

HCR

21

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: April 30, 1997

FURTHER REFERRALS:

Date of Committee Action: 3/19/98

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HCR 21

HOUSE CONCURRENT RESOLUTION NO. 21 PARITY FOR MENTAL HEALTH TASK FORCE

Establishing the Alaska Task Force on Parity for Mental Health.

recommends it be replaced with the following committee substitute CS HCR 21 (HES) the same title a new title

additional referral to _____ Committee
 attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept) _____ APPROVES PREVIOUS: (Dept/Date) _____
 fiscal note(s) _____ fiscal note(s) _____

zero fiscal note(s) House HESS Com. zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
<i>[Signature]</i>			✓	
<i>[Signature]</i>	✓			
<i>[Signature]</i>	✓			
<i>[Signature]</i>			✓	
<i>[Signature]</i>	✓			

CHAIR'S SIGNATURE *[Signature]*

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. HCR 21

Revision Date:

Title: ESTABLISHING THE ALASKA TASK
FORCE ON PARITY FOR MENTAL HEALTH

Dept. Affected

BRU

Sponsor: HOUSE HESS COMMITTEE

Component

Requester: HOUSE HESS COMMITTEE

Component Serial No.

Expenditures/Revenues

(Thousands of Dollars)

OPERATING EXPENDITURES	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES []						
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FUND SOURCE

(Thousands of Dollars)

FUND SOURCE	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1091 Designated Program Receipts						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY97) cost:

0.0

POSITIONS

POSITIONS	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Full-time						
Part-time						
Temporary						

ANALYSIS:

(Attach a separate page if necessary)

THERE WILL BE NO IMPACT TO THE GENERAL FUND.

Prepared by
Division
Approved by
Agency

REPRESENTATIVE CON BUNDE
HOUSE HESS COMMITTEE CHAIRMAN

C. Bunde

Phone 465-3759
Date _____
Date 3/13/98

CS FOR HOUSE CONCURRENT RESOLUTION NO. 21(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:

Referred:

Sponsor(s): HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

A RESOLUTION

1 Establishing the Alaska Task Force on Parity for Mental Health.

2 BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

3 WHEREAS persons in Alaska with mental health disorders and their families face
4 disparity in the adequacy, scope, and coverage of private health insurance that they need; and

5 WHEREAS it is estimated that mental health disorders cost the Alaska economy
6 \$187,272,000 in 1996 in lost productivity, absenteeism, disability, and early death; and

7 WHEREAS other states that have adopted insurance parity laws for mental disorders
8 have demonstrated that costs of parity have been far less than projected and that savings to
9 the public through decreased costs of Medicaid, Medicare, and other programs have far
10 outweighed the additional costs; and

11 WHEREAS the Alaska Mental Health Board estimates there are over 44,000 children,
12 youth, and adults in the state who experience serious mental illnesses and emotional disorders;
13 and

14 WHEREAS the Congress passed the Mental Health Parity Act of 1996 that does
15 address parity for lifetime benefits and annual reimbursement limits for mental health services,
16 but does not address differentiation between mental and physical illnesses with respect to co-
17 payments, deductibles, and benefit design; and

1 **WHEREAS** 15 other states have established laws addressing mental health parity in
2 insurance practices, and 25 other states introduced bills on the subject in 1997;

3 **BE IT RESOLVED** by the Alaska State Legislature that the Alaska Task Force on
4 Parity for Mental Health is established for the purpose of studying, after defining the terms
5 "mental disorders," "mental illness," "serious mental illness," and "mental health consumers"
6 for purpose of its work,

7 (1) differential treatment in health insurance coverage between a person with
8 a mental disorder and a person with a physical disorder;

9 (2) costs of mental health coverage in relation to other health care insurance,
10 with special emphasis on parity, and the extent of such coverage, including deductibles and
11 co-payments, disorders and conditions to be covered, and other pertinent issues;

12 (3) ways to define and quantify unmet mental health needs in the state and
13 recommending meaningful ways to measure the efficacy of treatment of mental health needs
14 by analyzing possible outcome data collection measures;

