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**THE COSTS OF INSURING MENTAL ILLNESS IN KANSAS
ON A BASIS OF PARITY WITH PHYSICAL ILLNESS:
A BRIEF REVIEW**

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EXECUTIVE SUMMARY

- The Kansas legislature is considering legislation to mandate that health insurance policies provide coverage for certain listed mental illnesses on a basis of parity with physical illnesses. The listed mental illnesses are believed by medical scientists to have a physical basis, and effective treatment is available. This report reviews studies and reports relevant to the likely costs of providing that coverage.
- The effect of parity mandates on insurance premiums would differ greatly across types of insurance policies. In general, parity mandates would have a moderately large effect on fee-for-services policies with limited mental health coverage; they would have essentially no effect on managed care policies having mental health coverage commensurate with physical health coverage.
- The Kansas Insurance Department (KID) has estimated that the mandate will increase the cost of insurance premiums by a little less than 3 percent on average, if the existing mix of policies and administrative procedures does not change. That estimate appears to be based on reasonable evidence.
- The KID study considered only the effects of the mandate on *existing* insurance policies. But in fact, a parity mandate is likely to hasten the shift from fee-for-service policies to managed care policies. The net effect on premiums may well be *negative*.
- The true cost of the mandate to society as a whole is not addressed by the KID report. There is evidence that economic costs net of benefits would be negative -- that is, that the mandate would be economically beneficial on net.
- The main cost to society of the mandate would consist in the additional demand for health care for mental illness it is likely to generate. However, this cost would be mitigated to some extent by the improved physical health enjoyed by mental health patients who receive additional or earlier intervention.
- A secondary social cost of the mandates is the adjustment and compliance costs they will impose on employers, insurance companies, and health care providers. These costs are likely to be relatively small in relation to the social efficiencies created by the mandate.
- The value of benefits received by policy holders is likely to exceed the additional premiums, on average. Many households would be protected against serious financial risks that are not presently covered. Some households would receive effective treatments they would not otherwise receive.

- Probably the main disadvantage of the mandates for consumers is the increase it will encourage in managed care policies at the expense of fee-for-service policies. Premiums aside, managed care policies are less valuable to consumers than fee-for-service policies with similar stated coverage. However, the capability of managed care procedures to lower premiums may outweigh this disadvantage. In any event, the transition to managed care is already proceeding rapidly; the mandates would merely speed the process.
- A theoretically important disadvantage of the mandates is the reduction in consumer choice they impose; in particular, they remove the option of selecting a lower mental illness coverage with a lower premium. In practical terms, however, consumers already have limited direct choice over insurance policies. Most medical insurance policies are selected by the consumer's employer or by the government. Moreover, consumers who buy directly on the open market often face vastly inferior choices to those covered by group plans, so that the most free segments of the market do not in fact work to the consumer's advantage.
- An explanation is that unregulated insurance markets suffer from an innate inefficiency known as "adverse selection." In particular, no insurance company can afford to offer full mental health coverage because it would become a "dumping ground" for high risk cases, unless most other insurance companies also offer full coverage. In the current open market, almost no companies do in fact offer full coverage of mental illness. This market failure can be specifically overcome by mandates. Although some individual consumers may suffer a loss of choice, parity mandates are likely to provide average consumers with an improved package of benefits net of costs.
- Businesses could also receive a positive net benefit, on average. The insurance package offered to their employees would provide a higher ratio of value to cost. There is at least some evidence that increased productivity resulting from improved care of mental illness could repay employers for the additional insurance costs, if any.
- The mandate may benefit government by reducing the burden of demand on Medicare, Medicaid, Veterans' benefits, and Social Security. In particular, by encouraging earlier treatment, the mandate would tend to help mental illness patients remain in the work force.

INTRODUCTION

The Kansas legislature is presently considering legislation proposed by the Kansas Alliance for the Mentally Ill (KAMI) which would mandate health insurance coverage for certain listed mental illnesses on a basis of parity with physical illnesses.¹ The mental illnesses covered by the proposed legislation are believed by medical scientists to have a biological or physical basis. The purposes of this legislation are to improve the quality, quantity, and timeliness of treatment provided for severe mental illness; to relieve some of the severe financial impacts of mental illness on affected households; and to remove some inequities in the provision of medical care.

