

- Possible indirect savings to counties from reduced expenditures for mental health treatment services at mental health service boards (ADAMH boards).
 - The Legislative Service Commission does not collect data on health care spending for employees of municipalities, townships, and school districts on a regular basis, and does not have the data currently to estimate the cost to those levels of government. LSC staff do not know of any reason why the costs to these levels of government would be significantly different from the costs to counties, however.
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Detailed Fiscal Analysis

Senate Bill 116 prohibits discrimination in the coverage provided for the diagnosis and treatment of biologically based mental illness in group sickness and accident insurance policies, in health insurance plans, and in group self-insurance programs operated by a multiple employer welfare arrangement. The bill defines "biologically based mental illness" to be "schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association." Health insuring corporations (HICs) are required to provide diagnostic and treatment services, except for prescription drug services, for biologically based mental illnesses as a basic health care service. An HIC that provides coverage for prescription drug services is required to provide them for biologically based mental illness according to the same terms and conditions as for other physical diseases and disorders. Sickness and accident insurance policies and health insurance plans are required to provide parity if the illness is diagnosed by any of the following health care professionals licensed by the state of Ohio: a physician, a psychologist, a professional clinical counselor, a professional counselor, an independent social worker, or a clinical nurse whose nursing specialty is mental health.

Neither HICs nor sickness and accident insurers are required to continue to provide the above-described benefits if they are able to document that providing them has increased their costs by more than 1%. Documenting such a cost increase would require a letter to the Superintendent of Insurance signed by an independent member of the American Academy of Actuaries certifying that the increase reflects actual claims experience. The approval of the Superintendent would be required before the requirement could be dropped.

The bill also expands the list of licensed health care professionals who may provide services included within the existing required minimum coverage for outpatient mental health services of \$550 per year. This minimum is imposed on policies of group sickness and accident insurance and self-insured health plans provided by employers that provide coverage for mental or emotional disorders. Current law requires the minimum coverage for services provided by, or under the supervision of, a licensed physician or psychologist. The bill would include services provided by (or under the supervision of) the following licensed professionals: professional clinical counselors, professional counselors, independent social workers, or clinical nurse specialists whose nursing specialty is in mental health.

The bill also imposes a 90-day moratorium on establishing, developing, or constructing a special hospital²⁷ in any Ohio county that has a population between 140,000 and 150,000. The moratorium does not apply if all local permits required to begin construction were obtained prior to the effective date of the bill.

Background information

As of April 2003, the National Conference of State Legislatures' (NCSL) Health Policy Tracking Service reported that 22 states require that health insurance policies and HMOs provide coverage for mental health and substance abuse benefits at full parity with other health benefits. The NCSL categorizes a law as requiring "parity" if it requires an insurer to "provide benefits for mental illnesses and/or substance abuse that are equal to those provided for other physical disorders and diseases." As of May 2003, the Health Policy Tracking Service reports that 13 states provide parity for mental illness only.

An actuarial report on the effects of implementing the provisions of H.B. 33 of the 124th General Assembly, which contained provisions similar to those of this bill, was produced during that General Assembly by Milliman USA. Such actuarial reports were required at that time under the provisions of H.B. 221 of the 123rd General Assembly for any bills that mandate health insurance benefits and that receive a second hearing. H.B. 33 required not only that health plans and policies not discriminate in the terms of coverage of mental health conditions, it also required that they not discriminate in providing coverage for substance abuse and addiction conditions. The actuarial report estimated that the provisions of H.B. 33 would increase health insurance premiums in Ohio by between 1.0% and 1.5% on average for plans affected by the bill's provisions, and by up to 5.0% or more for affected plans that currently provide low levels of coverage for mental illness and substance abuse services. The average increase was based on four distinct cost estimates,²⁸ one for a traditional fee for service (FFS) plan, one for a preferred provider organization (PPO) plan, one for a point of service (POS) plan, and one for an HMO plan. The estimated cost increases for each type of plan are shown in the following table:

Plan type	Estimated premium increase
FFS plan	3.4%
PPO plan	1.2%
POS plan	0.6%
HMO plan	0.4%

Source: Milliman USA Consultants and Actuaries

²⁷ For the purpose of this moratorium, "special hospital" refers to a hospital that is primarily or exclusively engaged in the care and treatment of patients (1) with a cardiac condition, (2) with an orthopedic condition, (3) receiving a surgical procedure, or (4) with any combination of these criteria. The Director of Health may specify additional specialized categories of service that would qualify a hospital as a special hospital.