15 (4) the positive and negative effects on mental health consumers if parity for
16 mental health coverage is mandated in Alaska;

17 (5) the feasibility of implementing any recommendations of the task force
18 through legislation; and

19 (6) the effect of the September 30, 2001, sunset date for the Mental Health
20 Parity Act of 1996 on matters set out in (1) - (5) of this clause; and be it

21 **FURTHER RESOLVED** that the task force shall be composed of 11 members, as
22 follows:

23 (1) two members of the Senate appointed by the President of the Senate; one
24 member shall be a member of the majority, and one member shall be a member of the
25 minority;

26 (2) two members of the House of Representatives appointed by the Speaker
27 of the House of Representatives; one member shall be a member of the majority, and one
28 member shall be a member of the minority;

29 (3) the commissioner of health and social services, or a designee;

30 (4) two members representing the Alaska Mental Health Board appointed by
31 the Alaska Mental Health Board;

1 (5) two members representing the insurance industry appointed by the President
2 of the Senate and the Speaker of the House of Representatives; one member may be the
3 director of insurance; and

4 (6) two members representing mental health consumers and community-based
5 mental health providers appointed by the President of the Senate and the Speaker of the House
6 of Representatives; one member shall be a consumer, and one member shall be a provider; and
7 be it

8 **FURTHER RESOLVED** that no general fund money shall be expended to support
9 the task force; and be it

10 **FURTHER RESOLVED** that a simple majority of the members of the task force shall
11 constitute a quorum for the transaction of business, and all actions of the task force shall
12 require the affirmative vote of a majority of the members present; and be it

13 **FURTHER RESOLVED** that the task force may conduct its work during the
14 legislative session and the interim between sessions, may use the teleconference network, and
15 may conduct public hearings to receive testimony about issues relative to parity for mental
16 health; and be it

17 **FURTHER RESOLVED** that the task force shall provide to the Speaker of the House
18 of Representatives, the President of the Senate, and the Governor a report of its findings and
19 recommendations on these matters not later than January 1, 1999; and be it

20 **FURTHER RESOLVED** that the task force is terminated at 11:59 p.m. on
21 February 28, 1999.

ALASKA MENTAL HEALTH BOARD

*Tony Knowles, Governor
State of Alaska*

*431 N. Franklin Street, #101
Juneau, Alaska 99801
Office: (907) 465-3071
FAX: (907) 465-3079
TTY: (907) 465-4764*

January 21, 1998

Dear Senator or Representative:

This information is being provided to you by a steering committee made up of several organizations working together to ensure that parity for mental health is evaluated. We are committed to passage of SCR 14 and HCR 21, which establishes a task force on parity for mental health.

We believe the attached information will provide the basis for your support on this important issue.

For additional information, please contact Walter Majoros, Executive Director of the Alaska Mental Health Board, at 465-3071 or Sharon Macklin, Bridges lobbyist, at 586-9518.

Mental Health Parity Steering Committee Participating Organizations

Alaska State Hospital and Nursing Home Association
Alaska Community Mental Health Services Assoc.
DH&SS, Advisory Board on Alcohol and Drug Abuse
American Psychological Association, Alaska Chapter
Building Bridges Campaign for Mental Health
American Psychiatric Association, Alaska Chapter
Mental Health Association in Alaska
Substance Abuse Directors Association
Disability Law Center of Alaska
Alaska Mental Health Trust Authority
NASW, Alaska Chapter
Rural Mental Health Directors Association
Alaska Alliance for the Mentally Ill

mhparltr.1/98

Mental Health Insurance Parity

Why Consider it?

