Policy Brief

Analysis of Ohio Issues

Mental Health Meddling

The Effects of Mental Health Parity Legislation in Ohio

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Tuesday, May 25, 1999

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Executive Summary

Mental health parity legislation in Ohio would likely raise premium costs for employers and employees.

Premium increases from mandates may cause many employees to lose their health insurance as their employers drop coverage. Premium increases would likely cause other employees to give up jobs with lower wages and expensive health insurance coverage in favor of other jobs with higher wages and no health insurance coverage.

If premiums increase a small amount (3.1%), between 30,100 and 45,100 Ohioans could either lose or drop their health care coverage. If premiums increase a large amount (7.9%), between 79,700 and 119,600 Ohioans could either lose or drop their health insurance.

The number of people affected by the mandate depends particularly on (1) the number of people covered under the Employee Retirement Income Security Act of 1974 (ERISA), who are exempt from state health care mandates; (2) the sensitivity of purchasers of employer-provided health insurance to changes in its price; and (3) the percentage increase in premium costs from the mandate.

Those losing their 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.

A recent study by researchers at Brigham and Women's Hospital and the Harvard School of Public Health found that following the loss of health insurance, individuals were more likely to delay medical care within four months after visiting an emergency department, were more likely to report no primary care provider, and were less likely to have recommended follow-up care within the four-month period. The researchers also found that the loss of insurance was associated with a lower likelihood of vaccine use and check-ups in the prior year.

The actual beneficiaries from mental health parity legislation would probably be a small group of high-cost users. According to most studies of

who uses mental health care, these users would likely be educated, high-income, middle-aged, white, and female.

Research shows that previous mandates enacted in 1993 (including guaranteed renewal, guaranteed issue, limits on pre-existing condition exclusions, and certain premium rate restrictions) could have caused 297,000 more Ohioans to become uninsured.

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1 Introduction

The following report is submitted as an analysis of mental health parity legislation in Ohio. There are two primary reasons for the report. First, state legislatures, including Ohio's, have increasingly sought to regulate health care, especially with respect to mental health benefits following the passage of the federal Mental Health Parity Act of 1996.[1] Often these regulations have come in the form of mandates, which compel insurance companies to provide certain benefits and guarantee issuance and renewal of policies. In 41 benefit areas alone, state mandates across the U.S. increased from 35 in 1970 to 860 in 1996.[2] The Ohio Revised Code lists 21 specific benefit mandates.[3] This report will address the general effects of health care mandates, such as those pending in the Ohio state legislature, as well as the specific effects of mental health parity legislation.[4]

Second, this report is submitted in response to testimony presented to the Ohio House Insurance Committee on April 13, 1999, by Ronald E. Bachman, an actuary with PricewaterhouseCoopers. Bachman has been retained by the Coalition for Healthy Communities and the American Psychological Association.[5] This report is also submitted in support of testimony presented by Robert Lawson, Ph.D., Associate Professor of Economics, Capital University, and Director of Fiscal Policy for the Buckeye Institute for Public Policy Solutions, who testified before the same committee on April 20, 1999.[6]

In his testimony, Bachman challenged an estimate presented by the Buckeye Institute of the number of Ohioans who could lose or drop their health insurance under a mental health parity mandate.[7] Bachman argued that a significantly smaller number of Ohioans would lose insurance coverage than was estimated by the Buckeye Institute. "I was very concerned to see that

study used to create a false number," he said.[8] Bachman offered no revision of the Buckeye estimate.

The original Buckeye calculation of the number of Ohioans who might lose their health insurance was based upon the work of William S. Custer, Ph.D., of Georgia State University.[9] Custer found that mandating mental health care within a state resulted in a 5.8% increase in the likelihood of an individual in that state becoming uninsured.[10] Using that figure, the Buckeye Institute, as a first approximation, estimated that about 70,000 Ohioans might lose their health care insurance after the enactment of a mental health care mandate.[11] In a telephone conversation, Custer stated that "[t]he Buckeye Institute correctly used my methodology in developing the approximation contained in their *Policy Note*," and that "[m]y study has shown that a mental health mandate is associated with a larger number of uninsured."[12]

This report will show that the Buckeye Institute's original estimate that 70,000 Ohioans might lose their health insurance is a reasonable estimate. Using the conservative assumptions (including those provided by Bachman), the Buckeye Institute estimates that the premium increases associated with mental health parity legislation in Ohio would cause between 30,100 and 119,600 Ohioans to either voluntarily drop or involuntarily lose their health insurance coverage. (This range can be reduced to 45,100 to 119,600 if a State of Ohio Department of Health assumption is used, as demonstrated in Section 5.) Second, Bachman's estimate that mental health parity legislation might be enacted with minimal cost, or in fact cost-savings over the present, is analyzed and rejected.[13]