Several other states have enacted similar legislation. Maine, New Hampshire, and Rhode Island mandate parity in coverage for biologically-based mental illnesses. Maryland and Minnesota mandate parity for all mental disorders, including substance abuse, minor disorders, and disorders not known to be biologically based. Texas has required nondiscriminatory coverage of severe mental illness for state employees.

Available treatments for biologically-based mental illnesses are at least as effective as treatments for many physical illnesses that are routinely treated and are comparable or lower in cost. Yet mental illnesses are greatly undertreated relatively to physical illnesses. Extending treatment to the untreated would more than pay for itself in terms of additional earnings received by treated patients and their employers. There would also be substantial additional economic benefits in terms of reduced crime, reduced demand for treatment of *physical* illnesses, and reduced demand for social services. A major reason for undertreatment of mental illness is discriminatory provisions contained in many private as well as public health insurance plans. Costs of treatment are high enough that many individual patients are not able to cover them out of their personal resources. As a result, the patient may go untreated, or taxpayers may end up footing the bill. It was estimated that 57 percent of costs of mental illness treatment in the US was being paid by government programs in 1991, as opposed to 42 percent for physical illness. (This discussion is based on conditions in the US as a whole, as described by National Advisory Mental Health Council, 1993.)

Strong though they may appear, these arguments by themselves are not sufficient to impel passage of the proposed Kansas mandate without addressing some additional issues. In particular, we still need to raise these questions:

- How high would the direct costs of imposing the mandate in Kansas be?
- Would those direct costs be borne by significantly different persons from those who would enjoy the benefits?

¹ See Appendix 1 for the list of mental illnesses subject to the proposed mandate.

- Will mandates actually lead to increased treatment of mental illness? Or would they merely reduce the level of insurance in general?

The Kansas Insurance Department (KID) has made a start at answering some of these questions (Johnston, 1997). They estimate that the proposed mandate for parity in coverage would increase the cost of insurance premiums (at least for particular policies as they now exist) by a little less than 3 percent on average. Presumably those costs would mainly be shared between employers and their employees who enroll in group health insurance plans.

This report reviews the KID study as well as several other studies and reports that are relevant to the premium increases likely to be caused by the mandate. This report also provides a less comprehensive review of costs of the mandate other than premium costs. The individual studies under review are listed in the bibliography. The review begins with a discussion of some important background issues. Next it discusses limitations of the KID survey and compares it with other similar studies. It also reviews some studies of a more general nature and then draws some conclusions.

BACKGROUND ISSUES

The concept of cost

The KID study addressed a very specific issue, namely the effect of the mandate on the average cost of insurance premiums. It is important to distinguish this cost from other important cost concepts, including:

- the average cost to employers of providing group coverage;
- the average out-of-pocket cost to insured parties for health care costs (direct payments as well as insurance premiums);
- the average cost net of the value of benefits received by insured parties; and
- the average cost net of benefits from the point of view of society as a whole. This concept of “net social cost” is important for Kansas public policy, because it measures whether Kansas as a whole would be made better off (i.e., incur a negative net cost), or worse off (i.e., incur a positive net cost), from adopting the mandate.

Each of these cost concepts is different from the average premium costs and may be substantially lower. Indeed, even if premium costs are positive, some of these net costs could well be negative -- i.e., the benefits may exceed the costs from the point of view of some of the affected parties. There are several offsetting effects which would need to be taken into account in order to make this determination, most importantly the following:

- How costs for premium increases of employment-based insurance are shared is generally subject to negotiation between employers and workers.
- Premium increases paid by insured parties are offset by the increased dollar value of medical benefits received, or by reduced out-of-pocket expenses.
- Insurance is valuable to the insured, over and above the average amount of benefits received, because of the “peace of mind” or reduction in financial and health risk it provides.

Behavioral responses

In addition to the obvious kinds of direct effects listed above, any change in insurance premiums and benefits can be expected to cause changes in the behavior of employers and insured parties. Estimating the size of these effects was generally outside the scope of the KID study. These behavioral changes are important because they can affect the costs in both positive and negative directions.

- Insurance companies may to make offsetting changes in benefits offered by policies and also offsetting changes in managed care procedures. Indeed, it is of critical importance to understand that the proposed mandate is fully compatible with *no*

increases in premiums. That is, Kansas insurance companies have the power to modify provisions in offered policies, e.g. deductibles, copayments, and maximums, in such a way as to fully offset any additional costs imposed by the mandate.²

Changes of this type would lower the effect on premiums and decrease mental illness care utilization, but they also would tend to raise the out-of-pocket expense borne by patients and reduce the overall value of the mandate to the insured.