- ◆ Nine out of 10 insurance companies treat mental illnesses differently from other physical illnesses
- ◆ Mental illnesses are biological brain disorders & should be treated like other illnesses
- ◆ Mental Illness is treatable and treatment costs less than treatment of many other common physical illnesses
- ◆ The *cost* of mental health parity is *minimal* to non-existent! Based on *actual* data from states that have passed parity legislation

Mental Health Insurance Parity

Fact Sheet

General

- Nine out of 10 insurance policies treat mental health differently from physical health problems.
- In 1996 the federal government passed the Mental Health Parity Act, otherwise known as the Dominici Wellstone Law, which goes into effect in January 1998. This law provides partial parity regarding lifetime and annual limits, but there are significant loopholes. It does not provide true parity.
- Fifteen states have passed parity legislation, these states include: Texas, Maine, New Hampshire, Maryland, Rhode Island, Minnesota, Maine, Arkansas, Arizona, Colorado, Connecticut, Indiana, Missouri, South Carolina, and Vermont.
- In 1997, 34 states considered parity legislation, nine states passed legislation while additional states passed legislation in one body and will seek passage in the other body in 1998.

Mental Illnesses are Treatable

- Treatment for bipolar disorder has an 80-90% success rate, treatment of major depression 70-80% successful, and treatment of acute schizophrenia is 60% successful. Treatment of heart disease has just a 45-50% success rate and often requires expensive, dangerous surgery. (1)
- Treatment of mental illness is more affordable now than in the past. With new generations of medications continually being developed, there is increased precision in relieving symptoms and eliminating side effects associated with past treatments.
- The annual cost of treating a person with severe diabetes has been found to be more expensive than treating a person with schizophrenia. (1) In Texas, the total cost of treating state employees and family members with brain disorders was one-fifth the cost of treating cardiovascular disease. (2)
- About 2.8% of all adult Americans, some 5 million people, suffer from a brain disorder. Approximately 40% of those people do not or can not seek treatment, in part, due to a lack of adequate insurance coverage. (3)
- It is estimated that 90% of insurance companies offer less benefits for treatment of mental illness than other physical conditions.

Costs of Mental Health Parity

- A study by the Rand Corporation, published in the *Journal of the American Medical Association*, showed that equalizing annual limits - a key to the provision of the federal Mental Health Parity Act - will only increase costs by only \$1 per employee per year. (4)
- The same study showed that more comprehensive change required by some state laws (i.e. removing limits on inpatient days and outpatient visits) will increase costs by less than \$7 per enrollee per year. (4)
- Since the 1994 passage of the Rhode Island parity bill, premium costs have only increased by 30 cents per person per month. (5)
- In North Carolina, where they passed a parity bill 1992, total mental health costs have actually *declined* 3.4%. (6)
- Persons who have inadequate mental health coverage and need extensive mental health treatment often end up using public resources such as Medicaid and Medicare.
A total of \$26.6 billion was spent on treating severe mental illness in the US in 1990. 57% of all treatment costs for severe mental illness was paid by federal and state entitlement programs at tax-payers expense, whereas, Tax-payers pay only 43% of the costs of all other illnesses. (3)

Alaska

- Prior to the enactment of the federal legislation, the state of Alaska limited the mental health benefits available for their own employees to a \$25,000 *lifetime* maximum cost cap, while other medical services were covered up to a \$1,000,000 lifetime benefit.
- Many private insurance plan in Alaska have low annual limits on mental health benefits or require larger co-payment for mental health services (such as paying 50% of the cost for mental health services, while paying 70% to 90% for other medical services).

References

- 1.) National Advisory Mental Health Council, Health care reform for Americans with severe mental illness; report of the National Advisory Mental Health Council, *American Journal of Psychiatry*, 1993; 150: 1447-1465
- 2.) FY 94-96, HealthSelect of Texas, administered by Blue Cross-Blue Shield of Texas.
- 3.) National Institute of Mental Health
- 4.) Sturm, R. (1997). How Expensive is Unlimited Mental Health Care Coverage Under Managed Care? . *Journal of the American Medical Association*. 278:18, p.1533-1537
- 5.) Emmet, W., Alliance for the Mentally Ill, Rhode Island, April 1996
- 6.) Cameron, S., Executive Director, North Carolina Psychological Association, "State Health Plan Data on the Mental Health Benefit," April 30, 1996.

