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IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE HOUSE RULES COMMITTEE

Amended: 4/24/98

Offered: 4/8/98

Sponsor(s): SENATE 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," "mental injury," and "mental
6 health consumers" 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) one member representing the Alaska Mental Health Board appointed by the
31 Alaska Mental Health Board;

1 (5) one member representing the state Advisory Board on Alcoholism and
2 Drug Abuse appointed by the state Advisory Board on Alcoholism and Drug Abuse;

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

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

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

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

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

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

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

Mental Health Parity Task Force Member Directory

Name	Representing	Address	Phone/Fax	E-Mail
Senator John Torgerson	Alaska Senate	PO Box 1068 Kasilof, AK 99610	(T) (907) 283-2690 (F) (907) 283-9267	
Representative Gary Davis	Alaska House of Representatives	145 Main St. Loop, Ste 223 Kenai, AK 99611	(T) (907) 283-7095 (F) (907) 283-3075	
Senator Johnny Ellis	Alaska Senate	716 West 4 th , Ste 440 Anchorage, AK 99501	(T) (907) 258-8182 (F) (907) 258-8734	
Representative Tom Brice	Alaska House of Representatives	119 North Cushman, #205 Fairbanks, AK 99701	(T) (907) 456-2414 (F) (907) 541-9293	
Marianne Burke	Alaska Division of Insurance	PO Box 110805 Juneau, AK 99811-0805	(T) (907) 465-2515 (F) (907) 465-3422	
Joe Heueisen	Insurance/Shattuck & Grummett	301 Seward Street Juneau, AK 99801	(T) (907) 586-2414 (F) (907) 586-3770	
Dr. Cynthia Dodge	MH Provider	2550 Denali, #1606 Anchorage, AK 99503	(T) (907) 566-1119 (F) (907) 258-7733	
Banarsi Lal	Advisory Board on Alcoholism & Drug Abuse	4532 Dartmouth Street Fairbanks, AK 99709	(T) (907) 452-6251 (F) (907) 456-4849	
Katsumi Kenaston	Consumer	1281 East 19 th Ave, #303 Anchorage, AK 99501	(T) (907) 272-8216	katsumi@alaska.net
Patrick Murphy	Alaska Mental Health Board	2400 Douglas Highway #2 Juneau, AK 99801	(T) (907) 364-2374	
Elmer Lindstrom	Alaska Health & Social Services	PO Box 110601 Juneau, AK 99811-0601	(T) (907) 465-3030 (F) (907) 465-3068	
Steven Hamilton	C & S Management Associates	PO Box 34757 Juneau, AK 99803	(T) (907) 789-0921 (F) (907) 789-1667	csmsgt@alaska.net
Matt Felix	C & S Management Associates	PO Box 34757 Juneau, AK 99803	(T) (907) 789-0921 (F) (907) 789-1667	csmsgt@alaska.net
Pat Ryan Clasby	Care Systems North (Observer)	211 Fourth St, Suite 114 Juneau, AK 99801	(T) (907) 463-6753 (F) (907) 463-6754	csn@alaska.net

Thelma-Snowden Div of Insurance

(907) 283-7902

Mental Health Parity Task Force

Tuesday, September 1, 1998

Alaska Psychiatric Institute

Meeting Agenda

10:30 a.m. to 3:00 p.m. (including working lunch)

Introductions/Roll Call

Dialogue with Ron Bachman of PricewaterhouseCoopers

- Adenda review with Mr. Bachman
- Approaches other states have taken to study Parity
- Actuarial Analysis
 - Scope of actuarial analysis to be provided
 - Experience of other states in developing/costing out options
 - Issues that must be addressed before Alaska's actuarial analysis can be completed

3:00 to 3:30 p.m.

Contract staffing update

Logistics for next Task force meeting

3:30 p.m.

