

HB

149

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. HB 149

Revision Date/Time (Note if correction) _____ Dept. Affected Commerce & Economic Development
 Title An Act relating to Insurance coverage for treatment BRU Insurance
of mental illness and substance abuse Component Insurance'
 Sponsor Davis
 Requester _____ Component Serial No. 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
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)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY99) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This bill has no fiscal impact on this component.

Prepared by Marianne K. Burke, Director Phone 465-2215
 Division Insurance Date/Time 4/6/99 2:30 PM
 Approved by Commissioner Deborah B. Sedwick Date 4.6.99
 Agency Commerce & Economic Development

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INSURANCE

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April 6, 1999

Representative Gary Davis
Alaska House of Representatives
Juneau, Alaska 99811

Re: HB 149 - Insurance for Mental Illness

Dear Representative Davis:

I have empathy for the purpose of this bill, because I have a sister who suffers with mental illness. However, this bill mandating health care benefits defeats the purpose of Health Care Reform, to lower health care costs and insure more people.

Mandated health care benefits drive up the cost of insurance and increasing the cost of insurance results in fewer individuals being insured. I know many self-employed people who can not afford major medical insurance at the present time, so with additional mandated benefits, there will be more people who can't afford it.

Sincerely,

A handwritten signature in cursive script that reads "Dave Moe".

Dave Moe

cc: Rep. Fred Dyson

FRA FRA

Paul Robinson, President
Dona Keppers, Vice-President
Joanne Trefathan, Treasurer
Barbara Blackshear, Secretary
Emily F. Ennis, Executive Director

FAIRBANKS RESOURCE AGENCY

805 AIRPORT ROAD, SUITE 1 • FAIRBANKS, ALASKA 99701 • (907) 456-8901 • FAX 452-5171

April 6, 1999

Dear HESS Finance Subcommittee Member:

Please restore the "DD Institutional Prevention" increment to its full funding of \$965,800, as included in the Governor's budget recommendations. This critical funding is needed to assure that DD Community Services can provide the care previously available at Harborview Developmental Center, our state's now-closed institution for adults with mental retardation and other developmental disabilities. The full funding will also assist in assuring adequate services for disabled children and adults living in our communities.

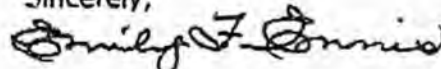
Without full funding, DD organizations cannot begin to solve the current workforce crisis facing them. Due to inadequate pay, benefits and training, qualified employees are not being recruited and retained by DD organizations to provide direct care services. In addition, the turnover rate for employees is exceedingly high, again due to factors related to compensation. These workforce problems increasingly impact the quality of services.

Although DD programs have been expanded over recent years, all new funds have been allocated toward the waitlist. The quality of services that organizations are able to offer has diminished as a result of rising costs without increased funding. The closure of Harborview saw very little savings that were redirected back to DD community services. Yet, these community services are the institutional "back-up" for the state of Alaska!

Please also remember that the state of Alaska made a promise to families when Harborview closed: that their sons and daughters would be just as safe and well cared for in their home communities. This assurance was made to the families who saw their children leave Harborview and to others who have similar needs. The DD community organizations are trying hard to keep that promise.

With full funding, we can prevent the further erosion of DD Community Services, especially in our critical workforce, and strive to keep the promise of well-being in our communities. Thank you for your consideration of the full funding of \$965,800 for DD Institutional Prevention.

Sincerely,



Emily F. Ennis
Executive Director

Employment Services • Residential Services • Family Services • Respite Care Services • Senior Services
A United Way Agency

TOTAL P.02

Connecting Ties, Inc.

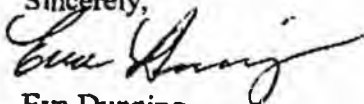
PO Box 2017
Valdez, AK 99686
(907) 835-3274

April 6, 1999

Dear Rep. Fred Dyson

I am a provider to people who experience mental and physical challenges. I have worked in this field for over 30 years. I strongly feel that by cutting funds to any program that helps people who experience mental and physical challenges will have a wide variety of repercussions. All I ask is for you to look very closely at what you do today how it will effect people tomorrow. Alaska worked hard at making Alaska institutional free, I would hope that you would not jeopardize their well being for a dollar.

Sincerely,



Eva Dunning
Executive Director



ALASKA STATE LEGISLATURE

REPRESENTATIVE GARY DAVIS

HOUSE BILL 149 SPONSOR STATEMENT

"An Act relating to insurance coverage for treatment of mental illness and substance abuse; repealing provisions of ch. 8, SLA 1997, that terminates required mental health benefit coverage; and providing for an effective date"

Last year the legislature established a task force to look into the issue of equality between insurance coverage of mental health compared to that of physical health. House Bill 149 contains the recommendations approved by the majority of the task force membership.

This legislation requires businesses with 20 or more employees that provide health insurance benefits for their staff to provide mental health and substance abuse insurance benefits that are equal to those for physical health. Specifically, an insurance plan providing health care cannot:

- require different deductibles, coinsurance or copayments;
- use different claim payment methodologies;
- require different pre-notification of treatment or second opinions;
- limit coverage by provisions for such things as preexisting illnesses that are not applicable to other covered illnesses, or limit treatment services to either inpatient or outpatient services;
- deny reimbursement solely because treatment was interrupted or not completed; and
- impose different annual or lifetime benefit limits, maximum out-of-pocket expenses, day limits or number-of-visit limits.

Coverage for substance abuse is included with mental health coverage because it is common for these ailments to co-exist. People suffering from mental illness may unconsciously attempt to "self-medicate" with drugs or alcohol. For this reason, it is inappropriate to treat one disorder and not address the other. Including substance abuse coverage allows the entire disorder to be treated rather than just one portion.

Recognizing that costs can be contained through managed care, the legislation does not prohibit the involvement of a managed care organization in providing mental health and substance abuse treatment. However, the involvement may not diminish or negate the legislation's requirements, nor may the organization use administrative or clinical protocols that reduce access to treatment.

Mental health disorders cost the economy hundreds of thousands of dollars each year. Whether for treatment, social services, disability payments or lost productivity, the costs are staggering. Many mental disorders are treatable. With early and appropriate treatment, many individuals are able to remain at work and continue to be productive, contributing members of society. To date, however, this treatment has not been readily accessible or financially viable. Even those with coverage normally have such low coverage that they soon run out of benefits and are forced to either discontinue treatment or leave their place of employment to qualify for public assistance.

House Bill 149 requires coverage for mental health disorders equal to coverage for medical health disorders. It recognizes that individuals with any type of medical disorder should be allowed access to coverage.

