandate: Mental illness: 10125 (group); 11512.5 (non-profits). ¹ Alcohol/drug abuse: 10123.6 (alcohol abuse: group plans); 11512.14 (hospital service plans) ¹	mandate: Mental illness: acute care, IP/OP; same coverage for biologically-based SMI as for other brain disorders. ¹ Alcohol abuse: negotiated between group and carrier. ⁴	mandate: Mental illness and alcohol abuse: mandated offering, specific to certain types of policies
COLORADO parity: HB 1192 enacted 4/1/97. ¹⁰	parity: The law requires coverage for the treatment of “biologically-based” SMI (defined as ‘schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder and panic disorder’) that is no less extensive than the coverage for other illness, in every group policy, plan certificate, and contract. ¹¹ Benefits do not duplicate previously mandated insurance benefits. ¹⁰	parity: Effective 1/1/98. ¹⁰ The first parity bill to pass state legislature in the 1997 session. ¹²
mandate: Mental illness: 10-16-104 (group) ¹ Alcohol abuse: 10-16-104 ¹	mandate: Mental illness: provide at least specified minimum benefits in every group contract, for “biologically-based” SMI (schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, OCD, panic disorder, and PDD or autism), under the same terms and conditions as for other types of health care for physical illness. ¹ Alcohol abuse only; provide offer of coverage in group contracts at least equal to minimums. ¹	
CONNECTICUT parity: Public Act 97-99 (HB 6883), enacted 6/6/97. ¹³	parity: Managed care reform legislation with language identifying “biologically-based” SMI (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 and other psychotic disorders, OCD, panic disorder, and PDD or autism’), specifying parity with any condition for which medical and/or surgical tx is required. ¹³	parity: Effective 10/1/97. ¹³

PARITY/MANDATE LEGISLATION	COVERAGE	STATUS
CONNECTICUT (cont.) mandate: Mental illness: 38a-514 (group) ¹ Alcohol abuse: 38a-533 and 38a-539 ¹	mandate: Mental illness: coverage for “biologically-based” SMI, with at least specified minimum benefits in every group contract. ¹ Alcohol abuse: coverage for ‘alcoholism or medical complications thereof.’ ¹	mandate: Mental illness and alcohol abuse: mandated coverage. ¹
DELAWARE parity: S 156 introduced 4/16/97. ¹⁴	parity: Applies to mental health benefits only, no autism. Amendment 1 relates to MH benefits; bill will sunset 6/30/02. ¹⁴	parity: Pending.
mandate: None. ¹	mandate: None. ¹	mandate: None. ¹
DISTRICT OF COLUMBIA WASHINGTON, DC parity: None.	parity: None.	parity: None.
mandate: Mental illness: 35-2302, 35-2304 ¹ Alcohol/drug abuse: 35-2301 to 35-2311 ¹	mandate: Mental illness and alcohol/drug abuse: provide coverage of at least specified minimum benefits. ¹	mandate: Mental illness and substance abuse: mandated coverage. ¹
FLORIDA parity: HB 41 and SB 268, both introduced 3/98. ^{15,16}	parity: “Biologically-based” SMI (additionally, substance abuse if accompanied with SMI): parity in tx with every insurer and HMO in group contracts. Must meet specified minimal limits if tx MI other than specified “serious mental illness.” ^{15,16}	parity: HB 41 is in Government Services Council, pending ranking, as of 3/5/98. ¹⁵ SB 268 is in Ways and Means Committee, as of 3/3/98. ¹⁶
mandate: Mental illness: 627.668 (group) ¹ Alcohol/drug abuse: 627.669 (group) ¹	mandate: Mental illness: IP 30 days, same as other illnesses, OP \$1,000 annual (co-pays may vary from other illnesses); P/R maximum cost of 30 IP days. Alcohol/drug abuse: OP 44 visits, \$35/visit. ⁴	mandate: Mental illness and alcoholism/drug abuse: mandated offering limited to group policies. ¹
GEORGIA parity: SB 245 introduced 2/10/97. ¹⁷	parity: Mental illness: 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. ¹⁷	parity: Pending. ¹⁷
mandate: Mental illness: 33-24-28.1 ¹	mandate: Mental illness: IP 30 days (individual plan), 60 days (group plan); OP 48 visits (individual plan), 50 visits (group plan). ⁴	mandate: Mental illness: offer coverage equitable to tx for physical illnesses. ¹

