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November 13, 2023

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Senator Jared Carpenter, Co-Chair
Representative Michael Meredith, Co-Chair
Interim Joint Committee on Banking and Insurance
700 Capitol Ave., Room 445
Frankfort, KY 40601

RE: Bi-annual report on Impact of Mental Health Parity on Health Insurance Cost in Kentucky

Dear Sirs:

As required by KRS 304.17A-665, the Commissioner of the Department of Insurance respectfully submits the following report on the impact of KRS 304.17A-660 to KRS 304.17A-669 since the previous report submitted in 2021.

Sincerely,

Sharon P. Clark
Commissioner of Insurance

SPC/ksh

cc: Ray Perry, Secretary of the Public Protection Cabinet
Shawn Boggs, Deputy Commissioner, Kentucky Department of Insurance

COMMONWEALTH OF KENTUCKY

PUBLIC PROTECTION CABINET

Department of Insurance

The Impact of Mental Health Parity on Health Insurance Cost in Kentucky

November 13, 2023

Sharon P. Clark
Commissioner

The Impact of Mental Health Parity on Health Insurance Cost in Kentucky

I. Background

Kentucky Law

The General Assembly enacted Kentucky's mental health parity law during the 2000 session. Kentucky law came after the passage of a federal law known as the Mental Health Parity Act of 1996. The Kentucky law applies to the large group market and requires an insurer offering a health benefit plan that provides coverage for the treatment of mental health conditions to provide this coverage under the same "terms and conditions" as the coverage of physical health conditions. KRS 304.17A-660 defines "terms and conditions" to include day and visit limits, deductibles, copayments, prescription coverage, coinsurance, out-of-pocket limits, and any other cost-sharing requirements.

Like the federal law, the Kentucky law does *not* require large group insurers to cover mental health benefits. However, the Kentucky law is more restrictive than the Mental Health Parity Act of 1996, which only addressed parity associated with lifetime and annual limits.

Recent Amendments to Federal Law

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) amended the Mental Health Parity Action of 1996. MHPAEA requires that a large group health benefit plan that provides both medical/surgical benefits and mental health/substance abuse benefits ensure that financial requirements and treatment limitation applicable to *mental health and substance abuse disorder benefits* are no more restrictive than those requirements and limitations placed on medical and surgical benefits. These federal parity requirements apply to all financial requirements, including deductibles, copayments, coinsurance, and out-of-pocket expenses, out-of-network benefits and to all treatment limitation, including frequency of treatment, number of visits, days of coverage, or other similar limits.

Again, it should be noted that mental health or substance use benefit coverage are not mandated under MHPAEA. However, if a large group health benefit plan offers such coverage, the coverage must be provided in the same manner as coverage for the physical health benefits.

Both the 1996 and 2008 federal acts allowed exemptions due to increased cost. If a large group health benefit plan experiences an increase in actual total costs with respect to medical/surgical and mental health/substance use benefits of 1 percent (2 percent in the first plan year that the Act is applicable), the plan can be exempted from the law. No such exemption is available under the Kentucky law.

In March of 2010, the Affordable Care Act (ACA) was passed into federal law. The ACA required all non-grandfathered individual and non-grandfathered small group products to provide Mental Health and Substance Abuse services beginning in January 2014. The ACA required the mental health and substance abuse services, without pre-existing limitations as well as cost share and limitations to be in compliance with MHPAEA. As such all non-grandfathered individual and non-grandfathered small group products began offering mental health and substance abuse services to their members effective January 1, 2014.

II. Impact of Mental Health Parity on Health Insurance Costs

KRS 304.17A-665 requires the Commissioner of Insurance to provide the Legislative Research Commission with information on the impact of mental health parity on health insurance costs prior to even-numbered year regular sessions. Over the years, compliance with this requirement has been problematic due to the lack of specific data. The Kentucky Act does not include a specific provision for the collection of data relating to the impact of mental health parity laws on health insurance costs. Furthermore, the Kentucky Insurance Code does not otherwise require insurers offering health benefit plans through individual, small or large employer groups to specifically report data relating to mental health parity costs.