2 The Economics of Mandates

Ninety-three percent of non-elderly, privately-insured Ohioans obtain their health insurance through their employers.[14] There are several reasons for this. First, the federal (and state) tax code does not give the same treatment to health insurance that it does to taxable income. Health care premiums for employers may be deducted as business expenses. Therefore, health insurance obtained through an employer has significant tax advantages for employers. Second, as Wayne State University economist Gail A. Jensen and University of Alabama (Birmingham) economist Michael A. Morrisey

state, "administrative costs on a per-individual basis are lower when coverage is purchased through an employer."[15]

Recently state lawmakers have chosen to impose their health care policy agenda by compelling employers to provide certain health care benefits to their employees. These compelled benefits are known as *mandates*. Mandates imposed by government redistribute real resources. Health care is not a free gift of nature. It cannot be created by government fiat. The cost of this redistribution must therefore be paid in one of several ways. Workers pay for mandated benefits in the form of reduced wages, fewer benefits, or higher insurance premiums.[16]

According to many economists, workers view wages and benefits as substitutes. As the cost of benefits increase, workers may choose to receive wages instead by changing their employers. Similarly, employers may restrict employee wage increases if benefits are mandated and costs increase. Massachusetts Institute of Technology economist Jonathan Gruber has found, for example, that mandated maternity benefits decreased wages 5.4% for women in states that passed mandatory coverage.[17] Largely because of health insurance premium increases, two economists with the federal Agency for Health Care Policy and Research found that even as more employees were being covered by health benefits, the percentage of employees choosing health benefits declined from 88.3% in 1987 to 80.1% in 1996.[18] Although some of this decline is certainly due to working spouses covering their partners on their employer-provided insurance (with the second spouse declining coverage at his or her employer), the evidence does suggest that a significant number of employees have substituted higher wages for increasingly expensive health care coverage.

Another way that workers may pay for mandated benefits is through higher insurance premiums. Mandates have a significant effect on insurance premium costs within states. Gruber reports that mandates account for 22% of premium costs in Virginia and Maryland and 18% in Massachusetts. He finds that the additional cost of adding a mental health mandate ranges from 4.2% to 7.8%.[19] (For reference, Bachman's study, presented below, asserts that "claim cost increases" will be 3.1% under a mental health mandate, with premiums increasing even less.)

Firms may also choose to self-insure to avoid higher health-care premiums.[20] By self-insuring, firms avoid the direct effects of the mandate. However, as

Section 5 demonstrates, one cannot claim that these firms or individuals have therefore avoided a cost from the mandate. The firms and individuals have chosen to self-insure *after* government intervention (which itself violates voluntary exchange), thereby choosing a second-best alternative; the preferred choice was the one that existed before the mandate.

By becoming self-insured, firms avoid the regulatory impact of state mandates and become regulated instead under the federal Employee Retirement Income Security Act of 1974 (ERISA).[21] Therefore, any state mandates would not directly affect these firms' health care costs. Bachman estimates that between 40% and 60% of Ohioans are covered under this federal regulation and are therefore immune from state mandates.[22]

3 The Groups Affected by a Mental Health Mandate

By demonstrated preference, it can be assumed that psychologists, psychiatrists, and social workers will benefit professionally from the passage of mental health parity legislation; their lobbying for the legislation argues for this view. This section, however, seeks to identify the immediate patient beneficiaries of parity legislation and the economic effects of it on affected employees.

Robert J. Franciosi, Ph.D., Melinda L. Ogle, and Michael K. Block, Ph.D., researchers at the Goldwater Institute, conclude that the "actual beneficiaries from parity would probably be a small group of high-cost users. According to most studies of who uses mental health care, these users would likely be educated, high-income, middle-aged, white, and female. Children are also high-cost users."[23]

In contrast, Custer states that "[t]he two groups most likely to reduce their purchase of health insurance are … those whose family incomes are low and those whose risks of needing health care services are low."[24] Custer's analysis applies to those individuals who choose to substitute wages for benefits. Other research describes who might involuntarily lose their health insurance.

Researchers at Brigham and Women's Hospital and the Harvard School of Public Health found that those losing their insurance were much more likely to have income under $15,000 and have less than a high school education.[25]

Furthermore, their research also shows that following the loss of their health insurance, these individuals were more likely to delay medical care within four months after visiting an emergency department, were more likely to report no primary care provider, and were less likely to have recommended follow-up care within the four-month period.[26] "Loss of insurance was also associated with a lower likelihood of vaccine use and check-ups in the prior year," states the study. According to the researchers, "a loss or change of insurance in the prior year has a measurable effect on access to health," and therefore could represent a significant determinant of health outcomes.[27]

Table 1 Association of insurance loss with health status

	Loss of Health Insurance	No Disruption in Coverage
No regular physician	53.4 %	21.0 %
Delayed seeking needed care	32.8 %	17.7 %
No physician follow-up in 4-month period	53.9 %	29.9 %

Source: Helen R. Burstin, Katherine Swartz, Anne C. O'Neil, E. John Orav, and Troyen A. Brennan, "The Effect of Change of Health Insurance on Access to Care," *Inquiry*, Vol. 35, No. 4 (Winter 1999), pp. 389-397.