²⁸ Technically, Milliman calculated a weighted average of these percentage increases, with the weights being the estimated share each type of plan has in Ohio's health benefit market. Starting with the premium increases in the table, Milliman calculated a weighted average premium increase of 1.2%. This estimate was widened to the 1.0% to 1.5% range reported above, presumably to allow for some uncertainty at each step of the calculation.

Milliman performed a separate set of estimates allowing for insurance companies to implement tighter controls on mental health care utilization in response to the implementation of the bill's provisions. Allowing for the tighter controls, Milliman estimated that premiums would increase by 0.6% in Ohio on average. Because the bill does not directly address such utilization controls, and because employers may adopt such controls whether the bill is enacted or not, the following analysis treats the adoption of such utilization controls as an indirect effect of the bill.

Unfortunately, the Milliman report did not provide separate estimates of the effect on premiums of providing nondiscriminatory coverage of mental illness and of providing nondiscriminatory coverage of substance abuse and addiction. Therefore, while the Milliman estimates described above may serve as upper bounds of the expected increase in premiums due to S.B. 116, the report does not provide a basis for determining the share of this increase attributable to providing parity only for mental illness. The Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services commissioned a study of the costs of similar parity legislation at the national level from Mathematica Policy Research, a private consulting firm. That study, entitled *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, was produced in 1998, and found that requiring parity for mental health conditions only, as defined by that study, would cause health insurance premiums to increase by between 94% and 100% of the increases associated with parity benefits for both mental illness and substance abuse treatment. The specific percentage found depended on the type of health benefit plan offered: the low percentage (94.1%) was for PPO plans, and the high percentage (100%) was for HMO plans. In addition to this adjustment, the difference in definitions of mental health conditions covered found in S.B. 116 (biologically based mental health conditions) and those involved in the Mathematica Policy Research study are assumed to result in 10% lower costs due to implementation of the H.B. 225 provisions. This adjustment is based on testimony of a H.B. 33 proponent who testified that just two biologically based mental disorders (schizophrenia and bipolar disorder) account for 90% of the costs associated with all mental disorders.

A number of other studies of mental health parity bills have been conducted in recent years, and Milliman reviewed several while preparing its report. Specifically, Milliman reviewed a 1998 study by the federal Department of Health and Human Services (HHS), a 2000 update to that HHS study, a 1996 study by the Congressional Budget Office (CBO), a 1997 study by Mathematica Policy Research, a 1999 study by PricewaterhouseCoopers (PwC), and a 2001 study by PwC.²⁹ Generally speaking, these studies estimated higher costs from implementing mental health parity than Milliman estimated in its report. Since several of the studies were based on national data, the Milliman report may be a better predictor of Ohio's experience should the bill be enacted.

In 1996, Congress enacted a law requiring that if a group health plan offers any mental health benefits, it cannot impose more restrictive annual or lifetime limits on spending for mental illness than on coverage of other health conditions. The federal law, known as the Mental Health Parity Act of 1996, provides limited parity. It does not require an insurer to provide or offer mental health benefits, does not include benefits for chemical dependency treatment, and does not apply to employers with an average of 2 to 50 employees. In addition, the law exempts plans

²⁹ Bibliographical details were provided in the Milliman report, and are available from LSC upon request.

that can show that meeting the requirements of the law would result in a cost increase to the plan of 1% or more. The law took effect January 1, 1998 and was scheduled to sunset on December 31, 2004, according to a web site sponsored by the federal Centers for Medicare and Medicaid Services.

In addition to the bill's potential impact on health insurance premiums, it would have a potential impact on the number of uninsured. The bill could result in an increase in the number of individuals who either voluntarily drop their health insurance because of increased premium costs or who lose their health insurance because their employer chooses to no longer provide health insurance. Estimates of the number of people who might lose their insurance coverage are highly uncertain. The Milliman report derived a tentative estimate that 4,300 Ohioans might have lost their insurance coverage had the provisions of H.B. 33 of the 124th General Assembly been implemented. The report goes on to say that the CBO report that served as the basis for Milliman's estimate could not rule out the possibility that there would be no effect on the number of insured persons. As with the Milliman estimate of premium increases, there are other studies that estimate that larger numbers of Ohioans would lose their insurance should the bill be enacted.³⁰ A recent study by RAND Health entitled *Are People with Mental Illness Getting the Help They Need?* found that people with mental disorders were significantly more likely to have lost health insurance coverage between 1996 and 1998 than those without mental disorders. Since the period analyzed in the study is the period immediately following passage of the Mental Health Parity Act, the RAND study may suggest this possible indirect effect of the bill should be taken seriously.