Adjournment

**Mental Health Parity Task Force
Teleconference Meeting Agenda
Thursday, October 1, 1998
11:00 a.m. to 1:00 p.m.**

Dial In Number: 1-800-315-6338 followed by PARITY# (or 727489#)

1. Introductions of Contractor staff and Task Force members
2. Review of services to be provided by Contractor (see attached description)
3. Communications between Contractor and the Task Force
4. Verification of key policy issues and tasks to be addressed by the Task Force
 - Definition of mental illness
 - Inclusion or exclusion of substance abuse
 - Definition of eligible expenses
 - Definition of employer pool
 - Mandatory versus voluntary coverage
 - Continuum of options from partial to comprehensive parity
 - Analysis of actuarial data, including Alaska-specific information
 - Consideration of public input
 - Review/approval of final report
 - Development of any proposed legislation
 - Others?
5. Discussion of options for public input into Task Force deliberations
6. Determination of future meeting schedule
7. Planning for next in-person meeting
 - Date, time, location
 - Expectations/outcomes desired
 - Agenda development

APPENDIX C

Services to Be Provided

The Contractor will provide staffing and consultation services to the Mental Health Parity Task Force. The Contractor shall perform all activities delineated in the Request for Informal Proposals resulting in this contract and all activities delineated in the contractor's proposal; these documents are hereby included as part of the contract. Specific tasks under the contract include the following:

1. Researching and gathering mental health parity information from various state, national and private sources. This includes obtaining information from the various states that have passed parity legislation, reports on the impact of implementing parity legislation and Alaska-specific information on various aspects of mental health parity (actuarial data, etc.).
2. Analyzing and summarizing information gained through research for consideration by Task Force members in developing its recommendations.
3. Staffing approximately three in-person Task Force meetings (averaging 6 hours per meeting), and periodic teleconference meetings. This includes agenda development, preparation of background materials, public notice and advertising; minute taking and distribution; and maintaining a repository for materials gathered and developed by the Task Force.
4. Revising the Task Force's draft work plan and time line to ensure that all essential tasks are completed.
5. Presenting for the Task Force's consideration, the pros and cons of all major policy-related issues which must be addressed in relationship to possible mental health parity legislation in Alaska. Key policy issues include: definitions of mental illness, inclusion or exclusion of substance abuse under parity legislation, definition of eligible expenses, definition of the employer pool to be covered under any proposed parity legislation, mandated versus voluntary coverage, and the continuum of options from partial to comprehensive parity.
6. Acting as liaison to PricewaterhouseCoopers, who are conducting the actuarial study for mental health parity in Alaska, and ensuring that the actuarial analysis contains as much Alaska-specific information as possible.
7. Writing a final report which includes the Task Force recommendations on parity and other pertinent information. The final report is due by January 15, 1999.
8. Assisting in the development of any proposed legislation and providing in person and/or telephonic testimony at key legislative hearings regarding the Task Force recommendations.

**Notice of Public Meeting
Mental Health Parity
Legislative Task Force**

The Legislative Task Force on Mental Health Parity will meet in Anchorage on October 26 to hold a regular meeting and to take public testimony.

Place: Legislative Information Office
716 W. 4th Avenue, Room 220
Anchorage, Alaska

Time: 9:30 am – 2:45 pm	Task Force Meeting
3:00 pm – 5:00 pm	In-person Public Testimony
7:00 pm – 9:00 pm	Call-in and In-person Testimony

Persons desiring to call in for testimony during the 7:00 to 9:00 pm period should dial 1-800-315-6338 and use the access code 727489# (PARITY#). Persons with disabilities needing assistance should contact the Alaska Mental Health Board at (907) 465-3071.



MANAGEMENT ASSOCIATES

P.O. Box 34757 • Juneau, Alaska 99803-4757

October 19, 1998

Mental Health Parity Task Force

Dear Task Force Member:

I am sending along the agenda and some additional materials for our meeting in Anchorage on the 26th. Because of scheduling conflicts with Alaska Psychiatric Institute, we will be using the Legislative Information Office at 716 W. 4th Avenue, Room 220. Our current plan is to order lunch in to minimize our down time. The meeting is scheduled to begin at 9:30 am.

The materials that I am enclosing with the agenda are but a sample of the material that we have gathered. I hope that you find them useful. I will be out of town Tuesday through Thursday but will be back in the office on Friday before the meeting. Please give me a call if you have questions.

I look forward to seeing you on the 26th.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Steven Hamilton'.