Although the number of Ohioans who might lose their employer-provided health insurance is open to analysis, recent history provides a more concrete case for the effect of health insurance mandates. Researchers from the Galen Institute found that the 16 states (including Ohio) that enacting widespread insurance regulations in the early 1990s to increase access to health care saw the number of uninsured increase 25.6% from 1990 to 1996. The remaining 34 states saw the number of uninsured increase 7.2%. The 16 high-regulation states also saw a decline of those with individual insurance, a decline of those with employer-based insurance, and an increase of those with Medicaid. The 34 low-regulation states saw different effects: an smaller decline of those with private insurance, an increase of those with employer-provided insurance, and a smaller increase of those with Medicaid.

The Galen Institute report found that after Ohio enacted guaranteed renewal provisions, guaranteed issue provisions, limits on pre-existing condition exclusions, and certain rate restrictions (among other measures), the number of uninsured in Ohio increased 297,000 from 1989-1990 to 1995-1996.[28]

4 Bachman / PricewaterhouseCoopers Report Analysis

For consistency and for clarity, this report accepts Bachman's estimates of the percentages of Ohioans in fee-for-service (FFS), managed indemnity (MI), preferred provider organization (PPO), point-of-service (POS), and health maintenance organization (HMO) plans. The premium (or "claim cost") increases which Bachman uses for "comprehensive parity" are used in this report as well, although these premium increases represent a low estimate.[29] The high estimate for premium increases is given by a Price Waterhouse estimate provided to the U.S. Department of Health and Human Services.[30] Bachman argues that his percentage increases are "claim cost increases," rather than premium increases, which, he argues, "should be less than the indicated percentages because the required administrative infrastructure is already in place."[31]

Unfortunately, Bachman's analysis assumes that managed health care organizations like HMOs and PPOs will continue to enjoy significant cost savings. However, this is far from certain. As Franciosi states

> [m]anaged care's efforts at controlling costs are crucial to predictions that mental health parity would have a negligible effect on premiums. The popularity of recent efforts to limits managed care's effectiveness has important implications for any cost estimates. If the tools managed care uses to hold down medical costs are attentuated due to other political action at the state and federal level, then the costs of mental health parity will be much higher.[32]

Because states and federal government are seeking to further regulate HMOs, it is questionable whether HMOs will enjoy the same cost savings that they have seen recently. As HMOs increase their market share, they lose the ability to enroll the healthiest candidates, thereby increasing the average claim for their pool of enrollees. Moreover, price and market competition in health care will likely cause mergers, acquisitions, alliances,

divestiture and other forms of industrial organization. While these changes in industry organization often improve economic efficiency, they may come under review by state and federal antitrust divisions, thereby preventing the health care market from achieving economies of scale and anticipated efficiencies.

Bachman recognizes the possibility of increased health care costs in the future: "[t]he most difficult cost argument to fight, however, is that the 2% increase estimated for parity will be coming on top of double digit health insurance premium increases that are expected in the next few years."[33] Health insurers, particularly HMOs, are already seeing significant cost increases in 1999 and they may rise more than 10% in 1999 (more than 5 times faster than projected inflation).[34]

Bachman cites Minnesota and Arizona as examples where claim cost increases have been kept low.[35] However, the results from these two states would likely not reflect the experience in Ohio. Arizona, for example, has a much different mix of health plan service providers than Ohio, with a far higher market penetration of HMOs.[36] Minnesota, too, has a far different structure of health care than that of other states including Ohio. In 1994, 83.9% of the Minnesota's population was enrolled in a MCO (the highest in the country), versus 52.2% for the U.S.[37] Additionally, Minnesota has the highest percentage of its population in a PPO – 55.9%, versus 31.7% for the U.S.[38] Minnesota also has a higher market penetration of HMOs than most other states – 36.6% of its insured population in 1997, versus 29.9% for the U.S.[39] It has also had HMOs since the 1970s, far earlier than other states.

Moreover, in 1992, Minnesota enacted HealthRight (now called MinnesotaCare), a government health program that guarantees universal coverage for every Minnesotan. The plan is unlike that of any other state. Combined with other regulatory measures passed by the Minnesota legislature between 1992 and 1995 (such as mental health parity legislation in August 1995), it likely was the cause of many large Minnesota employers forming the Buyers Health Care Action Group.[40] By forming this self-insured group, 200,000 covered employee-members were able to avoid the effects of costly state mandates. Moreover, the group enrolled its members in ChoicePlus, which gives the employees cash to purchase health insurance for services in 26 doctor-formed health networks. The effect of these legislative changes, together with the subsequent withdrawal of a large

number of insured employees from state regulation, likely caused a dampening effect of state mandates in Minnesota on premium increases.