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Email: Representative_Gary_Davis@legis.state.ak.us

SPONSOR STATEMENT



ALASKA STATE LEGISLATURE

REPRESENTATIVE GARY DAVIS

HOUSE BILL 149

SECTIONAL ANALYSIS

"An Act relating to insurance coverage for treatment of mental illness and substance abuse; repealing provisions of ch. 8, SLA 1997, that terminates required mental health benefit coverage; and providing for an effective date."

Section 1: Housekeeping measure amending AS 21.36.090 (d) to remove the reference to AS 21.42.365 which is repealed by section 4 of this bill.

Section 2: Repeals and reenacts AS 21.54.150, Coverage for treatment of mental illness and substance abuse, to require health care insurance plans providing coverage for five or more employees in a group market to provide coverage for the treatment of mental illness and substance abuse.

Prohibits the insurer from

- requiring a different deductible, coinsurance or copayment for the determination of mental illness and substance abuse coverage;
- using a different claim payment methodology in determining mental illness and substance abuse coverage;
- requiring prenotification of treatment or second opinions unless the requirement is applicable to other covered major illnesses;
- limiting coverage by provisions of the contract that are not applicable to other covered major illnesses such as preexisting illnesses or provisions requiring the exact date of onset to be known;
- limiting treating services to either an inpatient or outpatient service;
- denying reimbursement for services solely because treatment was interrupted or not completed; or
- imposing annual or lifetime benefit limits, maximum out-of-pocket expenses, day limits, or number of visit limits that are different for the determination of mental illness or substance abuse benefits than for determination of benefits relating to other covered illnesses.

Exempts employers with few than 20 permanent, full-time employees from having to provide this coverage.

States that a health insurance plan that provides coverage for treatment of mental illness through a managed care organization

- may not diminish or negate the provisions of this statute;
- must provide timely and appropriate access to care;
- must provide quantity location and specialty distribution of health care providers; and
- may not use administrative or clinical protocols that reduce access to medically necessary treatment.

Provides definitions for mental illness, substance abuse, treatment of mental illness and treatment of substance abuse.

Section 3 Housekeeping measure amending AS 21.87.340 to remove the reference to 21.42.365 which is repealed in Section 4 of this legislation

Section 4: Repeals AS 21.42.365, Coverage for treatment of alcoholism or drug abuse

Section 5: Repeals sections 116 and 122 of chapter 81 of the 1997 session laws which applied a sunset provision to the previous wording of the statute on mental illness benefits

Section 6: Provides an effective date of July 1, 1999.

Repealed by HB 149.

Sec. 21.54.150. Mental health benefits.

(a) Except as provided in (d) of this section, a health care insurance plan sold in the large employer group market that provides both medical and surgical benefits and mental health benefits shall meet the following requirements:

(1) if the plan does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan may not provide for an aggregate lifetime limit on mental health benefits;

(2) if the plan includes an aggregate lifetime limit on substantially all medical and surgical benefits, the plan must

(A) include the mental health benefits within the aggregate lifetime limit and may not distinguish in the application of the limit between medical and surgical benefits and mental health benefits; or

(B) provide an aggregate lifetime limit for mental health benefits that is not less than the aggregate lifetime limit for medical and surgical benefits;

(3) if the plan includes different aggregate lifetime limits or none on different categories of medical and surgical benefits, the plan must provide for aggregate lifetime limits on mental health benefits consistent with federal law;

(4) if the plan does not include an annual limit on substantially all medical and surgical benefits, the plan may not provide for an annual limit on mental health benefits;

(5) if the plan includes an annual limit on substantially all medical and surgical benefits, the plan must

(A) include the mental health benefits with the annual limit and may not distinguish in the application of the limit between medical and surgical benefits and mental health benefits; or

(B) provide an annual limit for mental health benefits that is not less than the annual limit for medical and surgical benefits; and

(6) if the plan includes different annual limits or none on different categories of medical and surgical benefits, the plan must provide for annual limits on mental health benefits consistent with federal law.

(b) Except as provided otherwise in this title, a health care insurance plan is not required to provide mental health benefits.

(c) Except as otherwise provided in this title, this section does not affect the terms and conditions relating to the amount, duration, or scope of mental health benefits under a health care insurance plan that provides mental health benefits, including cost sharing, limits on number of visits or days of coverage, and requirements relating to medical necessity.

(d) This section does not apply if application of this section would result in an increase in the cost under the health care insurance plan of at least one percent.

Repealed by HB 149

Sec. 21.42.365. Coverage for treatment of alcoholism or drug abuse.

(a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan, except for catastrophic illness insurance, providing coverage for five or more employees of an employer in the group market shall provide a covered employee or the employee's dependent the following coverage for treatment of alcoholism or drug abuse:

- (1) benefits of at least \$9,600 over two consecutive benefit years; and
- (2) lifetime benefits of at least \$19,200.

(b) The benefits described in (a) of this section shall be adjusted January 1, 1999, by the director and every three years thereafter to correspond with the change in the medical care component of the consumer price index for all urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor Statistics, United States Department of Labor. The base year for the first adjustment shall be calendar year 1996.

(c) A health care insurer that offers a health care insurance plan providing coverage under this section may not

(1) require that a covered employee or the employee's dependent be responsible for a deductible or copayment that is different for the determination of benefits relating to treating alcoholism or drug abuse than for the determination of benefits for treating another covered illness;

(2) use a different claim payment methodology in determining the benefits relating to treating alcoholism or drug abuse than that used in determining the benefits for treating another covered illness;

(3) require prenotification of treatment or a second opinion unless the requirement is applicable to other covered major illnesses;

(4) limit coverage by provisions of the insurance contract that are not applicable to other covered major illnesses, including provisions concerning preexisting illnesses or provisions requiring that the exact date of onset be known;

(5) limit treatment services under the insurance contract to either an inpatient or outpatient service;

(6) exclude from coverage the cost of medically necessary treatment, including medical or psychiatric evaluation, activity or family therapy, counseling, or prescription drugs or supplies received at an approved treatment facility; or

(7) deny reimbursement for actual services rendered solely because treatment was interrupted or not completed.

(d) Notwithstanding (a) of this section, if an employer employs fewer than 20 permanent, full-time employees for each working day during each of at least 20 calendar workweeks in either the current calendar year or the preceding calendar year, a health care insurer is not required to provide the coverage specified in (a) of this section to the employer but shall offer that coverage to the employer as optional coverage.