Persons losing their insurance could end up seeking state Medicaid benefits. Currently, pregnant women and families with incomes under specified thresholds would be eligible for Medicaid. Fiscal year 2006 Poverty Guidelines set 100% of poverty for a household of four at \$20,000 per year (in the 48 contiguous states and D.C.). According to the Department of Job and Family Services, the average annual Medicaid cost to cover one individual eligible under the Covered Families and Children Program in FY 2003 under managed care was \$2,002 (of which the federal government would pay approximately 59%).

This fiscal note examines the fiscal impact of this bill on the state, counties, municipalities, and school districts. The bill does not require that an employer (i.e., state, counties, municipalities, and school districts) assume responsibility for any additional cost to achieve parity. Therefore, some of the increased costs could be passed on to the employee.

State fiscal effect

According to a spokesperson for the Department of Administrative Services, all of the health care policies from which state employees may choose meet the bill's requirements. The state began to provide parity in mental health benefits in its Ohio Med plan in July of 1990. All of the health plans offered to state employees began to provide parity in benefits in July of 1995.

³⁰ PricewaterhouseCoopers estimated that similar legislation (H.B. 53 of the 123rd General Assembly) would increase the number of uninsured persons in Ohio by approximately 10,000. The Buckeye Institute estimated this number at 31,100 to 45,100 (assuming a 3.1% increase in premiums). The Buckeye Institute went on to point out that "those losing employer-provided health insurance tend to have incomes under \$15,000 a year and have less than a high school education. They tend to be younger and work for smaller companies."

Therefore, the bill would have no fiscal impact on the state's expenditures for state employee health benefits.

Local government fiscal effects

The Legislative Service Commission (LSC) does not have data on health care expenditures by local governments in Ohio, nor does it have information on the details of benefit packages offered by local governments. Due to the lack of data, it is not possible to provide a complete and reliable estimate of the fiscal impact that the bill would have on counties, municipalities, and school districts. Some of these local entities may already provide health care benefits that meet the bill's requirements, as the state does. Others, however, may not, and for those that do not it is assumed that the cost of providing expanded mental health care benefits would increase costs.

LSC staff members called selected counties to gather information about health benefits for workers in those counties for a similar bill (H.B. 225 of the 125th General Assembly). The information gathered was not derived from a random sample, and so cannot serve as a statistically reliable basis for estimating the costs to counties or other local governments of implementing the bill. It does provide information on the impact on the counties selected, however, and to the extent that these counties are representative of other counties in the state (which they may or may not be) could provide insight into the cost to counties from implementing the bill.

In FY 2002, Montgomery, Fairfield, Lucas, Hamilton, and Cuyahoga counties spent approximately a combined \$117.2 million to provide health benefits to employees. In each county there was a limit (30 days) on the number of days of hospitalization for which the benefit plan would pay for mental health conditions, and none of the counties had a corresponding limit on the number of days of hospitalization for other conditions. Lucas, Hamilton, and Cuyahoga counties also imposed a limit on the number of visits per year that the county would pay for outpatient mental health treatment. Montgomery and Fairfield counties required higher copayments from workers for mental health conditions than they required for other conditions, but copayments were approximately the same (or even lower for mental health conditions) in Lucas and Hamilton counties.

Because these counties will have to provide more benefits for mental health conditions than they did as recently as FY 2002, their costs of providing health benefits are likely to increase. The following estimate assumes, as the Milliman report did, that by including mental health treatment under basic health care services, the bill would prohibit limits on the number of days of mental health treatment for which a health insuring corporation would pay. Applying the Milliman estimates of the increases in premiums for HMOs (0.4%) and for FFS plans (3.4%), and the ratio of percentage premium increases for mental health conditions to those for mental health and substance abuse treatments (combined) taken from the Mathematica Policy Research study, these counties are likely to see a combined increase in the costs of providing health benefits to workers of \$549,000 to \$1.32 million per year.