- Perhaps the most significant potential adjustment of this type is a shift from fee-for-service to managed care policies. This kind of shift is already occurring at a rapid rate in Kansas and elsewhere because of the ability of managed care to contain and reduce medical expenses. Varmus (1997) reports that managed health care plans now cover nearly 75 percent of US employees (up from 35 percent in 1990).
- If premiums increase, employers and other policy holders will tend to shift towards less expensive policies. This will tend to lower the average effect of mandates on insurance premiums.
- If premiums increase, employers and employees may negotiate changes in salary increases and other terms of employment which partly offset the additional costs of insurance.
- If benefits increase, insured persons may seek mental health services more frequently, or at earlier stages in their illness. This kind of response increases demands on medical facilities and increases costs paid by insurance companies, and hence increases the insurance premium. However, it also increases the value of the benefits to the insured.
- According to some studies, persons who receive earlier treatment are provided with more effective treatment. They also may reduce their demands for treatment of physical illness. These effects would tend to reduce all of the costs borne by the various parties.
- Persons who receive improved mental health services tend to improve their productivity at work. This reduces net cost to the employer.
- Persons who receive improved mental health services are less likely to lose their jobs, and may be less likely to draw on Medicare and Medicaid resources for treatment of mental health. This would lead to a reduction in costs borne by taxpayers.

² However, the prospective estimates of the cost of mandates that are discussed below assume that insurance companies will not change the mix of benefits for physical illnesses.

- Insurance companies and medical providers would incur some “start-up” or adjustment costs in adapting to the change situation. This effect would increase the costs borne by each of the parties, but the effect is both relatively small and short-term and therefore can probably be disregarded.

The problem of “adverse selection”

A theoretically important disadvantage of the mandates is the reduction in consumer choice they impose. This could lead to social inefficiency, insofar as consumers could not tailor their insurance policies to their individual needs. In practical terms, however, this effect is relatively unimportant, because consumers already have limited direct choice over insurance policies. Most consumers are either covered by government programs or else find it advantageous to purchase group health insurance as a fringe benefit at work. The employee’s medical insurance policy (or at best, a small range of policies) is usually selected by the employer.

Moreover, consumers who do buy directly on the open market often face much inferior choices than those covered by group plans, so that the most free available market in health insurance does not in fact work to the consumer’s advantage. A partial explanation for this is an innate market failure in insurance markets known as “adverse selection.” This means that a policy that offers an attractive benefit, tends to be purchased only by high-cost consumers who most need it and use it; this kind of selectivity increases the costs and premiums for providing the coverage, which in turn reduces the number of purchasers who do not absolutely need the benefit. This kind of vicious circle can spiral downward until a particular benefit is just too expensive to offer, so that it is entirely eliminated from the market place. In particular, it appears to be the case presently that no insurance company can afford to offer full mental health coverage on the open market at a reasonable price, unless all other companies do likewise. Similar considerations deter employers from offering policies with full mental health coverage -- because they could become a dumping ground for employees with high mental health risk.

This market failure can be specifically overcome by mandates. On average, unless other factors prevail, and although some individual consumers may be made worse off, parity mandates can potentially provide most consumers with an improved package of benefits net of costs. For this reason, economists such as Frank and McGuire (1990, reported by Varmus, 1997) argue that states should mandate mental health coverage.

Sensitivity to existing provisions

The response of premiums to mandates is not merely hard to measure -- it is not even a fixed number. Instead, it depends on a number of variables, but most especially on the level of benefits being provided for mental illness in pre-existing policies. It also depends

on whether the coverage of *physical* illness that is being matched is generous or stingy. For policies that have very generous mental health coverage, premiums may not respond to mandates at all. But for policies with stingy or non-existent mental illness coverage combined with generous physical illness coverage, premiums might increase substantially. According to various sources, fully covered mental health expenditures generally constitute less than 15 percent of the cost of health care provision; the national average is only 7 to 8 percent (Coopers & Lybrand, 1996). That fact provides a range of values in which the premium response to mandates can vary, namely between 0 percent to 15 percent. The range of values seen in the individual survey responses received by KID was 2 percent to 16 percent, which covers most of the theoretically possible range.