PARITY/MANDATE LEGISLATION	COVERAGE	STATUS
HAWAII parity: Study of parity, HI HCR 18, was adopted on 4/23/97. ¹¹	parity: Study will estimate population in need as well as address cost of MI and SA services at level equitable to that for any other medical illness. ¹¹	parity: Auditor's report due before beginning of 1998 legislative session. ¹¹
mandate: None. ¹	mandate: None. ¹	mandate: None. ¹
ILLINOIS parity: HB 111 introduced mid-March, 1997 ¹¹	parity: Refers to SMI, including nine illnesses considered to be biologically-based, and other disorders that 'substantially limit the life activities of the person with the illness.' ¹¹ Substance abuse disorders are not included.	parity: Was referred to Senate Insurance Committee in May, 1997. ¹¹
mandate: Mental illness: 215 ILCS 5/370C (group) ¹ Alcohol abuse: 215 ILCS 5/367 (7) (group) ¹	mandate: Mental illness: payment must be at least 50% IP, OP, P/R; annual maximum \$10,000 or 25% lifetime maximum. Alcohol abuse: paid as any other illness in hospital contracts. ¹	mandate: Mental illness: mandated offering, limited to group policies. ¹ Alcohol abuse: mandated coverage, in group policies. ¹
INDIANA Parity: HB 1400 enacted 5/13/97. ¹⁸	parity: 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, however, for substance abuse or chemical dependency is excluded. ¹⁸ 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. ¹⁸	parity: HB 1400 effective 6/30/97. ¹⁸ The law sunsets 9/29/01. ¹⁸
mandate: None. ¹	mandate: None. ¹	mandate: None. ¹
KANSAS Parity: S 204 enacted 5/15/97. ¹⁹	parity: Limited parity for mental health benefits, refers to mental health services, as defined under the terms of the policy; treatment of substance abuse or chemical dependency is specifically excluded. ¹⁹ The law describes provisions for general health care, including long-term coverage, chronic and pre-existing conditions. ¹⁹ Mental health 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. ¹⁹	parity: Effective 1/1/98. ¹⁹