In summary, the minimal cost increases observed in other states, like Arizona and Minnesota, may not predict Ohio's experience, and the ability of HMOs to restrain costs in the future is far from certain. Bachman's estimates of minimal premium cost increases from mental health parity legislation may therefore amount to the uniqueness of historical data combined with simple conjecture.

5 Loss of Insurance Under Mental Health Parity

The Appendix included at the end of this report summarizes the Buckeye Institute's analysis of the economic effect of House Bill 53.

Under a low premium increase (defined as 3.1%), between 30,100 and 45,100 Ohioans might lose or drop their health insurance coverage. Under a high premium increase (defined as 7.9%), between 79,700 and 119,600 might lose or drop their health insurance coverage.

As the Appendix shows, the "high" scenario predictions (which are Price Waterhouse estimates) are more than twice as great as the "low" scenario predictions (which are based on Bachman's estimate). This is primarily due to two assumptions in the Price Waterhouse study: first, a shifting of costs from the public to the private sector; and second, a reduction in the ability of managed care organizations to control costs.

The estimate of how many Ohioans would lose their health insurance is based upon two primary factors: first, how many Ohioans are exempted from state mandates under federal ERISA regulation; and, second, how sensitive employees are to price changes in health care premiums. The second factor is known as "elasticity of demand." An elasticity of demand of -0.50 means that for a price increase of 10%, demand drops 5%. An elasticity of demand of -0.90 means that for a price increase of 10%, demand drops 9%.

The Appendix assumes, conservatively, that an increase in the price of mental health services will reduce demand by a factor of –0.30. (In other words, a 10% increase in price will reduce demand by 3%.) Furthermore,

Bachman estimated that between 40% and 60% of the U.S. is covered under ERISA plans. The Appendix therefore presents estimations for Ohioans being at both ends of this range. However, the Ohio Department of Health estimates that Ohio is at the extreme low end of this range, suggesting a higher number of individuals who would affected by state mandates and therefore possibly becoming uninsured. The Ohio Department of Health, in its *State Health Resources Plan 1999* states that "[a]pproximately 40% of insured Ohioans are in ERISA plans that are outside the scope of many state health insurance regulations."[41] Additionally, Bachman uses the comprehensive estimate as a maximum estimation when, in fact, it may represent a minimum. As stated previously, Price Waterhouse gave an estimate significantly higher than Bachman's.[42]

Additionally, other researchers have found significantly higher price sensitivities for mental health care. Table 2 summarizes other research on the elasticity of mental and physical health care presented by Franciosi, Ogle, and Block. In each example, the price sensitivity of mental health care is significantly higher than with physical health care. In other words, people are far more sensitive to price changes with mental health care than with physical health care: higher costs for mental health care – including premiums – result in fewer people demanding the service than under physical health care.

Table 2 Elasticity of demand for physical and mental health care

Study		**Elasticity**	
		Mental Health Care	Physical Health Care
Horgan (1986)	Use	- 0.27	- 0.06
	Expenditure	- 0.54	- 0.25
Keeler *et al*. (1986)		- 0.59	- 0.34
Taube *et al*. (1986)		- 0.98	- 0.12

Source: Robert J. Franciosi, Melinda L. Ogle, and Michael K. Block, "The Cost of Mental Health Parity in Arizona," *Arizona Issue Analysis 151* (Phoenix: Goldwater Institute, 1998), citing Constance M. Horgan, "The Demand for Ambulatory Mental Health Services from Specialty Providers," *Health Services Research*, Vol. 21, No. 2 (June 1986), Part II, pp. 291-319; Emmett B. Keeler, et

al, "The Demand for Episodes of Mental Health Services," RAND Corporation R-3432-NIHM (1986); and Carl A. Taube, Larry G. Kessler and Barbara J. Burns, "Estimating the Probability and Level of Ambulatory Mental Health Service Use," *Health Services Research, op cit*., pp. 321-340.

As Table 2 also demonstrates, this report's use of an elasticity equal to -0.30 is a very conservative estimate. The use of a low price sensitivity in this report is toward the low end of researchers' findings: the range of elasticities is from -0.27 (more inelastic) to -0.98 (nearly unit elastic). In other words, with the low estimate, a 10% increase in costs leads to a drop in demand of 2.7%. With the high estimate, a 10% increase in costs leads to a 9.8% drop in demand.

Measuring employee benefits more generally, other researchers have found a much higher sensitivity of employees to the costs of benefits. As stated previously, wages and benefits are often seen as highly substitutable. While employees often prefer benefits to wages (particularly because wages are taxed and benefits are not, and because the full cost of health insurance is not known to employees), employees are sensitive to the cost of those benefits. Two Michigan State University economists found elasticities of demand for employee benefits to be much closer to –2.0, so that, for example, an increase in cost of 1% leads to a drop in demand of 2%.[43]

Using a greater elasticity, such as those computed by presented by Franciosi, Ogle and Block would result in far more Ohioans losing or dropping their health insurance.[44] Table 3 presents estimations of insurance loss under differing price elasticities of mental health coverage. Each of the estimates assumes only the low premium-increase scenario.

