Fiscal Note & Local Impact Statement

127 th General Assembly of Ohio

Ohio Legislative Service Commission
77 South High Street, 9th Floor, Columbus, OH 43215-6136 ✧ Phone: (614) 466-3615
✧ *Internet Web Site:* http://www.lsc.state.oh.us/

BILL: **H.B. 384** DATE: **April 8, 2008**

STATUS: **As Introduced** SPONSOR: **Reps. Celeste and Peterson**

LOCAL IMPACT STATEMENT REQUIRED: **Yes**

CONTENTS: **Requires health care contracts, policies, and agreements to provide benefits for the diagnosis and treatment of mental illnesses and substance abuse or addiction according to the same terms and conditions that such benefits are provided for other diseases and disorders**

State Fiscal Highlights

- No direct fiscal effect on the state.

Local Fiscal Highlights

LOCAL GOVERNMENT	FY 2008	FY 2009	FUTURE YEARS
Counties			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	Potential increase	Increase, potentially in the millions	Increase, potentially in the millions
Municipalities, townships, school districts			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	Potential increase	Potential increase	Potential increase

Note: For most local governments, the fiscal year is the calendar year. The school district fiscal year is July 1 through June 30.

- Research done on FY 2002 health expenditures and health plan coverage in Montgomery, Fairfield, Lucas, Hamilton, and Cuyahoga counties indicated that the required benefits could increase expenditures for those counties to provide health benefits for employees by between $337,000 and $828,000 per year. The cost cap provided by the bill would eventually reduce the increase for these counties to between $291,000 and $390,000 per year.

- 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.

Detailed Fiscal Analysis

H.B. 384 requires group sickness and accident insurers and private and public employer group self-insurance plans to provide benefits for the diagnosis and treatment of mental illnesses and substance abuse or addiction conditions according to the same terms and conditions that benefits are provided for other physical diseases and disorders. Health insuring corporations (HICs) are required to provide diagnostic and treatment services for mental illnesses and substance abuse or addiction conditions as a basic health care service.

Neither HICs, sickness and accident insurers, nor self-insured employers 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.

Background information

S.B. 116 of the 126th General Assembly enacted the above-described requirements for "biologically based mental illness," with the additional difference that HICs were not required to provide benefits for prescription drugs to treat such conditions as a basic health care service. S.B. 116 defined "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."

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 H.B. 384, was produced during that General Assembly by Milliman USA. The most significant difference between H.B. 33 and this bill was that H.B. 33 did not include an exemption for employers whose costs increased by 1% or more. Milliman 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 its 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,[1] 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:

[1] 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.

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

S.B. 116 has already established the requirements for biologically based mental illnesses, which means that any fiscal effects that may be caused by H.B. 384 are likely to be less than those estimated for H.B. 33. As explained in the fiscal note for S.B. 116, due to the narrower range of conditions covered by that bill, its fiscal effects were assumed to be approximately 45% of the costs for the broader range of benefits provided by H.B. 33. Accordingly, the costs of H.B. 384 are assumed to be 55% of the costs of the broader range of benefits.

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.[2] 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 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 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.[3] A 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 federal Mental Health Parity Act, the RAND study may suggest this possible indirect effect of the bill should be taken seriously.

State fiscal effect

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

[3] 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 bill could increase the costs to the state of providing health benefits to employees and their dependents. However, 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. Therefore, the bill would have no fiscal impact on the state's expenditures for state employee health benefits.

Local government fiscal effects

The bill could increase the costs to political subdivisions of providing health benefits to employees and their dependents. Due to data limitations, LSC staff are unable to quantify the potential fiscal effect on political subdivisions. The cost to local governments depends on the number of employees who would be newly eligible for the required benefit times the cost of the benefit. LSC staff do not have data on benefit coverage of health plans at the local level, and therefore information on whether the bill's requirements are already provided, nor does LSC have data on health care expenditures by local governments in Ohio. 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 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 an HIC would pay. Applying the Milliman estimates of the increases in premiums for HMOs (0.4%) and for FFS plans (3.4%), and adjusting for the fact that S.B. 116 required coverage for some of the benefits that were included in the Milliman estimates, these counties are likely to see a combined increase in the costs of providing health benefits to workers of $337,000 to $828,000 per year. This cost would be reduced by the bill's

provision for an insurer to avoid the requirement of offering parity if the cost exceeds a 1% threshold. The cost cap would require some time to be implemented, since the bill provides that an insurer needs six months of experience to demonstrate that the cost increase exceeds the threshold. 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 plans after a year or so, the cost increases for these counties are estimated to fall to between $291,000 and $390,000.

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.

The bill does not require an employer to assume any additional cost to achieve parity. Therefore, some (or all) of the increased costs to political subdivisions 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 this argument is reversed. In addition, those Ohioans may eventually increase costs to the state for the Medicaid program. 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, similarly, 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. These indirect effects may be offset, in whole or in part, by cases of employees giving up health insurance due to increased premiums.

LSC fiscal staff: Ross Miller, Senior Economist

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