PARITY/MANDATE LEGISLATION	COVERAGE	STATUS
KANSAS (cont.) mandate: Mental illness and alcohol/drug abuse: § 402,105. ¹	mandate: Mental illness and alcohol/drug abuse: IP 30 days, 100% first \$100, 80% next \$100, 50% next \$1,640/yr; OP lifetime maximum \$7,500. ⁴	mandate: Mental illness and alcohol/drug abuse: mandated coverage. ¹
KENTUCKY parity: None.	parity: None.	parity: None.
mandate: Mental illness: 304.17-318 ¹ Alcohol abuse: 304.18-130 to 304.18-180 (group) ¹	mandate: Mental illness: must offer coverage at least that offered for treatment of physical disorders. ¹ For alcohol abuse only, group contracts must offer coverage of at least minimum specified. ¹	mandate: Mental illness: mandated offer of coverage; for alcohol abuse, mandated offer of coverage, limited to group policies. ¹
LOUISIANA parity: HB 946 and HB 1512 were both initiated in the 1997 legislative session. ²⁰	parity: Applies to mental health benefits only; ²⁰ Both HB 946 and HB 1512 address parity for SMI (schizophrenia or schizo-affective disorder, bipolar disorder, PDD or autism, panic disorder, OCD, major depressive disorder). HB 1512 features corrected language re: "option" of mental health tx; ⁹ both bills apply only to employers with greater than 50 employees and would exempt group health plans in which compliance resulted in greater than 1% increase in cost. ²⁰	parity: Both bills are pending in the Senate Committee on Insurance. ²⁰
mandate: Mental illness: 22:669 (group) ¹ alcohol/drug abuse: R.S. 22:215.5 (group) ¹	mandate: Mental illness: group policies must offer option for coverage to same extent as for physical disorders. ¹ Alcohol/drug abuse: group policies must offer optional coverage for physician-prescribed treatment. ¹	mandate: Mental illness and alcohol/drug abuse: mandated offering of coverage, in group policies. ¹
MAINE parity: PL 407 enacted 1995. ¹¹	parity: 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 <i>person suffering from a mental or nervous condition</i> 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. ¹¹	parity: PL 407 effective 7/1/96. ¹¹
Mandate: Mental illness: tit. 24 2325-A (non-profits), 2843-A (group); 4234-A (HMO); 2849-B (individual, group and blanket -- re: continuity, pre-existing conditions). ¹ Alcohol /drug abuse: tit. 24 2329(health service plans); tit. 24 2842-A (group /blanket) ¹	mandate: Mental illness: for SMI (schizophrenia, paranoia, bipolar disorder, autism, major depression)-- 90% co-insurance of \$1,500 (annual maximum) to 90% of \$25,000 (lifetime maximum); \$50,000 lifetime maximum (HMO); IP 30 days/yr., 60 days/lifetime maximum. \$1,500 annual maximum for unlisted MI. Maintain specified minimum benefits in every group contract and provide coverage at the same levels as physical disease. ¹ Alcohol/drug abuse: lifetime maximum \$25,000; IP 30/yr, 60 days lifetime maximum. Benefits shall be included in all group plans. ¹	Mandate: Mental illness: mandated coverage. Alcohol/drug abuse: mandated coverage, specific to group policies. ¹

PARITY/MANDATE LEGISLATION	COVERAGE	STATUS
MARYLAND Parity: HB 1359 enacted 1993; H 756 enacted 1994 (added alcohol/drug abuse benefits). ¹¹	parity: 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. ¹¹	parity: Effective 7/1/94. ¹¹
mandate: Mental illness and alcohol/drug abuse: 15-802 of the insurance article. ¹	mandate: Mental illness and alcohol/drug abuse: IP same as for any other illness (30 days/per person/per year, for large groups; 25 days/per person/per year, for small groups); OP (pays 80% 1-5 visits in calendar year, 65% 6-30 visits in calendar year, 50% thereafter in calendar year); medication management paid same as for any other illness (not considered OP visit); P (pays for at least 60 days/year); no separate deductibles, no lifetime maximum. ¹	mandate: Mental illness and alcohol/drug abuse: mandated coverage; applies to all contracts (small groups, however, do have separate mandates) ¹
MASSACHUSETTS parity: None.	parity: None.	parity: None.
mandate: Mental illness: Ch. 175:47B ¹ Alcohol/ drug abuse: Ch. 176A:10 (nonprofit hospital service corps); Ch. 176B:4A (medical service corp.); Ch.175:110(general/blanket); Ch. 176:4(HMO). ¹	mandate: Mental illness and alcohol/drug abuse: every policy must provide at least specified minimum benefits. ¹	mandate: Mental illness and alcohol/drug abuse: mandated coverage. ¹
MICHIGAN parity: None.	parity: None.	parity: None.
Mandate: Alcohol/drug abuse: 500.3609a (group); 500.3425 (health); 550.1414a (health service plans) ¹	mandate: alcohol/drug abuse: must offer coverage for IP and OP to specified limits. ¹	mandate: alcohol/drug abuse: mandated offering. ¹
MINNESOTA parity: SB 845 enacted 8/1/95. ¹¹	parity: 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. ¹¹	parity: Effective 8/1/95. ¹¹
mandate: Mental illness; 62A.152 (group) ¹ alcohol/drug abuse: 62A.149 ¹	mandate: Mental illness: contracts must provide at least specified minimum benefits in every group contract. ¹	mandate: MI & alcohol/drug abuse: mandated coverage for group contracts. ¹ Alcohol/drug abuse: mandated offer of coverage in policies. ¹