(e) In this section,

(1) "alcoholism or drug abuse" means an illness characterized by

(A) a physiological or psychological dependency, or both, on alcoholic beverages or controlled substances as defined in AS 11.71.900; or

(B) habitual lack of self-control in using alcoholic beverages or controlled substances to the extent that the person's health is substantially impaired or the person's social or economic function is substantially disrupted;

(2) "approved treatment facility" means treatment in a facility that is either

approved under AS 47.37.140 or located and licensed for treatment of alcoholism or drug abuse in another state;

(3) "catastrophic illness insurance" means a health care insurance plan that provides benefits for hospital and medical care with a lifetime maximum benefit per insured of at least \$250,000 and that has a deductible of at least \$5,000;

(4) "cost" means the least of the following:

(A) the actual charge for the treatment received for alcoholism or drug abuse;

(B) the usual, customary, and reasonable charge for the treatment as determined by the contract of coverage; or

(C) the charge agreed to by contract between the treatment provider and the health care insurer;

(5) "treatment" means medical care, including detoxification, as an inpatient or outpatient at an approved treatment facility.

Chapter 81, SLA 1997
Chapter: CH081
Source: HCS CSSB 104 (FIN)
Action Date: June 13, 1997
Effective Date: See Chapter
97

AN ACT

Relating to regulation and examination of insurers and insurance agents; relating to kinds of insurance; relating to payment of insurance taxes and to required insurance reserves; relating to insurance policies; relating to regulation of capital, surplus, and investments by insurers; relating to hospital and medical service corporations; relating to the portability and availability of health care insurance; making amendments to the insurance statutes to conform to federal requirements regarding health insurance; relating to the repeal of certain small employer health care insurance provisions; requiring that uninsured and underinsured motor vehicle insurance apply to claims of an insured even if other policy limits are not exhausted; repealing delayed provisions relating to dental, vision, and hearing insurance in secs. 3 and 4, ch. 101, SLA 1992; repealing delayed provisions relating to small employer health care insurance in secs. 4, 7, 9, and 12, ch. 39, SLA 1993; repealing the delayed effective date in sec. 5, ch. 101, SLA 1992, and in sec. 13, ch. 39, SLA 1993; and providing for an effective date.

Section 1. PURPOSE. The purpose of secs. 3, 11, 12, 31 - 34, 43 - 57, 59 - 90, 99 - 102, 108, 111, 112, 115 - 119, and 122 of this Act is to implement the minimum federal standards for health care insurance enacted under P.L. 104-191 (Health Insurance Portability and Accountability Act of 1996).

Sec. 116. AS 21.54.150, enacted by sec. 59 of this Act, is repealed.

Sec. 122. Section 116 of this Act takes effect September 20, 2001.

**POSITION STATEMENT OF
HEALTH INSURANCE ASSOCIATION OF AMERICA (HIAA)
ON HOUSE BILL 149 (MENTAL HEALTH PARITY)**

April 8, 1999

The Health Insurance Association of America ("HIAA") is a national trade association of commercial health insurance companies which provide health insurance for approximately 55 million Americans.

Over the past two years, an increasing number of states have considered legislation requiring expansive coverage for mental health benefits, far beyond what is required under federal law.

In 1998 alone, 32 states considered 88 bills requiring what advocates have termed "mental health parity." Wary of the cost associated with mental health parity mandates, most states have rejected such proposals. To date, only 14 states have enacted a mental health parity mandate exceeding what is required under federal law. The only state to do so this year is Pennsylvania. However, with only one exception (Vermont), the states that have chosen to adopt mental health parity mandates have placed significant limitations on parity requirements. Examples include: exempting individual and small employer group health plans; limiting the mandate to serious or biologically-based mental illnesses; and permitting employers who experience more than a minimal cost increase as a result of the mandate to opt out.

Position Statement

**Health Insurance Association
of America (HIAA)**

HIAA Position Statement
HB 149 - Mental Health Parity
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Significantly, most employers and many individuals already purchase insurance coverage for mental illness, often with reasonable limits on inpatient and outpatient treatment. According to the Employee Benefits Research Institute, 98% of employees in medium and large firms have coverage for inpatient mental health care and 97% have coverage for outpatient care. Although many purchasers of insurance opt for less than full "parity" between benefits for physical and mental illness, existing levels of coverage represent a significant commitment providing benefits for mental illness.

Health benefit mandates, including mental health parity mandates, constrain the ability of insurance purchasers and consumers to choose for themselves what is the appropriate level of coverage for their needs based on the best available information about medical technologies and treatments at the time. Mandates unwisely lock into law what should be a flexible and evidence-based decision about appropriate levels of coverage made in the context of rapidly advancing medical knowledge and evolving medical technologies. Choices about the distribution of health insurance dollars among different types of benefits should remain in the hands of purchasers and consumers, who are in the best position to determine what is the most efficient and appropriate allocation of their resources.

HIAA Position Statement
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Among other problems with mental health mandates are:

* Forcing the purchase of benefits that consumers may not want or can't afford only ensures that many more individuals will be unable to afford any insurance at all. Some national studies show that for every 1% increase in the cost of insurance, between 200,000 and 600,000 individuals lose coverage [1]. Similar research on small businesses has found that with each 1% increase in premiums, 2.6% of small employers offering health insurance drop the coverage [2]. If mental health parity increases the cost of insurance by 4 to 10%, as many studies estimate [3], states pursuing such mandates can expect that between 10.4% and 26% of their small employers no longer will be able to afford coverage.

* Small employers are singled out to bear the cost. Large employers who can afford to self-insure are unaffected by state mental health mandates. Under ERISA, they are exempt from such mandates and retain the ability to purchase coverage with reasonable limits on mental health benefits. Small employers don't have this option. They typically can't afford to establish a self-insured health plan governed by ERISA.

* Some of the studies referred to also assume that benefits for physical illnesses will be reduced to compensate for

additional mandated mental health benefits. For example, several studies conducted by Coopers & Lybrand place too much emphasis on cost offsets that may not materialize, and ignore the true cost increases that will be borne by employees and consumers. It is also important to note that the final cost estimates developed by Coopers & Lybrand only reflect the financial impact on employers. The analysis assumes that employers will find various ways to offset the cost increases -- such as passing the cost on to employees. This does not mean that those costs do not exist or are unimportant; it simply means that *someone else is paying the bill*, namely the employee or individual health insurance purchaser. To understand the full impact of any proposal, the full cost should be considered rather than just the employer's contribution portion.

* The term "mental health parity" is misleading. Open-ended mandates for "mental health parity" sound appealing but have the effect of eliminating accountability for determining what constitutes a medically recognized mental illness and may result in fewer available dollars for the treatment of serious mental diseases. Critics charge that the Diagnostic and Statistical Manual of Mental Disorders (DSM), a widely-used

classification of mental ailments, increasingly "medicalizes many behaviors once considered traceable to character flaws."