Steven Hamilton

Enclosure: (1) October 26 Meeting Agenda
(2) Assorted MH Parity Information

Mental Health Parity Task Force

Monday, October 26, 1998

Meeting Agenda

Legislative Information Office

716 W. 4th Avenue, Room 220

Anchorage, Alaska

9:30 am – 2:45 pm Task Force Meeting

Call to Order

/ Introductions

/ Approval of Agenda

/ Presentation of Work Plan – C & S Management Associates

/ Information needed by National Contractor

Discussion of Issues



Definitions used: Mental Disorders versus Seriously Mentally Ill (SMI)

Services Covered: Experiences of Other States

Needed Data (lives covered, description of plans, utilization) –

Approach/Problems

- / • Mandatory versus Optional Coverage; relationship to parity**

Next Steps; agenda items for next meeting

Note: Lunch will be ordered in

In-Person Public Testimony: 3:00 – 5:00 pm

Call-in and In-Person Public Testimony: 7:00 – 9:00 pm

Managed Care

- **Mental Health Parity**
- **Publications**
- **Database**
- **Links**
- **Calendar**
- **Homepage**

Parity**Chapter 1 - State Parity Laws**

Since 1994, at least 40 states and the U.S. Congress have considered mental health and substance abuse (MH/SA) parity bills. Insurance regulation traditionally has been a state responsibility. The federal Mental Health Parity Act of 1996 imposed a national minimum benefit standard for mental health benefits on employer-sponsored health insurance for the first time.

Federal Parity Legislation

In 1996, Senators Pete V. Domenici (R-NM) and Paul D. Wellstone (D-MN) proposed an amendment to S.1028, the Health Insurance Reform Act. This amendment would have required insurers to provide the same coverage for mental health and medical/surgical benefits. Actuaries predicted this amendment would raise health insurance costs by 3.2 percent to 8.7 percent (Bachman, 1996b; Rodgers, 1996).

In part because of fears about increased health insurance costs, the Domenici-Wellstone amendment did not pass. Instead, the federal government enacted the Mental Health Parity Act of 1996. This act requires that, starting January 1, 1998, insurers provide the same annual and lifetime spending limits for mental health benefits as they do for other health care benefits.

While this provision is a step toward parity for mental health care, it neither requires employers to provide mental health benefits, nor does it affect the terms and conditions of mental health coverage such as visits, days, and cost sharing. Furthermore, the provision exempts companies with 50 or fewer employees and companies for which the legislation results in increased costs of at least 1 percent. The Mental Health Parity Act does not apply to substance abuse benefits.

State Parity Mandates

By the end of September 30, 1997, 12 states had enacted parity laws that require more generous MH/SA benefits than those provided for in the Mental Health Parity Act of 1996 (Heiser, et al., 1998). These 12 states are Arkansas, Colorado, Connecticut, Indiana, Maine, Maryland, Minnesota, New Hampshire, North Carolina, Rhode Island, Texas, and Vermont. Eleven states passed bills to comply with the Mental Health Parity Act of 1996. Other states passed laws that increase MH/SA benefits but do not require parity, but these are not discussed in this report.

The 12 state MH/SA parity laws differ significantly from each other in the (1) conditions covered, (2) specificity of parity, (3) minimum benefit requirements, (4) approved providers, (5) use of managed care, and (6) exemptions/populations covered (Table 1.1).



TABLE 1.1
CHARACTERISTICS OF MENTAL HEALTH AND SUBSTANCE ABUSE PARITY LEGISLATION BY STATE

Characteristics of Legislation	State											
	AR	CO	CT	IN	ME	MD	MN	NH	NC	RI	TX	VT
Conditions Covered												
Definition of mental illness												
Does not define mental illness (i.e., covers mental illness broadly)				✓		✓	✓					
Defines mental illness	✓	✓	✓		✓			✓	✓	✓	✓	✓
Covers only serious mental illness or "biologically based" mental illness		✓	✓		✓			✓		✓	✓	
Designates particular diagnoses		✓	✓		✓			✓		✓	✓	
Covers substance abuse	✓					✓	✓		✓			✓
Specificity of Parity												
Provides specific language about how MH/SA benefits may not differ from those for physical health	✓			✓	✓	✓	✓		✓	✓	✓	✓
Minimum Benefits												
Specifies minimum benefit requirements					✓	✓			✓			
Approved Providers												
Specifies providers who may offer services under the mandate					✓				✓			✓

Managed Care												
Mentions managed care	✓		✓		✓	✓	✓	✓	✓	✓		✓
Contains medical necessity clauses	✓				✓	✓	✓ ^a			✓		
Exemptions/Populations Covered												
Only applies to government employees				✓					✓		✓	
Exempts small businesses	✓				✓	✓	✓ ^b					

^a Minnesota enacted a definition of medical necessity in 1997. This definition will become effective on January 1, 1998.