PARITY/MANDATE LEGISLATION	COVERAGE	STATUS
MISSISSIPPI parity: None.	parity: None.	parity: None.
mandate: Mental illness: 83-9-39. ¹ Alcohol abuse: 83-9-27 to 83-9-31 (group). ¹	mandate: Mental illness: IP 30 days/yr; OP 50% payment for 25 visits @\$50/visit; P/R 60 days; \$50,000 maximum. ² Alcohol abuse: up to \$1,000/yr; ⁴ group policies must cover same as for other illnesses. ²	mandate: Mental illness: mandated offering. ¹ Alcohol abuse: mandated coverage, specific to group plans. ¹
MISSOURI parity: HB 335 introduced 1/20/97. ²¹	parity: 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, ²² 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. ²¹	parity: HB 335 signed by the Governor 6/25/97. ²¹
mandate: Mental illness: 376.381 ¹ Alcohol abuse: 376.779 ¹	mandate: Mental illness: IP up to 30 days; OP 50% payment for 20 visits; P/R 50% payment up to \$1,500/yr. Alcohol abuse: IP up to 30 days; OP 80% payment up to \$2,000/yr. ⁴	mandate: Mental illness: mandated offering of coverage. ¹ Alcohol abuse: mandated coverage. ¹
MONTANA parity: SB 378 introduced 2/97. ²²	parity: 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. ²²	parity: SB 378 effective 7/1/97; Section 9 effective 1/1/98. ²²
mandate: Mental illness: 33-22-701 to 33-22-705 (group) ¹ Alcohol/drug abuse: 33-22-703 (group) ¹	mandate: Mental illness and alcohol/drug abuse: IP 30 days/yr.; OP 50% payment of at least \$1,000; \$10,000 or 25% of contract maximum. ⁴	mandate: Mental illness & alcohol/drug abuse: mandated coverage, ¹ limited to group policies.
NEBRASKA parity: None.	parity: None.	parity: None.
mandate: Alcohol abuse: 44-769 to 44-782 (group) ¹	mandate: Alcohol abuse: must provide at least 30 IP days and 60 OP visits or may not advertise policy as 'comprehensive'. ¹	mandate: Alcohol abuse: mandated offering. ¹
NEVADA parity: AB 521 introduced 5/22/97. ²³	parity: 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. ²³	parity: AB 521 effective 7/16/97; Section 88 of this bill not effective until 1/1/98 and expires 9/30/01. ²³

PARITY/MANDATE LEGISLATION	COVERAGE	STATUS
NEVADA (cont.) mandate: Alcohol/drug abuse: 689b.036 (group); 689A.046 (individual health); 695B.194 (medical service plans); 695C.174 (health) ¹	mandate: Alcohol/drug abuse: IP \$9,000/yr.; OP \$2,500 / yr.; P/R \$1,500/yr. for detoxification; \$39,000 lifetime maximum. ⁴	mandate: Alcohol/drug abuse: mandated coverage. ¹
NEW HAMPSHIRE parity: SB 767 introduced 1994. ¹¹	parity: 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. ¹¹	parity: SB 767 effective 1/1/95. ¹¹
mandate: Mental illness: 417-E:1; ¹ 415:18-a (group); 419%-a, 420:5-a (service corps.). ¹	mandate: “Biologically-based” SMI (as listed in parity law) IP and OP (15 hours/yr.) paid as for other illnesses; P/R must be included; major medical not less than \$3,000/yr. ⁴	mandate: Mental illness only: mandated coverage, limited to specific policy-types. ¹
NEW JERSEY parity: A 249 and A 660 were both introduced 1/13/98. ²⁴	parity: 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	parity: Both A 249 and A 660 were referred to the Assembly Banking and Insurance Committee, 1/13/98. ²⁴
mandate: Alcohol abuse: 17B:26-2.1 (individual health); 17B:27-46.1 (health); 17:48-6a (hospital service plans); 17:48A-71 (medical service plans); 17:48E-34 (health service plans) ¹	mandate: Alcohol abuse: provide coverage same as any other illness. ¹	mandate: Alcohol abuse: mandated coverage. ¹
NEW MEXICO parity: none. ²⁵	parity: none. ²⁵	parity: none. ²⁵
mandate: alcohol abuse: 59A-23-6 (group); 59A-47-35 (non-profit health care plans) ¹	mandate: Alcohol abuse: IP 30 days/yr; OP 30 visits/yr; maximum is 60 days, 60 visits. ⁴	mandate: Alcohol abuse: mandated offering, specific to certain contracts