It follows that the response to mandates depends heavily on the pre-existing average level of coverage for mental illness in the state. This response can vary over time, because the coverage being provided in the absence of mandates varies over time.

THE KANSAS INSURANCE DEPARTMENT STUDY

The KID study relied solely on surveys of some 30 Kansas insurance companies, requesting their estimates of the premium costs. The KID methodology is an entirely reasonable one and their results are useful. At the same time, it is important to understand that their methodology does have inherent limitations, such that the results should be viewed as addressing only a part of the picture. Among its minor limitations are these:

- Nonresponse bias. Around 60 per cent of the surveyed insurance companies responded to the survey in a usable form. While that response rate is good for surveys of this type, nevertheless it is not high enough to eliminate the possibility of significant bias if non-responding companies happen to differ very substantially from the companies that did respond.
- Policies not surveyed, and weighting across policies. Only the most widely used policies at each company were surveyed, and those policies were weighted as if they represented the entire market. That could lead to somewhat non-representative results.
- Possible responder bias. Businesses have a natural tendency to resist mandates on their operating behavior, and insurance companies are no exception.³ Consequently, the costs of mandates could tend to weigh heavily in the minds of the survey respondents.

More major considerations include the following:

- Prospective, not retrospective results. The study was not based on actual outcomes in states where mandates were imposed. Instead, it was based on hypothetical forecasts of what would happen in Kansas if mandates were imposed in the future. While insurance companies do have some capability to make forecasts of this type, the resulting data do not have the same reality as an actual event.
- Behavioral changes not considered. Most importantly the insurance companies were not asked to consider offsetting behavioral responses by insurance companies, employers, and patients. Instead they estimated effects on their most widely used policies as they now exist and are now administered. This methodology is quite reasonable, because insurance companies could not be expected to have much information on the more general question. But it is a limitation in the applicability of the results.

³ For example, Sullivan (1996) expresses the opposition of William M. Mercer, Inc. to mandates in Kansas, and also documents the opposition of the industry's Association of Private Pension and Welfare Plans to parity mandates at the US level.

Within these limitations, a comparison with other studies suggests that the KID results are acceptable measurements of what they purport to measure.

The KID study also contains a review of information received from other states. Much of that information was inconclusive. Various estimates from Maryland, Texas, and Maine suggest premium increases of between \$3 and \$17 per family per month. These numbers may represent prospective estimates; retrospective estimates for these states from Varmus (1997) cited below give much lower or even negative results for Texas and Maryland.

OTHER STUDIES

Prospective studies based on actuarial data

The Kansas study can be usefully compared with several earlier studies that looked at expected future effects on existing policies using actuarial data, since that is the method employed by the insurance companies the KID surveyed. Most of these studies did not attempt to model shifts towards managed care, which could potentially lower this figure. However, the studies did try to model increases in utilization rates on the part of consumers.

Melek and Pyenson (1996a, b) estimated that mandated mental illness coverage at the US level would increase premiums by about 2.5 percent. However the premium increase could be held to zero by adding an additional deductible of less than \$50 per calendar year. (The Congressional Budget Office (1996) states that they are unable to verify these results because of the proprietary nature of the Milliman & Robertson database used in the study).

Watson Wyatt Worldwide (in a 1996 report not reviewed) is reported by Melek and Pyenson and others to estimate premium increases of 8.3 percent to 11.4 percent at the US level. This is much higher than results obtained in other studies, and it seems implausible because it exceeds the current total share of mental illness treatment in the US health care budget. Watson Wyatt Worldwide assumed that the diagnosis of mental illness is relatively subjective, and that large co-payments are needed so as to keep psychiatric utilization under control. Melek and Pyenson believe that these costs would be controlled through existing managed care procedures. Watson Wyatt Worldwide's behavioral assumptions were based on late 1970's RAND data that mainly include fee-for-service policies (Manning *et al.*, 1989), which do not apply to modern managed care environments. Melek and Pyenson make several additional criticisms of the Watson Wyatt Worldwide study, all of which seem persuasive. The Congressional Budget Office (1996) states that the Watson Wyatt Worldwide study greatly exaggerates the morbidity of severe mental illness.