Table 3 Estimates of insurance loss under various elasticities with a low premium increase

		ERISA %	
Elasticity	Survey	60	40
0.30	Buckeye Institute	30,104	45,158
0.59	Keeler *et al.*	53,528	79,928

0.98	Taube *et al.*	88,507	132,762

Calculations by author based on assumptions presented by Ronald E. Bachman, "Executive Summary," An Actuarial Analysis of Comprehensive Mental Health and Substance Abuse Benefits and Other Options for Improved Coverages in the State of Ohio, PricewaterhouseCoopers (March 1999).

If the price sensitivity of mental health coverage is greater than that initially assumed in this report, then the range of those losing or dropping their health insurance rises to between 30,104 and 132,762, if premiums increase only at the minimum rate specified by Bachman. (Again, the Ohio Department of Health states than 40% of Ohioans are covered under ERISA, thus arguing for the higher estimate under the scenario presented.) Under this scenario for a low-premium increase (which was presented by Bachman for comprehensive parity) across the range of elasticities, the midpoint estimate is 59,306 who lose their insurance. This scenario posits a high estimate of those covered under ERISA. Under the same scenario with a low estimate of those covered under ERISA, the midpoint is 88,960 who lose or drop their insurance. The high-ERISA midpoint estimate of 59,306 represents 0.8% of non-elderly, privately-insured Ohioans losing or dropping their insurance. The low-ERISA midpoint estimate of 88,960 represents 1.2% of non-elderly, privately-insured Ohioans either dropping or losing their insurance. Using both estimates together, the midpoint is 81,433 who lose or drop their insurance, or 1.1% of non-elderly, privately-insured Ohioans.

Many cited in Table 3 would lose insurance as the employer drops coverage and becomes self-insured. Again, many others would choose not to receive health insurance, preferring instead higher wages as a substitute. This report makes no attempt to distinguish among the possible changes. It merely notes that voluntary exchanges in the market (such as choosing to purchase health insurance or not) necessarily benefit each participant without harming others. Involuntary exchanges (such as those resulting from government intervention) necessarily benefit some and harm others, although it is possible that *all* individuals in society could be harmed by such intervention.[45]

In closing, cost-benefit analysis has limitations. It cannot give any estimate of a social "benefit" (such as that from mental health parity legislation) for

several reasons. First, to speak of a societal "benefit" presupposes a collective choice by "society." However, nobody can know "society's" preferences because society itself does not have preferences; individuals do, and individuals do not choose with unanimity. Second, these preferences cannot be objectively measured because no common index exists by which to do so. Adam's demonstrated preference for more health care instead of more wages, for instance, cannot be objectively measured against Bob's demonstrated preference for more wages instead of more health care. All one may say is that, in the marketplace of voluntary exchange, Adam prefers more health care to more wages, while Bob prefers more wages to more health care. These preferences cannot be added together or subtracted from one another. Third, and lastly, political action by elected representatives cannot substitute for market decisions made by individuals, since political decisions, unlike market transactions, are non-consenual.[46]

6 Conclusion

This report establishes that a significant number of Ohioans would either lose or drop their health insurance coverage if a mental health mandate ("parity legislation") is enacted. Based on the best economic evidence available, with a 3.1% increase in insurance premiums, between 30,100 and 45,100 Ohioans could either lose or drop their employer-provided health insurance. With a 7.9% increase in insurance premiums, between 79,700 and 119,600 Ohioans could either lose or drop their health insurance. The range depends on (1) what percentage of Ohioans are covered under ERISA plans and are therefore immune from state mandates and (2) whether the premium increase will likely be low or high. A reasonable midpoint range is that between 54,928 and 82,396 Ohioans would either lose or drop their health insurance coverage. This represents about 0.8 to 1.2% of non-elderly, privately-insured Ohioans who obtain their insurance through their employer.

These estimates are based on a low sensitivity of workers to increases in benefit costs. If workers are more sensitive to costs, as demonstrated in Table 2, the number who are affected by mental health parity legislation could increase significantly.

Notes

[1] P.L. 104-204.

[2] Gail A. Jensen and Michael A. Morrisey, *Mandated Benefit Laws and Employer-Sponsored Health Insurance* (Washington, D.C., Health Insurance Association of America, January 1999), p. 2.