According to one commentator:

"There is a clear motive for defining new mental disorders and marketing psychotropic medications for adults. . . . [A]s recently as 18 years ago, the DSM had only 106 mental disorders [compared to the 300 now listed. As a result,] less money is available to treat those with serious, debilitating mental illnesses whose sufferers have little clout." [4]

* Open-ended mental health mandates will effect a massive shifting of costs from existing social programs to private, largely small employer-based, insurance. In many states, mental health activists have proposed mandates that would classify problems such as learning disabilities as a mental illness subject to mandatory coverage. If enacted, such proposals would effect a massive shift of costs from existing social programs to employer-sponsored health plans. Because ERISA exempts self-funded health plans maintained by large employers from state mandates, the weight of this cost shift will fall largely on small employers.

I would note one other small problem (no pun intended): There could be some coverage confusion regarding small employers. Alaska's Small Employer Health Care Insurance statute (AS 21.56) defines small employers as those with two to 50 employees.

This bill states an insurer shall provide coverage for mental illness and treatment of substance abuse in employer group plans covering five or more employees, but then says the insurer must only offer such coverage as an option if an employer has "fewer than 20 permanent, full-time employees," i.e., employers who have up to 19 employees. When is a small employer a small employer. You go try to figure it out.

- [1] Independent studies on file with HIAA.
- [2] See Morrisey, et al, "Small Employers and the Health Insurance Market." p.155, n. 16, *Health Affairs* (Winter 1994)
- [3] See HIAA fact sheet, *State Mental Health Mandates: Cost and Effect on Coverage* (summarizing studies on cost of mental health parity).
- [4] Herb Kutchins, Professor of Social Work, California State University, Sacramento (quoted in the *New York Times*, September 28, 1997).



Health Insurance Association of America

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FAX MESSAGE

TO: Wes Keller 907-465-4587
CC: Gordon Evans 907-586-3762
FROM: Joe Holahan
DATE: April 6, 1999
PAGES: 11 (including this page)

Wes,

I have attached an excerpt from the U.S. Health and Human Services (HHS) study with their cost estimates for mental health parity under the 1996 federal parity law. See page 6 for their estimate of the cost of substance abuse parity only. Note that the cost impact varies, depending on the type of health plan involved. The estimated effect is greatest for fee-for-service plans.

HHS estimates that full parity (mental health and substance abuse) would increase the cost of fee-for-service coverage by 5% (see chart on page 5). We believe this is a conservative estimate.

Managed Care

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Search

Parity**The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits**

Merrile Sing
 Steven Hill
 Suzanne Smolkin
 Nancy Heiser

U.S. Department of Health and Human Services
 Public Health Service
 Substance Abuse and Mental Health Services Administration
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Originating Office

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 Center for Mental Health Services, SAMHSA
 5600 Fishers Lane, 15C-17
 Rockville, MD 20857
 March 1998
 DHHS Publication No. (SMA) 98-3205 Printed 1998

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Options for Providing Parity in MH/SA Insurance Benefits

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Estimated Premium Increases for Families

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See also



Parity Report
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Parity

Chapter 4 - Cost Estimates

One main goal of this study was to project the costs of providing parity for mental health and substance abuse (MH/SA) insurance benefits. We did this by using an actuarial model to predict the premium increases for three benefit options. One option gives full parity, and the other two give partial parity, for MS/SA benefits. Information about the relative costs of parity options can be used by employers and benefit managers who want to assess the tradeoffs between offering full or partial parity for MH/SA benefits.

In this chapter, we present the three parity benefit options we developed and discuss the updated actuarial model we used to determine our cost estimates of premium increases for families. We also determine increases in premiums for child health plans with parity that states may develop as a result of the Balanced Budget Act of 1997. Finally, we offer some caveats for interpreting the results.

Options for Providing Parity in MH/SA Insurance Benefits

The three benefit options we analyzed in this study were developed in consultation with this project's policy advisory panel. The panel included representatives from the business community and from mental health, substance abuse, and managed care organizations in the public and private sectors (see Appendix C).

We estimated premium increases for one full and two partial MH/SA parity benefit options. In this study, "full parity" means that insurance benefits for any group of MH/SA diagnoses must be the same as insurance benefits for medical/surgical diagnoses with respect to three areas--cost sharing (such as copayment or coinsurance amounts), service limits (such as the number of outpatient visits or inpatient hospital days), and annual or lifetime spending limits (such as annual or lifetime benefit maximums).

Partial parity means that benefits for MH/SA diagnoses must be the same as benefits for medical/surgical diagnoses in two of the three areas listed above. One of the partial parity options requires parity with respect to cost sharing and spending limits. The other requires parity with respect to service limits and spending limits. Both partial parity options comply with the Mental Health Parity Act of 1996, since they require parity with respect to spending limits.

The costs of each full and partial parity option are predicted for the following diagnosis groups and plans:

- three diagnosis groups for families (all MH/SA diagnoses, MH diagnoses only, SA diagnoses only); and all MH/SA diagnoses for children only; and
- four plan types (FFS, PPO, POS, and HMO).

The baseline (initial), partial parity, and full parity MH/SA benefit options for a FFS plan are listed in Table 4.1. Full parity plans are listed in Table 4.2. For each plan type, the full parity benefit options have unlimited MH/SA

inpatient days and outpatient visits. The cost-sharing requirements are the same as the cost-sharing requirements for medical/surgical benefits for the typical plan. For FFS plans, the cost-sharing requirement for covered services under the full parity option includes a 20 percent coinsurance payment for inpatient and outpatient services.

The typical plan was determined based on a review of the literature (O'Grady, 1996; KPMG Peat Marwick, 1997). In addition, our expert of actuaries and economists reviewed our assumptions about the benefit packages.

**TABLE 4.1
PARTIAL AND FULL PARITY BENEFIT OPTIONS FOR A FEE-FOR-SERVICE PLAN**

MH/SA Service	Baseline Benefits (Typical FFS Benefits)	Partial Parity		Full Parity
		Parity in Service Limits	Parity in Cost Sharing	
Inpatient Hospital	30 days 20% coinsurance	Unlimited days Days 1-30: 20% coinsurance More than 30 days: 50% coinsurance	30 days 20% coinsurance	Unlimited days 20% coinsurance
Outpatient	20 visits 50% coinsurance	Unlimited visits 50% coinsurance	20 visits 20% coinsurance	Unlimited visits 20% coinsurance

**TABLE 4.2
FULL PARITY BENEFIT OPTIONS**

MH/SA Service	Fee-For-Service	PPO		POS		HMO
		In-Network	Out-of-Network	In-Network	Out-of-Network	
Inpatient Hospital	Unlimited days 20% coinsurance	Unlimited days 10% coinsurance	Unlimited days 30% coinsurance	Unlimited days fully covered	Unlimited days 20% coinsurance	Unlimited days covered in full
Outpatient Services	Unlimited visits 20% coinsurance	Unlimited visits 10% coinsurance	Unlimited visits 30% coinsurance	Unlimited visits \$10 copayment	Unlimited visits 20% coinsurance	Unlimited visits \$10 copayment

Method for Estimating Costs

We used actuarial cost models developed by the HayGroup to estimate the costs of the full and partial parity benefit options. The model in our study improves on models in previous actuarial studies in several ways. First, it was recently revised by the HayGroup. This revised version includes expense data from managed behavioral health care companies, separate expense data for substance abuse services, and separate data on MH/SA expenses for children. Earlier versions of the HayGroup model did not include these features.

