



Mental Health Parity, The Patient's Bill of Rights and Small Firms: Where Do We Stop?

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I. Introduction

The recently proposed Patients Bill of Rights (PBOR) will not help persons who are already uninsured. Nor will it help many small employers who are having trouble keeping their health insurance because of escalating costs and lower profits, whether from higher costs of prescription drugs, supplier costs, or labor costs. When the additional cost of the mental health parity reauthorization is added into already expensive (and escalating) health insurance costs, the result is often a further loss in profit by small business owners who are trying to survive during these uncertain times. According to an analysis by the Health Insurance Association of America, the high priced version of the PBOR will cause 6.5 million more people to lose their employer-sponsored health insurance.² Many of these will be in small firms.

This paper uses NFIB's new Regulatory Impact Model (RIM) to estimate the separate effect of the mandated mental health benefit, which may be a part of the proposed PBOR.³ While a variety of results come from the RIM model simulations, it is clear that the mandated PBOR will cost jobs, reduce small firm profits and cause additional firms to drop their health insurance—where everyone loses. As discussed further below, the Lewin group has demonstrated that every one percent increase in health cost premiums causes 300,000-400,000 individuals to lose their health care coverage.⁴

It has been estimated that of uninsured workers, 60 percent work in smaller firms.

¹ I wish to thank Lara Chamberlain and John Emling for comments on an earlier draft.

² Health Insurance Industry Association of America, "Under Dingell-Ganske-Norwood Bill 6.5 Million More Americans Would Lose Health Coverage," Press Release, July 18, 2001. HIAA also estimates that 5 percent of employers would also drop health insurance between 2002 and 2003, while a significant percentage of employees with incomes under 200 percent of the federal poverty standard would not be able to afford the increased co-pays associated with higher insurance costs.

³ For further, detailed information on NFIB's new Regulatory Impact Model (RIM), see "The Regulatory Impact Model (RIM) System Manual (NFIB Education Foundation, Washington, D.C., forthcoming September, 2001).

⁴ Need reference here.

While the RIM model cannot tell us with precision the sensitivity of small business owners to price increases in the cost of health insurance, it is likely that future price increases—especially in a slow growth economy—will cause significant numbers of business owners to consider dropping their health insurance. Put simply, for whatever the reason, as the cost of health insurance continues to escalate, there is a rising probability that small employers will have no choice but to drop their health coverage to survive.

II. Pre-PBOR: What Do We Know Now?

States such as Texas and Mississippi have had PBOR laws on the books for several years, and Congress is closely looking at these states to try and determine what the additional impacts might be if a federal PBOR becomes law. Our interest in the NFIB Education Foundation in particular is trying to determine additional negative small employer effects likely to result from such a bill. The following case demonstrates that small firms have already been exposed to needless lawsuits.

Consider the Mississippi experience. To keep a case in Mississippi, plaintiffs must at least have one Mississippi resident or company as a defendant. Jefferson County, Mississippi has only one drugstore, Bankston Drug Store, and it has been named in lawsuits against drug companies. Although it has never been found liable, the store has “incurred sizeable legal expenses.” One of the stores owners, Hilda Bankston, has said,

“It’s crazy. Our only role is that my husband filled prescriptions correctly. But we’ve been bombarded with lawsuits by everybody and their cousin.”⁵

While perhaps not typical, Jefferson County has only 9,740 residents and more than 21,000 people were plaintiffs in the county between 1995 and 2000, according to the national Blue Cross/Blue-Shield Association.⁶ While some of this is blamed on the below average education of the residents, it is not hard to see where the PBOR could go, in that small drug stores will become involved in lawsuits *only* because they happen to be doing business in a particular location.

The potential for abuse is enormous and could well drive innocent retail stores out of business due to no fault of their own.

The Texas experience has been more positive, possibly because of the several independent review processes set up by the law. In 1997, the Texas legislature passed the Health Care Liability Act. As of August 2001, there have only been 20 lawsuits under the law. However, 1,349 people requested HMO reviews under the law, with 58 percent of the decisions overturning HMO decisions.⁷ There is no data available as to the cost of the reviews or the

⁵ New York Times, August 20, 2001.