[3] The Ohio Revised Code (O.R.C.) mandates benefits in three areas: specific benefits provided as services, mandated benefits through an employer or to specific individuals, and lastly by compelling health care providers to perform covered services. The O.R.C. compels benefits for the following: treatment of AIDS or AIDS-related conditions without limit (§3901.45), outpatient kidney dialysis when inpatient dialysis is covered (§3923.25), outpatient mental/nervous treatment when inpatient treatment is covered (§3923.28 and §3923.30), alcoholism treatment (§3923.29 and §3923.30), breast and cervical cancer screening (§3923.52, §3923.53, and §3923.54), well-child benefits to age nine (§3923.55 and §3923.56), and maternity benefits as any other benefit (§4112.01 and §4112.02). Secondly, the O.R.C. regulates coverage through an employer or for specific individuals, including covering specific care given to newborns (§3923.26), mandating specific care given to adopted children (§3923.40), mandating coverage for over-age mentally or physically handicapped dependents (§3923.32), mandating continued coverage for dependents upon subscriber's death or change in marital status (§3923.32), mandating continued group coverage for six months after employment termination (§3923.38) or during military service (§3923.381 and §3923.382), mandating conversion rights on loss of group coverage (§3923.122), mandating coordination of benefits (§§3902.11 – 3902.14), mandating prompt payment of health care claims (§3901.38), limiting pre-existing condition exclusions (§3923.57 and §3924.03), mandating annual open enrollment for individual and small group health insurance policies (§3923.58), banning individual underwriting or individual riders for small group health insurance policies (§3924.03), limiting premium rates for small group health insurance policies (§3923.57 and §3924.03), guaranteeing renewals on individual and small group policies (§3923.57 and §3924.03), and mandating that employers must notify certificate holders if group health insurance is terminated for non-payment (§3999.32). Thirdly, and lastly, the O.R.C. compels health care providers to provide certain services: chiropractors (§3923.23), dentists (§3923.232), mechanotherapists (§3923.234), nurse midwives with physician supervision (§3923.233 and §3923.301), podiatrists (§3923.23), psychologists (§3923.231), optometrists (§3923.23), osteopaths (§3923.23), and state mental health facilities (§ 3923.27).

[4] As of May 1, 1999, the pending health care mandates are HB 53 (Olman) on mental health parity, HB 151 (Mottley) on insurance coverage appeals, HB 173 (Winkler) mandating coverage of anesthesia, HB 218 (Krebs) on mandating coverage of infant formula as a "basic need," HB 253 (Beatty) mandating that health care providers and insurers restrict fees charged for providing medical records, HB 272 (Britton)

mandating coverage of osteoporosis, and SB 80 (Latell) mandating coverage of second opinions for mastectomy procedures.

[5] The Coalition for Healthy Communities includes the Ohio Psychological Association, Mental Health Associations of Ohio, the Alliance for the Mentally Ill of Ohio, Ohio Alliance for Alcohol and Drug Policy, District 1199 Service Employees International Union AFL-CIO CLC, International Association of Psycho Social Rehabilitation Services, Metro Behavioral Health Care Network, National Association of Psychiatric Health Systems, AFL-CIO, Northeast Ohio Coalition for National Health Care, Ohio Advocates for Mental Health, Ohio Association of ADAMHS Boards, Ohio Association of Child Caring Agenices, Ohio Chapter National Association of Social Workers, Ohio Nurses Association, Ohio Psychiatric Association, Ohio Society for Clinical Social Work, People Against Panic Attacks, Ohio Counseling Association, Ohio Council of Behavioral Healthcare Providers, Employee Assistance Program Association of Southern Ohio, Family Service Council of Ohio, Universal Health Care Action Network of Ohio, and the National Council of Alcoholism and Drug Dependence.

[6] Ronald E. Bachman, "Executive Summary," An Actuarial Analysis of Comprehensive Mental Health and Substance Abuse Benefits and Other Options for Improved Coverages in the State of Ohio, PricewaterhouseCoopers (March 1999).

[7] See Gongwer News Service, Inc., *Ohio Report*, Vol. 68, No. 69 (April 13, 1999), p. 4. See also *idem*, *Ohio Report*, Vol. 68, No. 10 (January 15, 1999).

[8] *Ohio Report* (April 13, 1999), p. 4.

[9] See William S. Custer, *Health Insurance Coverage and the Uninsured* (Atlanta, Georgia: Center for Risk Management and Insurance Research, Georgia State University, December 10, 1998), available online from the Health Insurance Association of America, http://www.hiia.org and The Buckeye Institute, "Health care mandates increase number of uninsured," *Policy Note* (Dayton, Ohio: The Buckeye Institute for Public Policy Solutions, January 1999).

[10] Custer, *op cit.*, Chart 7, "Key state reforms have contributed to the likelihood of being uninsured," p. 18.

[11] A simple approximation of the number of Ohioans who might lose or drop their health care coverage may also be calculated as follows. A commonly cited estimate by the Congressional Budget Office (CBO) states that a 1% rise in premiums forces 200,000 in the U.S. to abandon private health insurance. The results can be assumed to be proportional to the number of non-elderly people in a state who are covered under private health insurance: 7.62 million people in Ohio, versus 167.53 million in the U.S. Therefore a 1% increase would cause 9,097 Ohioans to abandon private health insurance. Under the low premium increase (3.1%) assumed by Bachman and used a low estimate for this report, 28,201 would abandon their health insurance. Under the

high premium increase (8.5%) presented by Price Waterhouse and used as a high estimate for this report, 77,323 would abandon their health insurance. The original Buckeye Report concluded that as many as 74,240 Ohioans could lose their health insurance. See The Buckeye Institute, *op cit.*, Note 2.