Second, the assumptions we used to estimate the premium increases, as defined in chapter 3, were reviewed by this project's expert panel of actuaries and economists. Many of our initial assumptions were revised according to their comments. Third, our assumptions incorporate new data and case study findings that were not available in 1996. Finally, we produced separate estimates for a wider range of benefit options, diagnosis groups, and health plan types than previous studies. The updated actuarial model and assumptions are described more fully in Sing and Hill (1998a).

The Estimation Process

The estimation process is as follows. The models predict premiums for health plans by using data on the benefit packages of the full and partial parity benefit options. These data include information on covered services, service

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limits, and cost-sharing arrangements. The model then builds in assumptions about administrative costs, the level of utilization management, and patients' responses to changes in their out-of-pocket costs.

The cost of each parity benefit option is the difference between the predicted premium for that option and the estimated premium for a "baseline plan." In this study, a baseline plan is a typical health plan covering medical/surgical and MH/SA services. For each plan type, it is the benefit package that has the most enrollees (the statistical mode). For example, a typical FFS plan covers 30 days of inpatient care and 20 outpatient visits for MH/SA services (O'Grady, 1996). In comparison, a full parity FFS plan would cover unlimited inpatient days and outpatient visits for MH/SA services.

Appendix B illustrates how to compute the premium increase due to a benefit option with increased MH/SA insurance benefits. The new premium is the sum of the baseline MH/SA and medical/surgical expenditures plus the increase in MH/SA expenditures. The percentage premium increase is the difference between the new premium and the baseline premium, divided by the baseline premium. A large percentage change in MH/SA expenditures causes a small change in premiums, because MH/SA expenditures account for only a small part of premiums (4 percent to 6 percent of the expense data in the HayGroup model, depending on the type of health care plan).

The HayGroup Actuarial Model

The HayGroup actuarial model has been used extensively to study the effects of proposed policies for the federal government. Earlier versions of this model were developed under contract with the Congressional Research Service (CRS). These versions were used to predict the costs of the Mental Health Parity Act of 1996 and the Domenici-Wellstone amendment to the Health Insurance Reform Act of 1996. The model was recently updated in consultation with the National Institute of Mental Health. The updated model includes data from managed behavioral health plans, separate expense data for children, and substance abuse data (Hay/Huggins Company, Inc., 1997b).

Sturm (1997) recently criticized an older version of the HayGroup model. He believes that the model overstates the costs of parity because it does not adequately account for managed care in the delivery of MH/SA services. This criticism is no longer relevant since the revised model includes data and assumptions for managed behavioral health plans.

Assumptions about PPO and POS plan network use and provider discounts. The HayGroup actuarial model is adjusted to incorporate three features of PPO and POS plans. These features are (1) network provider discounts, (2) coverage for in-network and out-of-network services, and (3) the effects of utilization management by POS gatekeepers.

Enrollees in PPO and POS plans pay lower out-of-pocket costs when they use network providers. These lower costs encourage enrollees to use these providers. Enrollees in PPOs can self-refer to any provider they wish to see. However, many enrollees in POS plans are assigned to a primary care network provider called a "gatekeeper." The gatekeeper must authorize all in-network service use (Jensen, et al., 1997). Providers in PPO and POS networks agree to charge a discounted price for the services they provide to PPO and POS plan enrollees.

For PPO and POS plans, the HayGroup model assumes that 70 percent of care is given by network providers. The

model also assumes that the plan receives a 15 percent discount from network providers. For POS plans only, the model assumes that the use of in-network services is further reduced by 12 percent due to services denied by gatekeepers. The model assumes that POS out-of-network service use increases by 15 percent. This is based on the assumption that some POS plan enrollees will seek treatment out of network (and pay a higher coinsurance rate) when the gatekeeper denies in-network care.

Types of MH/SA treatment. The model does not separately compute expenditures for psychotherapeutic drugs, intensive nonresidential care, and SMI. This is because usable expense data for these services are not available. However, expenses for intensive nonresidential care services and partial hospitalization are included in the model's inpatient and outpatient expense data.

Estimated Premium Increases for Families

The model predicts that *full parity for all MH/SA diagnoses will raise family premiums for a composite of plans by 3.6 percent* (Table 4.3). By "composite" we mean a weighted average of fee-for-service (FFS), preferred provider organization (PPO), point-of-service (POS), and health maintenance organization (HMO) plans. Mental health care accounts for most of this increase (3.4 percent).

Although MH/SA expenditures would increase by 75 percent, the premium increase is 3.6 percent because MH/SA expenditures are only 4 percent to 6 percent of health expenditures at baseline, depending on the type of plan. Premium increases are the largest for FFS plans and PPOs (5.0 and 5.1 percent).⁵ Premium increases are lower for tightly managed HMOs (0.6 percent) (Table 4.4).

⁵ Total premiums rise slightly more in PPO plans than in FFS plans because MH/SA expenditures are a larger proportion of the PPO premium (4.3 percent) than of the FFS premium (3.9 percent).

Our tables do not report separate estimates for the parity options for serious mental illnesses (SMI), since the model cannot compute premium increases for changes in these benefits. However, a very "rough" estimate for SMI parity options can be obtained by pro-rating the predicted cost increases for the mental health parity options.

One way to do this is to use findings from two studies conducted by Milliman and Robertson, Inc. One study (Melek and Pyenson, 1996b) estimated that parity for SMI, as defined in S.298 (which did not pass), would increase premiums by 2.5 percent. The other study (Melek and Pyenson, 1996a) estimated that parity in benefits for all mental health diagnoses would increase premiums by 2.8 percent.

These studies suggest that expenses for SMI represent 89 percent of the increase in expenditures for all mental health diagnoses due to parity, since 2.5 percent is 89 percent of 2.8 percent. Therefore, to get a rough estimate of the increase in premiums due to parity for SMI, we can assume that the premium increase for SMI parity is 89 percent of the premium increase for mental health parity.