PARITY/MANDATE LEGISLATION	COVERAGE	STATUS
NEW YORK parity: A8315A introduced 6/97. ²⁶	parity: Amends insurance law in that it provides parity for MI (states that all mental illness is biologically-caused, but does not specify SMI); requires same coverage and benefits for MI tx as for other illnesses. ²⁶	parity: Pending. ²⁶
mandate: Mental illness: 3221(1)(5)(A)(group) ¹	mandate: Mental illness: IP 30 days/yr; OP 30 visits; 3 emergency visits/yr; maximum is no less than \$1,500/yr. Alcohol abuse: IP 7 day detoxification; 30 day rehabilitation; OP 60 visits. ²	mandate: Mental illness and alcohol abuse: mandated offering, limited to specific policy-types. ¹
NORTH CAROLINA parity: HB 434 introduced 3/16/97. SB 400 (and identical bill H 563) were introduced 3/97. ²⁷	parity: 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	parity: HB 434 enacted 7/1/97; now known as CH. SL 97-0259.SB 400 assigned to Insurance-Health Committee 5/19/97. ²⁷
mandate: Mental illness: 58-51-55. ¹ Alcohol/drug abuse: 58-51-50 (group) ¹	mandate: Mental illness: With several exceptions, policy that covers both physical and mental illness may not impose a lesser lifetime or annual dollar limit on mental health benefits. Mandate expires 10/11/01. ¹ Alcohol/drug abuse: Mandated offering of coverage for group policies. ¹	mandate: Mental illness: mandated coverage. ¹ Alcohol/drug abuse: mandated offering, specific to certain types of policies. ¹
NORTH DAKOTA parity: None.	parity: None.	parity: None
mandate: Mental illness: 26.1-36-09 (group) ¹ alcohol/drug abuse: 26.1-36-08 (group) ¹	mandate: Mental illness, alcohol/drug abuse: IP 60 days/yr; OP 30 visits @ 100% payment for first 5 visits, 80% thereafter; 2 days P/R = 1 IP. ⁴ Alcohol/drug abuse: Mandates benefits of at least \$500 yearly. ¹	mandate: Mental illness & alcohol/drug abuse: mandated coverage to certain policy types. ¹
OHIO parity: HB 420 introduced 5/97. ²⁸	parity: Mandates parity for "biologically-based" MI (listed as schizophrenia, bipolar disorder, major depression, panic disorder, OCD, schizoaffective disorder) as well as any other disorder identified as a MI; requires individual or group health insurance policies to provide benefits (i.e., 'IP, OP, medication, co-payments, individual/ family deductibles, maximum lifetime benefits') ⁹ for the dx & tx of MI exactly as benefits provided for all other physical disorders. ²⁸	parity: Pending. ²⁸
mandate:Alcohol abuse :3923.29 (group), 3923.30 (self-insured). ^{1,4}	mandate: Alcohol abuse, only: mandated benefits of at least \$500 yearly. ¹	Mandate: alcohol abuse: mandated coverage, limited to policy types. ¹