[12] Telephone conversation with William S. Custer, Ph.D., Associate Professor, Department of Risk Management and Insurance Research, Georgia State University, Atlanta, Georgia, April 15, 1999.

[13] With note, the research and methodology presented in this report are based extensively upon work done by Robert J. Franciosi, Melinda L. Ogle, and Michael K. Block, "The Cost of Mental Health Parity in Arizona," *Arizona Issue Analysis 151* (Phoenix: Goldwater Institute, 1998). All errors contained herein remain those of the author.

[14] Custer, *op cit.*, Table 2, "Health Insurance Coverage for the Non-Elderly," p. 9. According to Custer, 7.08 million of Ohio's 7.62 million non-elderly, privately insured Ohioans obtain their insurance through their employer.

[15] Jensen and Morrisey, p. 9.

[16] See Frank A. Sloan and Chrisopher J. Conover, "Effects of State Reforms on Health Insurance Coverage of Adults," *Inquiry*, Vol. 35, No. 3 (Fall 1998), pp. 280-293.

[17] Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review*, Vol. 84, No. 3 (1994), pp. 622-641.

[18] P.F. Cooper and B.S. Schone, "More Offers, Fewer Takers," *Health Affairs*, Vol. 16, No. 6 (1997), pp. 142-9.

[19] Jonathan Gruber, "State-Mandated Benefits and Employer-Provided Health Insurance," *Journal of Public Economics*, Vol. 55 (1994), pp. 433-464. For the Virginia data, Gruber cites KPMG Peat Marwick, *Blue Cross and Blue Shield of Virginia Mandated Benefits Study: Final Report* (BC/BS of Virginia, mimeo, 1989); for the Massachusetts data he cites Blue Cross and Blue Shield of Massachusetts, *Mandated Benefits: Impact on Group Master Medical Rates* (BC/BS of Massachusetts, mimeo, 1990); and for the Maryland data he cites Blue Cross and Blue Shield, *Mandated Benefits Study* (BC/BS of Maryland, mimeo, 1988).

[20] Gail A. Jensen and Jon R. Gabel, "State Insurance Regulation and an Employer's Decision to Self-Insure," *Journal of Risk and Insurance*, Vol. 62, No. 2 (1995), pp. 185-213.

[21] 29 U.S.C.A. 1001. Firms self-insuring incur reporting and disclosure requirements as well as duties and standards for fiduciaries. They also avoid the following: (1) state licensing requirements, (2) state minimum capital requirements, (3) minimum reserve standards, (4) coverage requirements, (5) restrictions on underwriting, (6) prohibitions

on unilateral reduction or termination of benefits during the plan year (unless the plan itself provides otherwise), and (7) premium rate adequacy requirements or any other premium regulation. See Edward F. Shay, "Regulation of Employment-Based Health Benefits: The Intersection of State and Federal Law," in Marilyn J. Field and Harold T. Shapiro, eds., *Employment and Health Benefits: A Connection at Risk* (Washington, D.C.: National Academy Press, 1993), pp. 293-322.

[22] Bachman, p. 2. This report accepts that estimate and uses it to arrive at different conclusions. The Ohio Department of Health estimates that 40% of Ohioans are covered under ERISA. See *State Health Resources Plan, 1999* (Columbus, Ohio: Ohio Department of Health, December 1998), p. 105.

[23] Francisosi, Ogle, and Block (1998).

[24] Custer, p. 11.

[25] Helen R. Burstin, Katherine Swartz, Anne C. O'Neil, E. John Orav, and Troyen A. Brennan, "The Effect of Change of Health Insurance on Access to Care," *Inquiry*, Vol. 35, No. 4 (Winter 1999), p. 393.

[26] Burstin *et al., op. cit.*, pp. 389.

[27] *Ibid*.

[28] Melinda L. Schriver and Grace-Marie Arnett, "Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations," *Heritage Foundation Backgrounder No. 1211* (August 14, 1998), p. 28. Produced by The Galen Institute.

[29] "Comprehensive parity" is defined by Bachman as "financial parity with mental health and substance abuse benefits reimbursed under health insurance plans on the same basis as medical/surgical benefits," Bachman, p. 3.

[30] Merrile Sing and Steven Hill, "Parity Study Background Report #3: Actuarial Assumptions," Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, DHHS publication no. SMA-983205 (1998).

[31] Bachman, p. 3.