States that have Passed Parity

State	Enactment	Type of Bill	Effective On
Texas	1990	Diagnosis-Based; covers all state employees, including local, county, municipal, public higher education and public school employees.	09/01/91
Maine	1993	Diagnosis-Based; covers all groups of 20 plus employees; raised minimum benefits to 100K lifetime; 60 days annual inpatient; 2K outpatient	01/01/94
New Hampshire	1994	Diagnosis-based; applies only to groups & HMOs regardless of size	01/01/95
Maryland	1994	All mental health and substance abuse; medical treatment only	08/01/94
Rhode Island	1994	Diagnosis-based; all health care and HMO policies; in and outpatient equal	01/01/95
Minnesota	1995	All mental Health and chemical Dependency Services equal to in-patient and outpatient medical services	08/01/95
Maine	1995	Diagnosis-based; groups of 20 plus employees; all co-pays and caps, both annual and lifetime equal to all other medical coverage	07/01/96
Arkansas	1997	Equal coverage for mental health and developmental disorders; limitations are cost increase may not exceed 1.5%; only groups of 50 plus employees	06/01/97
Arizona	1997	Mental Illness, mirrors Federal Domenici-Wellstone law, no substance abuse	
Colorado	1997	Diagnosis-based; all co-payment and caps both annual and lifetime are equal to all other medical coverage	
Connecticut	1997	Diagnosis-based; all insurance and HMOs; coverage equal to medical / surgical	10/01/97
Indiana	1997	Mental illness, mirrors Federal Domenici-Wellstone law, no substance abuse and full parity for state employees; including co-pays, caps and lifetime limits	
Missouri	1997	All DSM-VI in managed care plans only; part of larger managed-care regulatory bill	09/01/97
South Carolina	1997	Mental illness, mirrors Federal Domenici-Wellstone law. no substance abuse	
Texas	1997	Diagnosis-based; employee groups of 50 plus; limitations: 60 outpatient visits & 45 inpatient days annually.	01/01/98
Vermont	1997	All mental health and substance abuse	01/01/98

STATES THAT HAVE PASSED PARITY

December 3, 1997

Senator Gary Wilken
Chairman
Senate Health & Social Services Committee
State Capitol, Room 128
Juneau, AK 99801-1182

The TRUST

The Alaska Mental Health Trust Authority

Dear Senator Wilken:

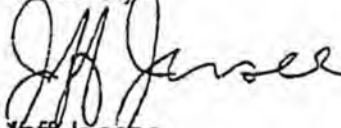
This is to inform you that the Alaska Mental Health Trust Authority has approved \$50,000 to fund the Mental Health Parity Task Force. The Trustees obligated these funds on July 22, 1997 contingent upon passage of SCR 14 or HCR 21 which establishes the Task Force.

The Trust supports addressing the issue of health insurance parity for mental health. It is our expectation that the Task Force would provide more clarity of state policy for mental health services and a report which will guide legislative activity addressing insurance parity.

We understand that this funding will be used for travel, conference calls, printing, staff to the Task Force and other costs related to compiling information regarding parity for mental health.

We appreciate your foresight in introducing this legislation and look forward to continuing to work with you on this important issue to ensure it moves forward.

Sincerely,



Jeff Jessee
Executive Director

3601 C Street, Suite 742 • Anchorage, Alaska 99503

Telephone: (907) 269-7960 • Fax: (907) 269-7966

CORRESPONDENCE FROM THE ALASKA MENTAL HEALTH TRUST AUTHORITY

THE MENTAL HEALTH PARITY ACT OF 1996 SUMMARY OF THE LAW

President Clinton signed the Mental Health Parity Act of 1996 (P.L. 104-204) into law on September 26, 1997. This landmark law, which received unprecedented bipartisan support, begins the process of ending the long-held practice of providing less insurance coverage for mental illnesses, or brain disorders, than is provided for equally serious physical disorders.