The Congressional Budget Office (1996) estimates that parity mandates would potentially increase premiums by 4 percent. However, this amount includes costs of coverage for substance abuse treatment and mild mental disorders as well as severe mental illness; the amount for severe mental illness alone (as proposed in Kansas) would be around half as large. They also state that less than 2 percent of employer-provided plans in 1991 had parity for mental illness treatment.

Coopers & Lybrand (1996) estimate that parity mandates would increase premiums by 3.2 percent. This amount includes costs of less severe disorders and substance abuse;

severe mental illness coverage taken alone would presumably cost about half as much. Unlike other studies, they assume there would be a substantial shift towards managed care. In their model, there would also be drastic cost savings for government as a result of shifts from public funding of mental health care to private funding; it is these public cost savings that keep the private insurance premiums from actually dropping.

Using 1989 Maryland data, Krizay (1992) estimated that mandated coverage would increase costs by around \$1.00 per covered person per month, which is under 1 percent of premiums. Krizay made demographic adjustments to extrapolate Maryland experience to the US as a whole, but he did not attempt to model any substantial behavioral changes.

Newman Noyes Associates (1994) estimated that mandated coverage in New Hampshire would increase health insurance premiums by a little over 1 percent. Their report contains a useful analysis pegging existing utilization of mental illness services in New Hampshire at about 60 percent of morbidity; they argue that equal coverage would raise the utilization level to about that of physical illnesses, which is around 80 percent. Therefore the mandate is expected to increase demands for mental illness treatment by around 1/3. (Their utilization model may have been taken from an essentially similar analysis contained in National Advisory Mental Health Council, 1993.)

Mark (1996) reviews a number of prospective studies, including those described above. Out of eight studies of the costs of parity for biologically-based illness in various geographical regions of the US, all except Watson Wyatt Worldwide predicted premium increases of under 4 percent. Five of the eight studies predicted premium increases of under 2 percent. Mark also reviewed seven studies of the costs of parity for more general mental illnesses and substance abuse, and found comparable results.

The KID study is generally in the range of results obtained by these earlier studies. Therefore, the KID result should probably be accepted at its face value as the best available estimate of what mandated parity would entail for *existing insurance policies and practices* in Kansas.

As noted previously, because of offsetting behavioral changes not accounted for in these prospective estimates, the KID results should probably be taken as the upper bound of the effect of parity on the costs of premiums in Kansas. For example, parity is expected to have much smaller effects on managed care policies than on fee-for-service policies, and fee-for-service policies hold a declining share of the Kansas market.

Some retrospective results

Even though it is preliminary, the most authoritative report on the costs of a parity mandate would appear to be that of Varmus (1997; additional information on the study is

available in Regier, 1996). Varmus' report is very recent, it draws on new data sources that include actual retrospective experience in states that have adopted parity mandates, it also reviews earlier sources, it reviews a variety of important issues, and it comes from a highly prestigious institution. Varmus concludes that US-wide parity mandates are actually rather likely to *lower* premiums, on net, because they will somewhat hasten the adoption of managed care programs which reduce medical costs. In two reviewed cases (Texas -- state employees; and Rhode Island -- limited statewide parity), the introduction of parity was followed immediately by increased provision via managed care and reduced overall costs of treatment for mental illness. In Maryland, full statewide parity in an environment already dominated by managed care led at most to very slight increases in costs in managed care policies (by a small fraction of 1 percent); this effect however may be offset by shifts towards increased use of managed care, which has not yet been analyzed. In all cases, numbers of mental health patients rose but days of treatment per patient fell.

At the same time, managed care plans, including those with very generous stated mental health coverage, can sometimes over-restrict actual utilization by means of severe utilization review and various other internal policies. Varmus points out that, in practice, these restrictive management methods have been applied in a manner which discriminates against treatment for mental illness. Moreover, neither the patient nor the doctor has any very effective recourse available. While channels of internal appeal are nearly always available for a denial of benefits, the final decision is made by the insurance company itself. Moreover, under the Employment Retirement Income Security Act of 1974 (ERISA), malpractice suits against health insurance companies are severely restricted. Therefore, parity mandates by themselves may not be able to expand the provision of mental health services by a very large amount.