⁶ “Patients Rights: Mississippi is Lawsuit Mecca.” [National Journal .com](http://www.nationaljournal.com), August 21, 2001.

⁷ “Texas Has Long Had “Patients Bill of Rights.” <http://www.healthy.net/asp/templates/news.asp?id=2757>

lawsuits. In order to make a judgment as to the potential costs of a federal PBOR law, specific state cost information is needed.⁸

III. Extending the 1996 Mental Health Parity Act

The Mental Health Parity Act (P.L. 104-204) passed in 1996 required that employers that provide health insurance treat physical health benefits similarly to mental health benefits. Firms with fewer than 50 workers were exempt at the time the law was signed. The result of this act was that firms' mental health coverage increased fairly rapidly between 1991 and 1995, in anticipation of the passage of the original act.⁹ By 1995, 89 percent of employers with 51-199 workers who offered a health plan also offered mental health coverage. Virtually, all firms with 200 or more employees also offered mental health coverage.¹⁰ Somewhat surprisingly, small employers with fewer than 50 employees also offered mental health insurance about 80 percent of the time.

Therefore, Jensen et al concluded in 1998 that state mental health mandates made it no more likely that small employers who offered health plans would offer a mental health benefit than those employers in states without mandates. However, to compensate for offering the mental health benefit, many employers also lowered the "depth" of benefits by using increased co-pays, coverage limitations, visit limitations and more gatekeepers.

How much did the additional mental health coverage cost? Very few estimates are available, but Acs, Winterbottom and Zedlewski put the additional increased cost between 4 and 13 percent per participant per state, depending on location, firm size and type of health plan.¹¹ Therefore, in the analysis described below using the RIM model, it was assumed that the average cost increase caused by extending the mental health parity law to firms with less than 50 employees would be 8.5 percent—or about the midpoint of the cost increases in states surveyed by the researchers. Since three quarters of that increase is assumed to be paid by business owners, the resulting cost increase is about 6.4 percent.

In another study done for the National Institutes of Health by Mathematica, Inc, in 1998, the annual increased cost of the Mental Health Parity Act of 1996 was about 0.5 percent for persons in HMO's, to 5 percent in traditional fee for service plans. At that time, the authors admitted the increases might be low or high, but could not be predicted with great accuracy depending upon the secondary effects of the changing insurance market (e.g. the switching of companies from traditional fee for service plans to HMO's and PPO's).¹²

⁸ As of September, 2001, there are nine states which have some version of a PBOR "on the books." While it is too early to know how the costs of these laws pass through in higher premiums, it is certainly possible that better HMO decisions have resulted in a lower probability of lawsuits. However, the precise increase in HMO costs associated with these PBOR laws is still evolving.

⁹ Gail A. Jensen, Kathryn Rost, Russell P.D. Burton and Maria Bulycheva, "Mental Health Insurance In the 1990's: Are Employers Offering Less To More?" *Health Affairs*, May/June, 1998, pp. 201-208.

¹⁰ Jensen, et al, op. cit.

¹¹ The ACS Et Al study was published in 1992 and cited in Gail A Jensen and Michael A Morrisry, "The Milbank Quarterly," 77 (4), 1999.

¹² National Advisory Mental Council, National Institutes of Health, "Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access and Quality: A Report to Congress, May, 1998, pp. 14-15.

There is also one major demographic trend which seems to eradicate the small 1-2 percent cost increases coming out of the Congressional Budget Office and the American Psychiatric Association, based on a recent study done by PriceWaterhouseCoopers, under contract. It is well known that basically two parts of the population disproportionately use mental health services. These are teenagers and adults over 50 years of age. Since Census population and labor force projections show large increases in the latter due to the aging of the baby boom generation, it is highly likely that the demand for mental health services will be rising rapidly in the future. Therefore, cost projections based upon the past usage of such services are unlikely to be valid, and we have therefore used the higher cost assumption in the RIM model.