^b Small employers may choose an alternative benefit design without parity.

Conditions Covered

All state mandates require mental illness to be covered in the same way as other medical care. However, they differ in how this term is defined, and sometimes limit coverage to serious or biologically based illnesses. Coverage for substance abuse treatment may or may not be mandated.

In some states, mental illness is broadly defined, and substance abuse is also covered. In Maryland, Minnesota, and North Carolina, the mandates include all mental illnesses broadly defined, and they explicitly state that substance abuse is included. In Vermont, the mandate covers all mental illnesses listed in the *International Classification of Diseases Manual*, and the mandate explicitly includes substance abuse.

In Arkansas, the mandate includes all mental illnesses listed in either the *International Classification of Diseases Manual* or the *Diagnostic and Statistical Manual of Disorders*. The mandate does not include substance abuse (Health Policy Tracking Service, 1997). Arkansas did, however, pass legislation in the late 1980s requiring parity for substance abuse (Scott, Greenberg, and Pizarro, 1992). In Indiana, the mandate includes all mental illnesses, but explicitly excludes substance abuse.

In the remaining states, the mandates list particular mental illnesses that are covered. Specifically, in Colorado, Connecticut, Maine, New Hampshire, Rhode Island, and Texas, the mandates cover only serious or biologically based mental illnesses. The list of specific illnesses that must be covered includes bipolar mood disorder, major depressive disorder, schizophrenia, schizo-affective disorder, obsessive-compulsive disorder, panic disorder, autism, and paranoia/psychotic/delusional disorders (Table 1.2). Substance abuse is not covered by these state mandates (Health Policy Tracking Service, 1997).

Specificity of Parity

The parity mandates in all 12 states require health plans to provide coverage for mental illnesses that is comparable to coverage provided for other illnesses. Some laws provide little more direction than that, leaving what is meant by "coverage" (for example, service limits, cost-sharing requirements, annual/lifetime spending limits) and "comparable" open to interpretation by the carrier. Others are more specific about ways in which benefits for mental and physical illnesses may not differ.

In Colorado, Connecticut, and New Hampshire, the mandates do not specify the ways in which mental health benefits must be equal to those for physical illness. For example, in Colorado and New Hampshire, the laws simply state that health plans shall provide coverage for mental illness that is no less extensive than the coverage provided for any other physical illness.

TABLE 1.2
SERIOUS/BIOLOGICALLY BASED MENTAL ILLNESSES SPECIFIED IN PARITY LEGISLATION

Serious Mental Illnesses/ Biologically Based Disorders	States					
	CO	CT	ME	NH	RI	TX
Bipolar mood disorder	✓	✓	✓	✓	✓	✓
Major depressive disorder	✓	✓	✓	✓	✓	✓
Obsessive-compulsive disorder	✓	✓	✓	✓	✓	
Panic disorder	✓	✓	✓	✓		
Paranoia/psychotic/delusional disorder		✓	✓	✓	✓	✓
Pervasive developmental disorder/autism		✓	✓	✓		
Schizo-affective disorder	✓	✓		✓	✓	✓
Schizophrenia	✓	✓	✓	✓	✓	✓

In the other nine states, the legislation contains more specific language about how the benefits for mental illness may not differ from those for physical illness. For example, the laws assert that benefit and service limits must be at least as generous for mental illnesses as for other illnesses. However, the mandates vary in the level of detail provided.

In Indiana, for example, a health insurance contract "may not permit *treatment limitations or financial requirements* on the coverage of services for mental illness if similar limitations or requirements are not imposed on coverage of

services for other conditions." Whereas Indiana refers to "limitations and requirements," Arkansas elaborates on this area by defining financial requirements as including "co-payments, deductibles, out-of-network charges, out-of-pocket contributions or fees, annual limits, lifetime aggregate limits imposed on individual patients, and other patient cost-sharing amounts." Some states also require minimum mental health benefits, as described below.