PARITY/MANDATE LEGISLATION	COVERAGE	STATUS
OREGON parity: None.	parity: None.	parity: No data available.
mandate: Mental illness: 743.556 (group) ¹ Alcohol abuse: 743.412 (indiv.) ¹	mandate: Mental illness: must provide coverage with at least specified minimum benefits in every group contract, with same deductible and co-insurance amounts as for other disorders. ¹ Alcohol abuse only: must offer coverage. ¹	mandate: Mental illness: mandated coverage for group policies. ¹ Alcohol abuse: mandated offer of coverage in certain types of policies. ¹
PENNSYLVANIA parity: HB 1286 introduced 4/97. ²⁹	parity: Parity for MI, in group and individual contracts equitable to those for other physical illnesses. ²⁹	parity: Pending. ²⁹
mandate: alcohol abuse: 40-62-102 ¹	mandate: alcohol abuse: IP 7 days for detoxification; OP 30 visits/cycle plus 30 visits above maximum; P/R 30 days/yr plus 15 days beyond maximum; lifetime limits are 4 - IP and OP cycles, 3 - P/R cycles. ⁴	mandate: alcohol abuse: mandated coverage. ¹
RHODE ISLAND parity: H 7746 introduced 2/3/98. ³⁰	parity: Has had parity law for SMI (lists, but not limited to: schizophrenia, schizoaffective disorder, delusional disorder, bipolar depressive disorder, major depression, OCD), since 1994. New legislation proposes coverage for general MI. ³⁰	parity: H 7746 was read and referred to Committee on Corporations 2/13/98. ³⁰
mandate: Mental illness: 27-38.2-1 ¹	mandate: Mental illness: cover SMI same as coverage provided for other illnesses. Must include same duration of coverage, amount limits, deductibles and co-insurance amounts. ¹	mandate: Mental illness: mandated coverage. ¹
SOUTH CAROLINA parity: S 288 introduced 1/30/97. ³¹	parity: 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	parity: S 288 approved 3/31/97; effective for group plans on or after 11/1/98 and does not apply to services furnished on or after 9/30/01. ³¹
mandate: Mental illness and alcohol/drug abuse: 38-71-737 ¹	mandate: Mental illness and alcohol/drug abuse: group policy must offer rider for psychiatric benefits (including MI and alcohol/drug abuse) with minimum \$2000 coverage/member/benefit year. ¹	mandate: Mental illness and alcohol/drug abuse: mandated offering, limited to certain types of policies. ¹
SOUTH DAKOTA parity: HB 1262	parity: 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.	parity: HB 1262 signed by Governor on 3/13/98
mandate: Alcohol abuse: 58-18-7.1 (group); 58-41.35.1 (health); 58-40-10.1 (hospital service plans); 58-38-11.1 (medical service plans) ¹	mandate: Alcohol abuse: IP 30 days/6 months; P/R same as inpatient days; lifetime maximum is 90 days. ⁴	mandate: Alcohol abuse: mandated offering. ¹

PARITY/MANDATE LEGISLATION	COVERAGE	STATUS
TENNESSEE	parity: This bill features a section (17) with language	parity: SB 1699 signed by