IV. Estimating the Effects of Further Mental Health Mandates—together with the PBOR—2001

This section describes the use of the RIM model to analyze the impact of extending the mental health mandate to all small firms and to firms with 25-49 employees. This was accomplished by dividing industries into sectors and associating the increased costs with different sized firms in each sector. These cost increases will be shown in tables below. In addition, the RIM modeling effort allowed a variety of assumptions regarding regulatory compliance.

Using the RIM model, the effect of extending the PBOR's mental health mandate to all firms was estimated. The data sources included employer cost information by industry and firm size from the Kaiser Family Foundation (KFF)¹³, firm size data from the SBA¹⁴, data on per capita mental health expenditures from the web sites of the National Institute of Mental Health¹⁵, the Blue Cross Blue Shield Industry Association¹⁶ and the Employment Benefit Research Institute (EBRI).¹⁷

To meet the requirements of the RIM model, cost data had to be developed by major industry and firm size. Due to differences between the required RIM size classes and the categories for which data was available, many assumptions had to be made. For example, small firm categories in the KFF study were defined as those having 3-9, 10-24, 25-49 or 50-199 employees; large firms had 200-999 employees. In the RIM model, small firms have less than 20, less than 100 or less than 500 employees. Therefore, data for different size categories had to be made to match and assumptions were made.¹⁸

In addition, based upon common practice, we assumed that 75 percent of any additional health care costs would be paid by employers and that 25 percent by employees. (This is standard in many plans, but can vary). It was also assumed (based upon KFF data) that 60 percent of small firms with less than 10 employees offered health insurance in 2000, and that would not change in

¹³ Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2000 Annual Survey (Menlo Park, CA, October, 2000).

¹⁴ Found on the SBA Web-Site at www.sba.gov/advo/stats.

¹⁵ Found on the NIMH Web-Site at www.nimh.gov

¹⁶ <http://bcbshealthissues.com/proactive/newsroom/> various issues

¹⁷ Paul Fronstin and Ruth Helman, "Small Employers and Health Benefits: Findings from the 2000 Small Employer Health Benefits Survey." (Washington, D.C. EBRI Issue Brief 226 and Special Report SR 35, October 2000).

¹⁸ These assumptions are listed in Tables __ and ____.

the immediate future, *absent further mandates*.¹⁹ When larger firm size categories were included, such as owners with 10-24 and 25-49 employees, the *weighted average* of small employers offering health insurance was 65.2 percent. Since the RIM model requires a regulatory “compliance rate” in order to become operational, the 65.2 percent rate was used as a compliance rate.²⁰

By major industrial sector, the percentage of small employers offering health insurance in the RIM modeling exercise ranged from 55 percent in retail trade to 93 percent in manufacturing.²¹ Based upon the data sources and assumptions made above, we developed an assumed Annual Additional Cost by Industry and Firm Size: Mandated Mental Health Mandates. The RIM model was run with different compliance rates and cost assumptions for each major industry sector.

For the smallest employers with 3-9 employees, the additional direct costs caused by the mental health mandate were \$1,558 on average per worker in manufacturing firms to \$1,118 extra dollars per worker in construction, mining and agricultural services.²² These costs, as well as others by firm size, were then entered into the RIM model to calculate further indirect and induced costs.

V. Output from the RIM Model²³

A number of different simulations were run from the RIM model. Compliance rates varied from 65 percent to 100 percent, while the percentage of business owners complying with a mental health mandate varied from 40 to 80 percent to test for the sensitivity of the RIM model. Some of the major conclusions are below.

1. In terms of jobs and income lost in the economy, the compliance rate had the most influence. The percentage of each industrial sector providing health insurance had smaller impacts.
2. When compliance rates were reduced from 80 percent to 40 percent (e.g. 60 percent of each industrial sector still had to comply with the mandate), job losses in the overall economy rose from the 100-400 range during the first few years of the mandate to 1,000-2,000 jobs during those same years. Job losses came from all sectors, but retail sectors lost 3,000-4,000 jobs during

¹⁹ While about 65 percent of small firms offer health insurance, about 20 percent of employees turn down such insurance because a parent, spouse or other source covers them. There, the “take up rate” of insurance in very small firms is closer to 40-45 percent.