Minimum Benefit Requirements

Mental health parity does not prevent insurers from providing a low level of benefits for mental illness by lowering the level of benefits provided for physical illness. To ensure that people with mental illness get a minimum acceptable level of care, three states (Maryland, North Carolina, and Maine) designate specific services that must be provided for mental illness, independent of the services provided for other illnesses. Though carriers may need to offer more services, if necessary, to achieve parity with other illnesses, they may not offer fewer services than specified by the laws.

Maryland mandates a minimum benefit package in which there can be no annual limit on outpatient visits. Outpatient visits must be covered at a level of at least 80 percent for the first 5 visits, 65 percent for the next 25 visits, and 50 percent for any other visits. The law further states that a minimum of 60 partial inpatient days must be covered.

North Carolina and Maine specify that certain care for mental illness is "necessary" and must be provided regardless of provisions for other illnesses. These two states do not specify the level at which such services must be provided, however. North Carolina's law states that "allowable institutional and professional charges for inpatient psychiatric care, outpatient psychotherapy, intensive outpatient crisis management, partial hospitalization, and residential care and treatment" are necessary and must therefore be covered. Maine's legislation says that "at a minimum, inpatient, day treatment, and outpatient services must be provided."

Approved Providers

In three states--North Carolina, Maine, and Vermont--only specific providers identified by the law can offer services covered under the mandate. In all likelihood, the states did this to protect patients by ensuring that their diagnosis and treatment would be provided, or at least supervised, by qualified mental health providers, and to protect insurers by lessening the chances that they would have to reimburse unnecessary or inappropriate care.

For example, the Maine legislation defines "provider" to include licensed physicians, accredited public hospitals or psychiatric hospitals, and community agencies licensed at the comprehensive service level by the Department of Mental Health and Mental Retardation. The mandate further states that services offered by these providers must be supervised by a psychiatrist or licensed psychologist. It also specifies that mental illnesses must be diagnosed by a licensed allopathic or osteopathic physician or psychologist¹.

¹The original parity legislation in Maine was amended in 1996 to include psychologists among those who can diagnose the mental illnesses covered. Prior to that amendment, only illnesses diagnosed by licensed allopathic or osteopathic physicians were covered.

Managed Care

Mandates in nine states mention managed care, primarily to state that managed care plans are included as health insurers covered by the mental health parity requirements, or that mental health benefits covered by the parity law may be delivered in a managed care system. Four states--Arkansas, Maine, Maryland, and Rhode Island--address the managed care concept of medical necessity by stating explicitly that medical necessity determinations are not prohibited. Arkansas, for example, defines medical necessity and does not prohibit plans from applying medical necessity determinations. Maine's mandate states that when determining medical necessity, providers must use the same criteria for medical treatment of mental illness as for medical treatment of physical illness.

North Carolina's mandate, which only covers the insurance plan for government employees, is relatively specific about managed care. It states that the benefits provided "shall be subject to a managed, individualized care component" that includes inpatient utilization reviews, readmission and length-of-stay reviews, and a network of qualified providers. Furthermore, care received outside the network is subject to an additional coinsurance rate of 20 percent above the general coinsurance rate in the package.

In Minnesota, the regulations specify criteria for exempting managed care plans and for determining which services are subject to parity. In some cases, the services covered differ for managed care and indemnity plans. For example, among large groups, only managed care plans are required to provide both inpatient and outpatient coverage (Blewett, 1997).

Exemptions/Populations Covered

Government employees are the only population affected by the legislation in Indiana, North Carolina, and Texas. Three other states--Arkansas, Maine, and Maryland--exempt small businesses from the parity provisions. The law in Arkansas does not apply to individual plans or to employers with 50 or fewer employees as long as they offer the parity provisions as an option. The law also does not cover state employees and health benefit plans if provisions would result in a cost increase of 1.5 percent or more. Maryland exempts small employers with 2 to 50 employees, and Maine exempts small employers with 20 or fewer employees.

In all states, Medicare and Medicaid, federal employee health insurance plans, and employer self-insured plans, which are not regulated by state health insurance laws, are automatically exempt. Private employers who are self-insured are exempt from state health insurance laws under the federal Employee Retirement Income Security Act of 1974 (ERISA). But unlike the state laws, the federal Mental Health Parity Act of 1996 does apply to self-insured plans.