TABLE 4.3
AVERAGE PREMIUM INCREASES AGGREGATED ACROSS PLAN TYPES

MH/SA Diagnoses	Average Premium Increase		
	Parity in Cost Sharing	Parity in Service Limits	Full Parity
MH/SA	0.4	1.2	3.6

4

MH only	0.3	1.1	3.4
SA only	0.1	0.03	0.2

NOTES:

1. The premium increases for FFS, PPO, POS, and HMO plans were aggregated by assuming the following distribution of enrollees among plan types:

FFS 20%
PPO 30%
POS 20%
HMO 30%

2. The table indicates increases in family premiums. Family premiums are computed from the individual adult and child premiums using the following formula:

$$\text{Family premium} = (1 + .84 * 1.08) * \text{adult premium} + 1.22 * \text{child premium}$$

This formula assumes that 84 percent of employees are married, the cost of coverage for the spouse is 1.08 times more than the cost for the employee, and that there are 1.22 children per family on average. The demographic assumptions are based on data from the Current Population Survey. The cost of coverage for a spouse relative to the employee is based on data for a typical plan (Hay/Huggins Company, Inc., 1997a).

3. Premium increases do not necessarily add up within columns due to rounding.

TABLE 4.4
PERCENTAGE INCREASES IN TOTAL PREMIUMS BY DIAGNOSIS AND PLAN TYPE

Diagnosis	Percentage Increase in MH/SA Expenses			Percentage Increase in Total Family Premium		
	Parity in Cost Sharing	Parity in Service Limits	Full Parity	Parity in Cost Sharing	Parity in Service Limits	Full Parity
FFS						
MH/SA	15.4	41.7	126.8	0.5	1.4	5.0
MH only	13.5	40.5	119.8	0.4	1.3	4.8
SA only	1.9	1.2	7.0	0.1	0.05	0.3
PPO						
MH/SA	17.0	40.0	117.7	0.6	1.5	5.1
MH only	14.8	38.7	111.4	0.5	1.4	4.8
SA only	2.2	1.3	6.3	0.1	0.1	0.3
POS						
MH/SA	0.2	33.9	64.6	0.00	1.7	3.5
MH only	0.2	33.4	63.1	0.00	1.7	3.4
SA only	0.00	0.4	1.6	0.00	0.02	0.1

	HMO					
MH/SA	6.1	3.7	11.6	0.3	0.2	0.6
MH only	5.5	3.7	10.9	0.3	0.2	0.6
SA only	0.6	0.00	0.7	0.03	0.00	0.04

NOTE: Premium increases do not necessarily add up within columns due to rounding.

→ **Parity for substance abuse benefits.** Full parity for substance abuse would increase expenditures on substance abuse care by about 26 percent (not shown), but the total premium for the composite plan would increase by 0.2 percent. This premium increase is low relative to the premium increase for all mental health diagnoses for two reasons.

First, and most importantly, few people would use expanded benefits. Consumers of long-term substance abuse treatment are rare in the privately insured population, because few are employed. For employed people who do receive substance abuse treatment, few require long-term care. Wesson (1995) reports that most detoxification patients do not need inpatient or residential treatment. Furthermore, inpatient treatments are short-term, so that 30 days per year of inpatient substance abuse benefits are reasonable.

Second, our projections use a baseline plan with more generous substance abuse benefits than the typical plan. We assume that the lifetime benefit maximum for both mental health and substance abuse treatment is \$50,000 for the typical plan before parity. This implies that the lifetime benefit maximum for substance abuse services only for the typical plan is less than \$50,000 (by the amount of the mental health benefits used).

Under the Mental Health Parity Act of 1996, the lifetime benefit maximum for mental health treatment is \$1 million, but no benefit maximum is specified for substance abuse services.

For purposes of this study, we assume that there is a \$50,000 lifetime benefit maximum for substance abuse services. Therefore, the benefit maximum for substance abuse treatment under the act is greater than the benefit maximum for substance abuse treatment before the act.

Partial parity options. The premium increases predicted by the model for the partial parity options as defined in this study are much lower. For all MH/SA diagnoses, the composite premium increases are 0.4 percent or less if there is parity in cost sharing. If there is parity in service limits, the composite premium increases are 1.2 percent or less.

The partial parity premium increases are higher when there is parity for service limits compared with parity for cost sharing because there is a greater increase in benefits when there is parity for service limits. Specifically, for most plan types, parity for service limits increases the number of covered inpatient hospital days from 30 days to 365 days and increases the number of covered outpatient visits from 20 visits to an unlimited number of visits.

In contrast, when there is parity for cost sharing, there is generally no change (or a relatively small change) in the out-of-pocket expenses for inpatient care because the typical health plan already offers parity with respect to inpatient cost sharing. For outpatient visits, there is a decrease in the FFS coinsurance rate of 50 percent to 20 percent, and a decrease in the HMO copayment amount from \$20 to \$10.

Estimated Premium Increases for Child Health Plans

Under the Balanced Budget Act of 1997, states will receive block grants to fund health insurance for uninsured, low-income children (Mann and Guyer, 1997). States may either expand Medicaid eligibility and provide full Medicaid benefits for uninsured children, or they may establish or expand a separate state program for children.

Estimating the costs of parity in this program is difficult for two reasons. First, we do not know what the baseline benefit packages are. States that do not expand Medicaid may use any of three standard benefits packages or a package that is actuarially equivalent to one of these. Second, we do not know the prevalence of MH/SA disorders among the covered children. States have great latitude in choosing which children are covered. Within the scope of this project, we could not fully address the costs of parity for these programs for uninsured children, but we make predictions that are likely to be conservative estimates of the true costs of parity for separate state programs for children. Our estimates are not relevant for Medicaid expansions.

We produced actuarial estimates of the costs of full and partial parity for all MH/SA diagnoses for currently insured children of employees of medium and large employers (Table 4.3). The premiums are estimates of the average costs of coverage for one child. Unlike employer-sponsored insurance, the premiums do not include any costs for covering adults.

We estimate that full parity for child health plans would increase MH/SA expenditures for currently insured children with FFS coverage by 158.9 percent and the total premiums by 7.0 percent. In contrast, full parity for children's MH/SA benefits in a tightly managed HMO would increase premiums by 0.8 percent. We do not present a composite premium, because we do not know what types of delivery systems states might use for their block grant programs.

The estimated increases in MH/SA expenses and premiums for children are greater than the estimates for families shown in Table 4.1 because MH/SA expenses account for a greater portion of children's premiums. Data on children's MH/SA expenses indicate that children use such services at a much lower rate than adults, but children who use MH/SA services have, on average, higher expenditures than adults (Sturm, 1997; Grazier and G'Sell Associates, 1997).