²⁰ Actually, if 65 percent of small firms offer health insurance, and about 80 percent *of that group* offer a mental health benefit, then 80 percent of 65 percent or 52 percent of *all* small firms are already in compliance. The RIM model allows compliance rates to vary.

²¹ The differences are a result of the greater proportion of full-time employees in manufacturing, as well as the greater likelihood of unionization in manufacturing as well as wholesale trade. The data is from KFF (2000), pp. 35. exhibit 3.3.

²² These numbers were derived by using 8.5 percent (.085) of the average cost of annual family health coverage costs in 2000 by sector. It was then assumed that employers would pay three quarters of the increased cost, and employees would pay the remaining quarter. The modeling activity did not specifically include farms. Firm size in the first category of 3-9 employees was determined by a weighted average between firms with 1-4 and 5-9 employees. A similar calculation was made for each firm size group.

²³ The discussion below is only a summary. Detailed tables are in the appendix.

most of the forecast years, which were set at 2001-2010. Probably the most realistic result is a job loss in the aggregate economy in the 2,000 range per year.

3. The major sector that gained from the mental health mandate was the health services sector, which gained from 2,000-7,000 jobs annually, based upon the varying compliance rates. This might be called the “psychiatric relief benefit” from the model. Apparently Say’s law in economics still works: supply creates it’s own demand.

4. The RIM model shows that income is taken out of the aggregate economy to fully comply with mental health mandates. Approximately \$66 million is removed from the economy to pay for the health care mandate during the first year it is imposed and \$40 million during the second year. These income losses appear as lost purchasing power in other sectors (such as retail trade and construction) and contribute to employment losses in these sectors.

5. As a result of the mental health mandate, consumers and businesses have about \$200 million dollars a year less to spend. While this might not sound like much in a \$17 trillion dollar economy, it is only the cost of ONE regulation isolated from an average regulatory cost of almost \$7,000 per employee for firms with fewer than 20 employees.²⁴

VI. Summary and Conclusions

So long as health insurance is tied to employment, mandates that increase the burden on employers will invariably have negative effects on business owners and employees. The RIM model provides NFIB with a tool to investigate the validity of the assumption that health care costs will rise only about one percent, according to the Congressional Budget Office, when a mental health mandate is extended to firms with 25-49 employees and ultimately to all business owners.

Because extending the mental health mandate is part of the proposed PBOR, it is highly likely that small business owners will unfortunately be involved in lawsuits with which they should have no involvement at all. After all, employers are only the *mechanism* through which health care is delivered in this country, not a health care provider, a judge, or a jury. Nor should they be.

The evidence reviewed to date from the enactment of the 1996 Health Care Parity Act has indicated that costs have risen in the range of 3-6 percent, depending upon the kind of health care plan, it’s location and the industry in question. If our cost estimates are at the higher end of the cost increases, then about 2.4 million employees could directly lose health insurance, with another few thousand indirectly impacted through the RIM calculations.²⁵

²⁴ The regulatory cost for firms with less than 20 employees is from W. Mark Crain and Thomas D. Hopkins, “The Impact of Regulatory Costs on Small Firms.” Prepared for the Office of Advocacy of the U.S. Small Business Administration under contract, August 2001.

²⁵ For a good discussion on understanding the difficulty of estimating the indirect costs of regulation see, “Joseph Johnson, “A Review of and Synthesis of the Cost of Workplace Regulations.” Mercatus Center, George Mason University, August 30, 2001.

As the American work force ages, there *is* agreement that the demand for mental health care benefits will rise. Someone has to pay for that increase, assuming that employers are still able to afford to provide health insurance. A rising demand for a service usually implies a cost increase and the increase will likely hurt some of the very same people the PBOR is intended to help – lower paid employees working in very small firms who will no longer have access to health insurance.

The models used to estimate the impact of additional mental health mandates have studied this regulation in isolation. But with more and more regulations being applied to smaller employers, unintended cost increases are threatening the very firms whose employees whom the PBOR and the mental health parity acts are designed to help.