Additional laws have been proposed in various jurisdictions that would regulate utilization review. In Kansas in particular the "Patient Protection Act" recently passed in the legislature. It provides that insurers must provide sufficient resources so as to implement the coverage promised in the policy, and it provides important procedural safeguards during utilization reviews, but there is no language requiring nondiscriminatory review standards or nondiscriminatory outcomes, and the final substantive decision in each case continues to rest with the insurance company. The practical results of this act will not be known until after it has been in effect for some time, and will depend on specific rules to be adopted by the KID.⁴

Varmus points out that increased private coverage of mental illness is likely to reduce the demand for government medical benefits under Medicare, Medicaid, and Veteran's

⁴ I am grateful to Chip Wheelen, Executive Director of the Kansas Psychiatric Society, for drawing my attention this Act.

Benefits. It is also likely to reduce the demand for disability benefits under Social Security and private disability insurance. However, the size or importance of these various effects has not been clearly determined by the existing research.

The cost-effectiveness of treatment

The National Advisory Mental Health Council (1993) cites studies showing that treatment of mood disorders, for example, is highly effective. However, according to several sources cited by Varmus (Regier *et al.* 1993; Kessler *et al.* 1994) only a third of Americans with these disorders receive treatment.

Greenberg *et al* (1993) conclude that over 70 percent of the direct economic costs of depression and schizophrenia are caused by effects of the disease, rather than treatment costs. (Economic costs were restricted to lost work, lost productivity, and treatment costs.) In other words, the preponderance of costs are caused by neglect or inadequate treatment. Varmus reports a finding by Rupp (1995) that treatment for mood disorders returns about two dollars in additional earnings by treated employees, per dollar of treatment costs. Zhang (1996) found an even higher ratio of social benefits, but on a more restricted sample.

Moreover, these calculations omit the social value of the alleviated suffering and emotional pain experienced both by patients who are successfully treated and by their families. Under any reasonable reckoning, that value is substantial.

CONCLUSIONS

- The literature on mandated costs generally states that treatment is effective, in the sense that a majority of patients are made better off as compared to untreated controls. There is evidence that treatment is cost-effective, in the sense that the expected value of benefits from treatment of the listed illnesses does normally exceed the expected costs.
- KID predicted an insurance premium increase of a little under 3 percent from the mandate. Given their methodology, this estimate is entirely reasonable. However, their estimate assumes that the mix of policies and administrative procedures will remain constant. There does exist independent evidence that the actual effect on premiums could be smaller, and quite possibly could be negative, because of changes in the mix of policies and procedures.
- It is reasonable to assume that the mandates would increase the level of economically justifiable treatments provided for mental illness. Consequently, net economic costs of the mandate would be negative, i.e., the overall dollar value of benefits would exceed the overall dollar value of the costs, when added up across all parties.
- There are several related reasons why overall social benefits from the mandate appear likely to exceed overall social costs.
 - Insured parties would receive a reduction in risk which has a positive value to them, over and above the average direct benefits they would receive from the mandate. This risk reduction has a positive value. This is especially true because a majority of insured persons receive their health insurance as part of an employment compensation package, in which they have limited choice over the scope of benefits.
 - Treatment for mental illness is effective and has positive externalities or side effects on family members, employers, and taxpayers. It seems likely that such treatment is being underprovided under existing insurance arrangements.
 - Insurance markets tend to suffer from a market failure known as “adverse selection,” meaning that customers who most need insurance are driven out of the market when insurance companies “cherry pick” customers who least need insurance and/or syndromes that least need to be insured for. Mandates can be a specific remedy for this problem.
- At the same time, we should expect the overall benefits of parity mandates *by themselves* to be relatively limited. Managed care programs increasingly rely on administrative methods to reduce utilization of mental as well as physical health

treatment. They may have an incentive to discriminate against mental illness coverage in these reviews. These administrative procedures are not covered by parity mandates *per se*. Therefore Kansas may need to impose regulation of utilization review standards in order to obtain the full social benefits potentially available from mandated parity in insurance coverage for mental illness.

APPENDIX. MENTAL ILLNESSES PROPOSED FOR COVERAGE

- 1) Schizophrenia, shizoffective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis.
- 2) Major affective disorders (bipolar and major depression), cyclothymic and disthymic disorders.
- 3) Obsessive compulsive disorder.
- 4) Panic disorder.
- 5) Pervasive developmental disorder, including autism.
- 6) Other childhood mental illness, including attention deficit disorder and attention deficit hyperactivity disorder.
- 7) Borderline personality disorder.

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