SB 1699 introduced 2/20/97 (compatible bill HB 1825 introduced 2/24/97). ³³	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. ³³	the Governor on 4/30/97 and is now known as Public Chapter Number 157; effective 1/1/98. ³³
mandate: Mental illness: 56-7-1003 (group) ¹ Alcohol/drug abuse: 56-7-1009 (group) ¹	mandate: Mental illness: mandated coverage with specified minimum benefits in all group policies unless refused by insured. ¹ Alcohol/drug abuse: all group policies subject to mandated offer of coverage. ¹	mandate: Mental illness: mandated coverage, particular to group policies; alcohol/drug abuse: mandated offer of coverage in all group policies. ¹
TEXAS parity: HB 1173 introduced 1997, building on previous parity law (H2, 9/1/91 ¹¹) covering contracts for SMI tx for state and local employees. ³⁴	parity: 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. ³⁴	parity: HB 1173 was signed 6/20/97 by the Governor; effective 9/1/97. ³⁴
mandate: Mental illness: art.3.51-14 (group) ¹ Alcohol/drug abuse: art.3.51-9 (group) ¹	mandate: Mental illness: must offer same benefits and equal amount limits, deductibles and co-insurance factors for serious MI as for physical disorders. ¹ Alcohol/drug abuse: group policies are required to provide equitable coverage as other illnesses. ¹	mandate: Mental illness: mandated coverage. ¹ Alcohol/drug abuse: mandated coverage in group policies. ¹
UTAH parity: None.	parity: None.	parity: None.
mandate: Alcohol/drug abuse: 31A-22-715 (group) ¹	mandate: Alcohol/drug abuse: must provide coverage in licensed facilities or accredited hospitals. ⁴	mandate: Alcohol/drug abuse: mandated offering of coverage in group policies. ¹
VERMONT Parity: HB 57 enacted 5/28/97. ³⁵	parity: 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 mental health 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. ³⁴ MCOs must comply with standards set by the state insurance commissioner to maintain quality and access in delivery of services. ³⁵	parity: Effective 1/1/98. ³⁵

PARITY/MANDATE LEGISLATION	COVERAGE	STATUS
VERMONT (cont.) mandate: Mental illness and alcohol/drug abuse: Tit. 8 4089b (group). ¹ Alcohol abuse: Tit. 8 4097 to 4100 ¹	mandate: Mental illness and alcohol/drug abuse: insured must be given at least one choice for care that places no greater burden on the insured than treatment for physical illness. ¹ alcohol abuse: IP 5 days detoxification / incident; OP 90 hours/occurrence; P/R 28 days/occurrence. ⁴	mandate: Mental illness and alcoholism/drug abuse: mandated coverage. ¹
VIRGINIA parity: None.	parity: None.	parity: None.
mandate: Mental illness and drug/substance abuse: 38.2-3412.1 ¹	mandate: Mental illness: mandated coverage same as other illnesses, but may be limited to IP 30 days/per policy year; OP up to \$1,000 at 50% payment (as are other illnesses). Alcohol abuse: IP (90 day lifetime); coverage is no more restrictive than that for other illnesses. ¹	mandate: Mental illness: mandated coverage; alcohol/drug abuse: mandated offer. ¹
WASHINGTON parity: SB 6566 introduced 1/21/98. ³⁶	parity: Mental illness benefits only; refers to any dx listed in DSM-IV, to be on par with benefits for medical/surgical care. ³⁶	parity: Pending. ³⁶
mandate: Mental illness: 48.21.240 (group) ¹ Alcohol/drug abuse: 48.21.180 (group); 48.46.350 (HMOs); 48.44.240 (health service plans) ¹	mandate: Mental illness: Mandated offering of coverage in group policies at least equal to minimums specified. ¹ Alcohol/drug abuse: \$5,000 /24-months, \$10,000 lifetime limit, covered same as physical illness. ⁴	mandate Mental illness: mandated offering, specific to group policies. ¹ Alcohol/drug abuse: mandated coverage, specific to group policies. ¹
WEST VIRGINIA Parity: None.	parity: None.	parity: None.
mandate: Mental illness: C 33-16-3a (group) ¹	mandate: Mental illness: IP 45 days, OP 505 to \$500 for 50 visits/year; alcohol abuse: IP 30 days, OP 50% up to \$750, \$10,000 lifetime limit. ⁴	mandate: Mental illness and alcohol abuse: mandated offering, specific to group contracts. ¹
WISCONSIN parity: None.	parity: None.	parity: None.
mandate: Mental illness and alcohol/drug abuse: 632.89 (group) ¹	mandate: Mental illness and alcohol/drug abuse: IP 30 days or \$7,000; OP 90% payment to \$1,000. ⁴	mandate: Mental illness and alcohol/drug abuse: mandated coverage, specific to group policies. ¹