The estimates in Table 4.5, which are based on data for children who are currently privately insured, are likely to be lower than the actual costs of parity for uninsured children. If states provide insurance coverage to currently uninsured children, these children are likely to use more MH/SA services than those who are currently insured. For example, Frank, et al. (1994) estimate that, if the uninsured population (adults and children) were given insurance coverage, the number using MH/SA treatment services would be 0 percent to 5 percent higher than the currently insured population.

However, the costs of covering uninsured *children* are uncertain, especially because states may choose to cover only some uninsured children. In addition, the state may establish a program with more or less generous medical/surgical benefits than those typical of medium and large employers, depending on how the state applies the benefit standards law.

TABLE 4.5
INCREASES IN CHILDREN'S MH/SA EXPENDITURES AND PREMIUMS FOR FULL PARITY BY PLAN
TYPE

Plan Type	Percentage Increase in MH/SA Expenses			Percentage Increase in Total Child's Premium		
	Parity in Cost Sharing	Parity in Service Limits	Full Parity	Parity in Cost Sharing	Parity in Service Limits	Full Parity
FFS	14.4	56.3	158.9	0.5	2.2	7.0
PPO	15.6	53.2	143.7	0.7	2.3	7.0
POS	0.3	38.0	81.3	0.00	2.2	4.9
HMO	6.0	3.5	11.2	0.4	0.2	0.8

NOTE: Estimates based on privately insured children, using typical benefit packages of medium and large employers. The premiums are estimates of the average costs of coverage for one child. Estimates do not adjust for likely greater service use among uninsured children or differences between private insurance benefits and those of health block grant programs for children.

Interpreting the Estimates

Readers should keep several features of the model and our assumptions in mind when interpreting the predicted premium increases. First, this model (and other actuarial models) does not account for employer responses to parity mandates. Employers could respond to an anticipated premium increase due to a parity mandate by increasing employee contributions, dropping health insurance coverage, dropping or reducing coverage for MH/SA services, reducing other benefits, or increasing management of MH/SA services. These responses would lead to a lower premium increase than that estimated by this model. Therefore, our estimates indicate only the *initial* premium increase due to parity.

Second, these estimates are made with a baseline benefit package that is more generous than those used in previous actuarial estimates. Our baseline benefit package for each plan has a \$1 million lifetime spending limit for mental health services, which reflects the Mental Health Parity Act of 1996. However, the baseline packages for previous actuarial estimates have a much lower lifetime spending limit for MH/SA services (such as \$50,000). If our baseline packages had this lower limit, our projected premium increase for a composite of plans would be 4.2 percent instead of 3.6 percent.

Third, these estimates are based on the characteristics of a typical health plan for each plan type. But among each plan type there is great diversity in benefit and management levels.

Fourth, in this study we estimated premium increases for family coverage. Many previous studies estimated premium increases for single adults. This model predicts lower premium increases for single adults than for families. According to the model, full parity in MH/SA benefits for single adults would raise premiums for the composite plan by 3.1 percent (as opposed to 3.6 percent for families). For FFS plans, the model estimates a 4.3 percent premium increase for single adults, compared to 5.0 percent for families.

The adult-only premium increase for expanded MH/SA benefits is lower than the estimate for family coverage because the relative cost of MH/SA coverage for children in this model is higher than the relative cost of non-MH/SA benefit coverage. For non-MH/SA benefits, the revised HayGroup model assumes that the relative cost of children to adults is 58 percent (i.e., for every \$100 in adult costs, children cost \$58). For MH/SA benefits, the relative costs of children to adults is about 68 percent.

April 8, 1999

FAX TO:

Rep. Fred Dyson	465-4587	Rep. John Coghill	465-3258
Rep. Joe Green	465-4316	Rep. Carl Morgan	465-2197
Rep. Jim Whittaker	465-2070	Rep. Tom Brice	465-2937
Rep. Allen Kemplin	465-6615		

SUBJECT: Mental Health Parity (HB-149)

We strongly support HB-149. I feel it will really enhance the ability of mentally effected residents of the State of Alaska to lead productive and independent lives instead of becoming public burdens.

We have two examples in our immediate family which the passage of this bill would effect positively.

1. We have a son who has mental chemical imbalance problems. With psychiatric consultation and prescribed medication, he can function normally and operate his own commercial fishing business. He carries his own independent medical insurance but unfortunately, it does NOT cover psychiatric care or medications for the same. Because his income is currently below the poverty level, he cannot afford to pay for this treatment himself. The burden to pay for this expensive treatment therefore falls on us his parents. We are of retirement age which also makes the financial burden greater. As our income diminishes our ability to sustain this assistance may be overwhelming. His alternative would be to go on Medicaid and public assistance, but he would have to divest himself of his business, thus reducing his ability to support himself and his minor child. The passage of HB-149 would go a long way to solving this catch 22 situation.

2. We have a nephew who, after several years of in house treatment in a state mental institution has been able to cope with his mental disabilities and with proper on going consultation and medical treatment, been able to be discharged to live an independent life. In order to fund this treatment, he has been forced to go on permanent disability thru Social Security and Medicaid programs and assistance from his mother. Under this program, he can have no earned income. If insurance was available to cover his mental health costs, he possibly could work to support himself and alleviate the needs for Social Security and Medicaid assistance. A productive individual is a much more happy, secure and useful citizen.

We sincerely hope we can count on you and the other committee members to show your support for HB-149 and help move it on into law. Let's make it happen for Alaskan Citizens of all abilities. Better health make stronger constituents.

Respectfully
Dean & Melinda Dewey



2355 Ke-See-An Drive, Juneau AK 99801 FAX 789-7076


 Coastal Helicopters,
Inc.

Fax

To: Representative Fred Dyson **From:** Dot Wilson *Dot Wilson*

Fax: 465-4587 **Pages:** 1

Phone: 789-5800 **Date:** April 8, 1999

Fax: HB149 **CC:**

Urgent
 For Review
 Please Comment
 Please Reply
 Please Recycle

• Comments: Please do not pass HB 149. Mandated benefits as outlined in this bill will cause a burdensome increase in health care costs for small businesses and will likely result in those business cancelling health insurance they now provide. Others may decide not to provide health insurance in the first place.

In looking at the task force which drew up this legislation, it is interesting to note that the business community was not included. The only people assigned to the task force were the ones who would directly benefit from the passage of this bill; i.e.; Commissioner of H&SS, Insurance industry representatives and mental health care advocates. **What about someone to represent the EMPLOYER WHO WILL BE PAYING THE BILLS!**

This is essentially a tax being imposed on employers who are trying to provide support to their employees. Why are all state and local governments exempted? Are their employees exempt from mental illness and substance abuse also?

At the moment we do not have 20 employees eligible for health insurance coverage. If this bill passes, and if we ever do have 20 employees, we will no longer provide health insurance coverage. We will simply insist the employees pay all their own premiums.