[32] Robert J. Franciosi, "The Cost of Mental Health Parity in Oklahoma," *OCPA Policy Paper* (Oklahoma City: Oklahoma Council of Public Affairs, March 1999), p. 10. See also Robert Franciosi, Melinda L. Ogle, and Michael K. Block, "The Cost of Mental Health Parity in Arizona," *Arizona Issue Analysis 151* (Phoenix: Goldwater Institute, 1998).

[33] Nan Heim and Jody Fischer, "OPA continues to fight for mental health parity," *Capitol Notes* (Oregon Psychological Association, n.d.).

[34] Milt Freudenheim, "Health Insurers Seek Big Increases in Their Premiums," *The New York Times* (April 24, 1998). See also Monte Williams, "H.M.O. Cutbacks Strand Thousands of Clients," *The New York Times* (November 17, 1998); and Peter T. Kilborn, "Reality of H.M.O. System Does Not Live Up to Hopes for Health Care," *The New York Times* (October 5, 1998); Rhonda L. Rundle, "California Retirement System to Pay Rate Rises of 9.7% to HMOs Next Year," *The Wall Street Journal* (May 20, 1999), p. A11.

[35] Ronald E. Bachman, *An Actuarial Analysis of Non-Mandated Catastrophic Mental Health and Substance Abuse Benefits and Other Options for Improved Coverages in the State of Missouri*, Appendix A, "Additional Information on Parity Options," in *Report of the Joint Interim Committee on Mental Health Insurance and Availability*, State of Missouri (January 1999); and Mental Health Parity Task Force Final Report, Alaska Task Force on Parity for Mental Health, State of Alaska (February 1999), pp. 10-11.

[36] See Ron Winslow, "Health-Care Inflation Revives in Minneapolis Despite Cost-Cutting," *The Wall Street Journal* (May 19, 1998), p. A1; and Miles Benson, "Medical Inflation on Rise Again," *Arizona Republic* (March 15, 1998), p. H1.

[37] Kathleen O'Leary, Scott Morgan, and Mark A. Uhlig, eds., *Health Care State Rankings 1998* (Lawrence, Kan.: Morgan Quinto Corporation, 1998), p. 297.

[38] O'Leary, *et al*., *op cit*., p. 305.

[39] O'Leary, *et al*., *op cit*., p. 302.

[40] See Robert M. Goldberg, "Why HMOs Now Love Regulation," *Wall Street Journal*, July 17, 1998.

[41] Ohio Department of Health, *State Health Resources Plan, 1999* (Columbus, Ohio: Ohio Department of Health, December 1998), p. 105.

[42] See Sing and Hill.

[43] Stephen A. Woodbury and Daniel S. Hammermesh, "Taxes, Fringe Benefits and Faculty," *Review of Economics and Statistics*, Vol.. 74 (1992), pp. 287-296.

[44] See Emmett B. Keeler, et al., "The Demand for Episodes of Mental Health Services," RAND Corporation R-3432-NIMH (1986); and Carl A. Taube, Larry G. Kessler and Barbara J. Burns, "Estimating the Probability and Level of Ambulatory Mental Health Services Use," *Health Services Research*, Vol. 21, No. 2 (June 1986), Part II, pp. 321-340; Franciosi (1999).

[45] As Harvard University law professors Louis Kaplow and Steven Shavell show, any "policy evaluation that gives any weight to principles or factors independently of their effect on individuals' utility might lead to choices under which everyone is worse off." Louis Kaplow and Steven Shavell "Any Non-Individualistic Social Welfare Function Violates the Pareto Principle," *NBER Working Paper 7051* (Cambridge, Mass.: National Bureau of Economic Research, March 1999), p. 4.

[46] *Ibid*.

Appendix Increase in uninsured due to mental health parity mandate

Scenario		Low		High	
Percent Covered by ERISA		60	40	60	40
Payment Plan	% of insured	Premium Increase		Premium Increase	
FFS	15	4.2 %	6,098	9,148	9.9 %	14,375	21,562
MI	25	3.4	8,228	12,342	*	*	*
PPO / POS	35	3.3	11,180	16,771	10.0	58,080	87,120
HMO	25	1.9	4,598	6,897	2.9	6,316	9,474
TOTAL		**3.1 %**	**30,104**	**45,158**	**7.9 %**	**79,752**	**119,634**

Key: FFS fee-for-service provider
MI managed indemnity provider
PPO / POS preferred provider organization / point-of-service provider
HMO health maintenance organization

Note: Merrile Sing and Steven Hill in "Parity Study Background Report #3: Actuarial Assumptions," U.S. Department of Health and Human Services (1998), cite a Price Waterhouse study with a different distribution of insured among the various payment plans. If its distribution is used, then the total number of uninsured arising from a mental health mandate would be higher under the low scenario. With 60% of Ohioans under ERISA, there would be 32,187 uninsured. With 40% of Ohioans under ERISA there would be 48,280

uninsured. Since the Price Waterhouse study did not include a managed indemnity category, the distribution of insured under the high premium increase was assumed to be 20% for FFS, 50% for PPO and POS, and 30% for HMO.