The bill's provision for an insurer to avoid the requirement of offering parity if the cost of providing parity exceeds a 1% threshold implies that the cost to counties may fall over time. Although the bill states that an insurer needs only six months of experience to demonstrate that

the cost increase exceeds the threshold, the cost increases may grow over time as awareness of the benefits grows, meaning that it may take a year or longer for the threshold to be exceeded. The Milliman estimates imply that cost increases under both FFS plans and PPO plans would exceed the 1% threshold. Assuming that the Milliman estimates are correct and that the requirements therefore lapse for these two types of plans³¹ after a year or so, the cost increases for these counties are estimated to fall to between \$391,000 and \$548,000.

Although we cannot reliably project the cost to all 88 counties in the state from this sample, it seems likely that the cost of the bill could be in the millions of dollars for all counties in the state. LSC has not collected data from any Ohio municipalities, townships, or school districts, but we are not aware of any reason why the health benefit arrangements for those local governments would differ significantly from the arrangements made by counties. Therefore, although LSC cannot project the costs of the bill to these entities, we cannot rule out the possibility that the cost could be in the millions of dollars per year.

As stated earlier, the bill does not require an employer (i.e., state, counties, municipalities, and school districts) to assume any additional cost to achieve parity. Therefore, some (or all) of the increased costs could be passed on to the employee.

Indirect fiscal effects

Any direct fiscal effects of the bill would be limited to changes in costs to provide health benefits to workers. However, indirect fiscal effects could arise in a number of ways. For the state, early treatments provided because of the bill could reduce expenditures in the future for inpatient care at state mental health facilities. Individuals with private medical insurance who currently have limited inpatient mental health coverage may, in the future, be able to seek services from a private facility rather than from a state hospital. Thus, some costs may be shifted from the state to insurers, and the bill could indirectly reduce state expenditures. However, if some Ohioans lose insurance coverage and are eventually insured by the Medicaid program as a result, the bill could increase state expenditures indirectly, offsetting part or all of the indirect decreases discussed above. LSC cannot predict whether future state expenditures would likely increase or decrease as a result of the combined effect of the various indirect effects.

At the local level, the bill could reduce local expenditures for mental health treatment services at mental health service boards (ADAMH boards). Individuals with private medical insurance who currently have limited mental health treatment coverage may seek services from a private provider in the future rather than from a community mental health treatment provider. Thus, some costs may be shifted from ADAMH boards to insurers, decreasing costs for the boards. Moreover, counties, municipalities, and school districts all incur costs currently that may be attributed to untreated mental health problems on the part of some of their employees, such as missed work days and use of disability leave. Early treatment of the underlying mental health problem due to the provisions of the bill may reduce such costs. These indirect effects may be offset, in whole or in part, by cases of employees giving up health insurance due to increased

³¹ The requirements are assumed to lapse for all FFS plans, since Milliman estimates that costs would increase by 3.4% for such plans: well above the 1% threshold. Since Milliman estimates that costs would increase by just 1.2% for PPO plans, we assume that the requirement lapses for 80% of all PPO plans. The remaining 20% of PPO plans are assumed to see cost increases of just under 1%.

premiums, foregoing any treatment of a condition due to the cost, and increasing their missed work days or use of disability leave.

Fiscal effect of the moratorium on construction of certain hospitals

The moratorium does not impose a fiscal effect on the state. The Ohio Department of Health registers hospitals, but does not license them.

The moratorium may delay the receipt of revenue for a political subdivision located in a county of the specified size if that political subdivision issues building permits that would be required to construct such a hospital.³² It may also delay expenditures related to building inspections in such a political subdivision. Any such delay would likely involve minimal revenue and expenditures, and would likely not delay them beyond the end of the current fiscal year.³³

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³² Based on population estimates for 2005 by the U.S. Census Bureau, only Clark County has a population within the specified range. Three other counties, Delaware, Fairfield, and Greene, had estimated populations within 2,000 of the range.

³³ The 90-day moratorium ends during the summer of 2007 and the fiscal years of most political subdivisions are the calendar year. Therefore any receipts or expenditures that may be delayed would still likely occur in FY 2007.