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

Population	1995	2000	2050	2010	Percent (%)
Total Florida	11,014,012	12,095,616	13,184,043	14,287,630	100%
Severely Mentally Ill (2.8 percent)	308,392	338,677	369,163	400,053	

Age					
18-64	305,962	340,543	367,038	394,392	97%
65+	9,965	10,884	11,751	13,050	3%

Gender					
Male	111,949	113,823	122,726	143,654	35%
Female	203,978	228,701	244,966	263,788	65%

Race					
White	249,234	272,078	295,509	315,423	81%
Non-White	58,742	66,403	74,572	83,335	19%

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

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

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

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

Source: Petrila J, Stiles P (1996).

Source: Petrila J, Stiles P: Chronically mentally ill Florida Policy Center on Aging, 1995.

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

Subtotal = State ADM + Medicaid + Third party/Other + Local Govt + Medicare

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

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

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

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

Hospital Inpatient	65 %
Community Outpatient	35 %
Total Dollar Amount	\$1,600,247,974

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

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

Chart 3
Estimated Cost of Adult Mental Health Per Service Type

	State Hospital	Community Hospital	Community Outpatient
State ADM	\$238,269,661	0	\$208,924,407
Medicaid	\$ 13,846,765	\$258,000,000	\$120,000,000
Third Party/Other ¹	0	\$246,511,486	\$185,538,399
Local Govt ³	0	0	\$ 57,619,086
Medicare ²	0	\$273,538,170	0

- (1) The data for Third Party/Other and Medicare costs in community hospitals is derived from AHCA data. However, the figures presented exclude one private psychiatric facility's report which has questionable accuracy.
- (2) Although there is likely significant Medicare outpatient expenditure, figures estimating the costs for Medicare outpatient services were not available for inclusion in any charts.
- (3) Local government expenditures are subsumed under the Third Party/Other category for AHCA data.

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

Chart 4
Percent of Adult Mental Health Dollars by Revenue Source

State ADM	28 %
Medicaid	24 %
Third Party/Other ^{2,3}	27 %
Local Govt	4 %
Medicare	18 %

- (2) Although there is likely significant Medicare outpatient expenditure, figures estimating the costs for Medicare outpatient services were not available for inclusion in any charts.
- (3) Local government expenditures are subsumed under the Third Party/Other category for AHCA data.

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

Chart 5
Percent of Adult Mental Health Dollars by Revenue Source

	Inpatient ³	Outpatient ²
State ADM	22 %	37 %
Medicaid	26 %	20 %
Third Party/ Other	24 %	33 %
Local Govt	0 %	10 %
Medicare	28 %	0 %

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

(3) Local government expenditures are subsumed under the Third Party/Other category for AHCA data.

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

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

1994	\$ 1,600,247,974
1995	\$ 1,705,837,661
2000	\$ 2,390,401,310
2050	\$ 3,324,620,761
2010	\$ 4,597,316,157

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

* Projections are based on a 5 percent annual inflation rate
and the annual growth in population.

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

1994	\$ 1,077,197,833
1995	\$ 1,187,610,610
2000	\$ 1,664,206,404
2050	\$2,314,613,507
2010	\$ 3,200,529,739

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

Chart 8
 Projected Cost* of Adult Mental Health to 2010
 By Service Type

	1994	1995	2000	2005	2010
State Hospital Inpatient	252,116,426	264,722,247	370,956,991	1,515,934,838	1,265,470,442
Community Hospital Inpatient	781,049,656	845,679,937	1,185,056,747	1,648,202,019	2,279,148,906
Community Outpatient	567,081,407	595,435,477	834,387,572	1,160,483,904	1,604,727,813

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

** Projections are based on a 5 percent annual inflation rate
 and the annual growth in population.*

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