III. Claim Costs Associated with Treatment of Mental Health as a Percentage of Total Claims Costs for Large Group for 2009 through 2017

KRS 304.17A-330 requires all insurers authorized to write health insurance in this state to submit annual data relating to the payment of claims for health and medical services provided under a health benefit plan issued to large groups. Therefore, cost of claims for health and medical services, including mental health services, reported by insurers for calendar years 2011 to 2017 were analyzed to determine mental health care cost compared to total health care cost for large group health benefit plans.

For the purposes of this analysis, it will be assumed that all large group health benefits plans issued from 2011 to 2017 provided mental health benefits. Note the following data as reported for the years indicated:

Dollar Amounts Paid for Insurance Claims (in thousands)
Data is for Large Group

Year	Total Claims Paid by Insurer	Total Claims Paid by Insured	Total Combined Claims	Behavioral Health Claims Paid by Insurer	Behavioral Health Claims Paid by Insured	Total Combined Behavioral Health Claims
2017	$640,790	$167,724	$808,514	$5,402	$2,733	$8,135

2016	$697,117	$180,749	$877,866	$5,392	$2,885	$8,277
2015	$731,084	$190,066	$921,150	$7,933	$3,337	$11,270
2014	$658,323	$180,738	$839,061	$4,756	$2,261	$7,017
2013	$693,310	$187,378	$880,688	$3,099	$1,509	$4,608
2012	$711,575	$178,620	$890,195	$3,496	$2,134	$5,630
2011	$704,504	$182,875	$887,379	$3,531	$1,923	$5,454
2010	$684,587	$182,018	$866,605	$3,122	$1,912	$5,034
2009	$701,094	$178,839	$879,933	$3,359	$2,000	$5,359
Total	$5,303,893	$1,404,469	$6,708,362	$42,735	$20,689	$63,424

On average, over this nine-year period, behavioral health claims represent 0.91 percent of total claims for Large Groups 2009 through 2017

IV. Claim Costs Associated with Treatment of Mental Health as a Percentage of Total Claims Costs for Individual, Small and Large Groups

The Affordable Care Act required all non-grandfathered individual and non-grandfathered small groups to provide mental health and substance abuse services beginning in 2014. KRS 304.17A-330 requires all insurers authorized to write health insurance in this state to submit annual data relating to the payment of claims for health and medical services provided under a health benefit plan issued in Kentucky. Therefore, cost of claims for health and medical services, including mental health services, reported by insurers for calendar years 2016 to 2022 were analyzed to determine mental health care cost compared to total health care cost for individual, small and large group health benefit plans. For the purposes of this analysis, it will be assumed that all individual, small and large group health benefits plans issued from 2016 to 2022 provided mental health benefits. Note the following data as reported for the years indicated:

Dollar Amounts Paid for Insurance Claims (in thousands)
Data is for Individual, Small and Large Groups

Year	Total Claims Paid by Insurer	Total Claims Paid by Insured	Total Combined Claims	Behavioral Health Claims Paid by Insurer	Behavioral Health Claims Paid by Insured	Total Combined Behavioral Health Claims
2022	$2,214,312	$530,008	$2,744,320	$26,343	$12,148	$38,491
2021	$1,989,593	$506,854	$2,496,447	$21,178	$9,310	$30,488
2020	$1,805,998	$418,603	$2,224,601	$17,830	$6,054	$23,884
2019	$1,962,305	$500,349	$2,462,654	$17,019	$7,765	$24,784
2018	$1,883,269	$497,814	$2,381,083	$16,153	$7,964	$24,117
Total Years	$9,855,477	$2,453,628	$12,309,105	$98,523	$43,241	$141,764

On average, over this five-year period, behavioral health claims represent 1.15 percent of total claims.

In addition to the analysts of the cost of claims for health and medical services, including mental/behavioral health services, the department analyzed the cost per member per month for all health care services, as compared to the cost per member per month for mental health services during 2022. In 2022, the cost per member per month was $590.84. Of the $590.84, a total of $8.68 per member per month (1.47 percent) was spent on mental health care.

V. Conclusion

Based upon the data provided, it appears that the cost of mental health care continues to fluctuate annually. There is no clear pattern or evidence that mental health parity laws have dramatically affected the overall health care costs since implementation in 2000. The Department will continue to monitor complaints and costs related to mental health care coverage. Since the recent passage of MHPAEA, it is likely that mental health care coverage will remain a topic for analysis in the future.