Key Provisions

- ⇒ The law takes effect on January 1, 1998, and expires on September 30, 2001.
- ⇒ The law equates aggregate lifetime limits and annual limits for mental health benefits with aggregate lifetime limits and annual limits for medical and surgical benefits. *(Typical caps for mental illness coverage are \$50,000 for lifetime and \$5,000 for annual, as compared with \$1 million lifetime and no annual cap for other physical disorders.)*
- ⇒ The law covers mental illnesses (i.e., "mental health services," as defined under the terms of individual plans); it does not cover treatment of substance abuse or chemical dependency.
- ⇒ Existing state parity laws are not preempted by the federal law (i.e., a state law requiring more comprehensive coverage would not be weakened by the federal law, nor does it preclude a state from enacting stronger parity legislation).
- ⇒ The law applies only to employers that offer mental health benefits; it does not mandate such coverage.
- ⇒ The law allows for many cost-shifting mechanisms, such as adjusting limits on mental illness inpatient days, prescription drugs, outpatient visits, raising co-insurance and deductibles, and modifying the definition of medical necessity. *(Therefore, lower limits for inpatient and outpatient mental illness treatments are expected to continue, and in some cases, actually expand to help keep costs down.)*
- ⇒ The law applies to both fully insured state-regulated health plans and self-insured plans that are exempt from state laws under the Employee Retirement Income Security Act (ERISA), which are regulated by the Department of Labor.
- ⇒ The law has a small business exemption which excludes businesses with 50 employees or less.
- ⇒ The law allows an increased cost exemption; employers that can demonstrate a one percent or more rise in costs due to parity implementation will be allowed to exempt themselves from the law.

What's Not Covered

The Mental Health Parity Act of 1996 does not provide:

- ⇒ A mandate for mental health benefits to be offered in health insurance plans;
- ⇒ Coverage for treatment of substance abuse or chemical dependency;
- ⇒ Rules for service charges, such as co-payments, deductibles, out-of-pocket payment limits, etc.;
- ⇒ Designations for the number of inpatient hospital days or outpatient visits that must be covered;
- ⇒ Coverage in connection with Medicare or Medicaid;
- ⇒ Restrictions on a health insurance plan's ability to manage care; or
- ⇒ Provisions for business with 50 or fewer employees.

Federal Regulations

The Clinton Administration issued interim final regulations in the *Federal Register* (December 22, 1997) that set forth the guidelines for implementing the Mental Health Parity Act. The White House and the Office of Management and Budget (OMB) ruled that employers must first comply with the law in 1998 and develop a cost history of at least six months (retrospective data) before seeking an exemption. By contrast, some business groups had argued that firms be allowed to use the exemption based on estimates of higher costs (prospective data), thereby relieving them of the responsibility to ever comply. Those employers who had planned on using the prospective formula have been given a three-month grace period and must comply with the law by March 31, 1998, if they reasonably believed that the one percent cost increase would have been available to them on a prospective basis.

The regulations require employers using the exemption to notify all plan participants and the appropriate enforcement authority (e.g., state insurance commissioner, U.S. Department of Labor, U.S. Department of Health and Human Services, and the U.S. Department of Treasury). While neither the government, nor plan participants, will be able to see the "proprietary" data upon which the exemption is based, employers must provide a summary of the data upon which their one percent cost increase claim is based. This summary must include overall plan expenditures, the dollar value of claims that would have been denied if parity were not in place, and administrative costs attributable to compliance with the law. Plan sponsors will be specifically barred from including any individually identifiable information in a data summary. Once an employer submits a notice under the one percent exemption, they will have to wait 30 days before the exemption becomes effective. However, this notice is not a formal application and employers do not have to wait for approval from the government before proceeding.

The notices that employers provide to the government under the one percent exemption will be part of the public record and will allow third parties, including NAMI and its state and local affiliates, to access the names of these employers.

Benefits for American Families

The principle beneficiaries of the Mental Health Parity Act will be persons with the most severe, persistent and disabling of brain disorders because they are, on average, more likely to exceed annual and lifetime benefits.