ALLEN MARINE TOURS, INC.
P.O. BOX 1049
SITKA, ALASKA 99835

FACSIMILE TRANSMITTAL SHEET

TO:	REP. FRED DYSON	FROM:	LAUREN ALLEN
COMPANY:	ALLEN MARINE	DATE:	April 9, 1999
FAX NUMBER:	465-4587	TOTAL NO. OF PAGES INCLUDING COVER:	1
ALLEN MARINE PHONE NUMBER:	907 747 8100		
RE:			

Comments on HB 149, Mental Health Insurance:

Please vote no. Small businesses are already inundated with costs... this added insurance would cost thousands of dollars. This is coverage that employees may not want or need.

ALASKA STATE HOUSE OF REPRESENTATIVES

Interim Address:
119 N. Cushman, Suite 211
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State Capitol
Room 416

REPRESENTATIVE JOHN COGHILL

Mandated Mental Health Coverage

Federal law mandates that if employers provide health insurance and have 50 employees or more, they must also provide mental health and substance abuse insurance as well. HB 149 expands this provision to include employers who have 20 or more employees. The assumption is that this legislation will increase the mental health coverage available for the estimated 44,000 Alaskans who require mental health treatment. I am not convinced this HB 149 will accomplish that. In fact, I believe it is possible that by mandating mental health parity we are at risk to reduce the availability of insurance coverage.

I have two major concerns with the mandated approach:

1. Are we really expanding to more mental health patients, mental health services?
2. Are we unfairly placing an added burden on Alaska's small businesses without a real compelling interest on the part of the State of Alaska?

While it is estimated that there are about 44,000 Alaskans that need mental health services, we do not know how many of these people are currently getting those services through Denali Kid Care, medicaid, medicare, and private sources. According to information provided to this committee by the Alaska Mental Health Board, 14,700 of those are children that most likely qualified under the expanded eligibility guidelines set by Denali Kid Care. We certainly do not know how many more, if any, Alaskans will receive those services if we umbrella small businesses under federal mandates and increase the pool of eligible employees.

Nationally, statistics show that state mandated general health insurance benefits have increased insurance premiums by 15 to 30 percent and the number of insured Americans has been on the rise with 40 million Americans in January of 1997 were uninsured.¹ Part of the reason behind the increase in uninsured might be that mandating certain levels of coverage eliminates the availability of no-frills, large deductible insurance plans that are available to middle-classed citizens. According to Dr. William Custer with Georgia State University, the probability for being uninsured increases by almost six percent when state mandates require mental health service coverage.²

¹ <http://www.alcapital.com>: "Should Uncle Sam Control Your Health Insurance?" by John C. Goodman; Jan. 2, 1997.

² *Health Insurance Coverage and the Uninsured*, William S. Custer, Ph.D., Center for Risk Management and Insurance Research, Georgia State University

Estimates put the cost of mandating mental health care anywhere from 1 percent to 12 percent. Added insurance mandates could cost the small business with 20 employees between \$2,500 and \$15,000 a year. Maybe the increase is only a 1% increase in costs or the employer could pass the increase on to the employees, but are we increasing availability of mental health services if that 1 percent increase is enough to cause the small business owner to not offer insurance.

In a 1998 analysis by The Urban Institute, it was determined that benefit mandates for drug and alcohol treatment decrease overall insurance coverage. *"While most firms may not drop coverage because such a mandate is enacted, the mandate may contribute to higher premiums over time, and these higher premiums lead some people to drop their employer-sponsored or individual coverage."*³

Dr. Michael Morrissey, Director of the Hill Center, and his colleague, Dr. Gail Jensen, have concluded that state insurance mandates "probably don't" make most workers better-off:

*"The laws often add substantially to the cost of coverage, and the higher costs of insurance are paid by workers in the form of lower wages. Some firms and their workers choose to go without insurance entirely as a result of the insurance mandates. While some workers will benefit, many are made worse-off."*⁴

Morrissey and Jensen concluded in a report to the Health Insurance Association of America that state mandates cost one in four Americans their health insurance.⁵ Further statistics in the report are as follows:

- One-fifth to one-quarter of the uninsured have no health insurance because of the high cost of mandated benefit requirements. That equals more than 10 million Americans.
- State mandates raise premiums by up to 13 percent for businesses that offer health insurance to their employees.
- 18 percent of small businesses without health coverage would buy it in the absence of state mandates.

Dr. Mark Schiller, board member of the Association of American Physicians and Surgeons, said in a guest opinion of the New York Times that mental health parity will cause more Americans to become uninsured and distracts us from searching for solutions to the real problems in our health care system.⁶

³ *Variations in the Uninsured: State and County Level Analysis*, The Urban Institute, June 1, 1998, <http://www.urban.org/health/variater.html>

⁴ "Do State Insurance Mandates Make Most Workers Better-Off?" *HealthPolicy*, Volume 10, Number 2; December 17, 1999;

⁵ *Mandated Benefit Laws & Employer-Sponsored Health Insurance*, Gail A. Jensen, Ph.D and Michael A. Morrissey, Ph.D, Jan. 1999 for the Health Insurance Association of America

⁶ *The New York Times*, "Mental Health Misstep", Mark Schiller, June 15, 1999

If more people become uninsured, the pressure will be on us to once again redefine poverty so more people will be eligible for medicaid services. The end result is that we take medical choice away from more middle-class Alaskans and make their medical needs the decision of government.

Does the State of Alaska have a compelling interest to impose more state mandates on that sector of our private economy that is made up of small businesses, when we do not even know what the benefits or negative impact will be? Considering the outcome is more predictably a negative one, I feel we have a compelling interest to go down this road very cautiously.

I would like to see us adopt a health care policy that will put the patient in control of the type of insurance and services he or she wants and needs. We need a program that provides more commercial medical choice for our working citizens.

I remain committed to working on better private health care delivery for all Alaskans through private insurance access.

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: March 19, 1999

FURTHER REFERRALS: Labor and Commerce
Finance

Date of Committee Action: 4/11/00

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 149

HOUSE BILL NO. 149 INSURANCE: MENTAL HEALTH & SUBSTANCE ABUSE

"An Act relating to insurance coverage for treatment of mental illness and substance abuse; repealing provisions of ch. 8, SLA 1997, that terminates required mental health benefit coverage; and providing for an effective date."

recommends it be replaced the same title
with the following committee substitute _____ a new title

additional referral to _____ Committee
 attached amendment(s)

A.ADOPTS: _____ Letter of Intent

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

zero fiscal note(s) _____ zero fiscal note(s) CEID

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

CHAIR'S SIGNATURE *[Signature]* 4/11/00