Appendix B

Alternative Language for SMI Mental Health Parity

Vermont is not proposing SMI parity coverage. This appendix is presented to provide additional details on the definitions used for SMI parity. SMI is not common, but it is frequently a part of any mental health parity debate. Costs for SMI are shown only in anticipation of that discussion. Problems associated with "diagnosis creep" and the lack of savings relative to full and comprehensive parity led the national proposal by Senators Domenici and Wellstone away from SMI.

The C&L model most closely follows the National Advisory Mental Health Council (NAMHC) definition of severe mental illness. This is because the best data available on SMI analysis is developed under that definition. The definition of serious mental illness is important because substantially greater benefits are paid as a result of a professionally rendered diagnosis.

A. National Advisory Mental Health Council

Coopers & Lybrand conducted analyses of parity language for serious mental illness during national debates on health care. Senator Domenici attempted to define serious mental illness following the language developed by the National Advisory Mental Health Council. Some of the statistical basis of the actuarial work presented in this document is developed from the National Advisory Mental Health Council definition of SMI. C&L uses this definition for statistical analysis because it allows consistent use of existing data.

Severe mental illness is defined through diagnosis, disability, and duration, and includes disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, manic depressive disorder, autism, as well as severe forms of other disorders such as major depression, panic disorder, and obsessive compulsive disorder.

B. Expanded SMI Language for Children

The following definition for severe mental illness establishes parity language that includes diagnoses for illness that inflict children.

The term "severe mental illness" means an illness that is defined through diagnosis, disability and duration, and includes disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, bipolar disorder, dementia, autism, and other pervasive developmental disorders, as well as severe forms of other disorders such as major depression, panic disorder, obsessive compulsive disorder, multiple personality disorder, anorexia nervosa, bulimia, learning disorder associated with brain damage, phobia associated with significant functional impairment, and disruptive behavior disorders of childhood, as determined by the Secretary of Health and Human Services.

C. United States Substance Abuse and Mental Health Services Administration

The Center for Mental Health Services also established definitions for children and adults with "serious emotional disturbance" and "serious mental illness", respectively. States use these definitions to include incidence and prevalence estimates of the two populations as part of a State application for a Community Mental health Services Block Grant awards. The definitions are:

A. Children with a serious emotional disturbance are person:

1. from birth up to age 18,
2. who currently or at any time during the past year,
3. have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R,
4. that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community.

B. Adults with serious mental illness are persons:

1. age 18 and over,
2. who currently or at any time during the past year,
3. have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R,
4. that has resulted in functional impairment which substantial interferes with or limits one or more major life activities.

These definitions were adopted by the Substance Abuse and Mental Health Services Administration (SAMHSA) and published in the Federal Register on May 20, 1993. This language was proposed by the mental health community as an amendment to the Domenici-Wellstone Amendment in 1996. Severe and/or serious mental health definitions never became a part of the Domenici-Wellstone Amendment or the Mental Health Parity Act of 1996.

Definitions of Mental Illness

1. The term "mental illnesses" includes mental disorders defined in the **Diagnostic and Statistical Manual IV** or subsequent editions published by the American Psychiatric Association, except those codes defining substance abuse disorders (291.0 to 292.9 and 303.0 to 305.9) and the "V" codes.

2. Mental disorder diagnosis codes are limited to the diagnosis range of 290.0 to 301.9, inclusive, and 306.0 to 315.9, inclusive contained in the **ICD-9-CM**.

3. The term "mental health benefits" means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.

4. SAMHSA (Substance Abuse and Mental Health Services Administration):

Children: children with a serious emotional disturbance are persons from birth up to age 18, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most recent edition of the **Diagnostic and Statistical Manual of Mental Disorders** published by the American Psychiatric Association, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Adults: adults with a serious mental illness age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria within the most recent edition of the **Diagnostic and Statistical Manual of Mental Disorders** published by the American Psychiatric Association that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

5. The term "severe mental illness" means an illness that is defined through diagnosis, disability and duration, and includes disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, bipolar disorder, dementia, autism, and other pervasive developmental disorders, as well as severe forms of other disorders such as major depression, panic disorder, obsessive compulsive disorder, multiple personality disorder, anorexia nervosa, bulimia, learning disorder associated with brain damage, phobia associated with significant functional impairment, and disruptive behavior disorders of childhood as determined by the Insurance Commissioner.

6. National Advisory Mental Health Council Definition of SMI: The term "severe mental illness" is defined through diagnosis, disability, and duration, and includes disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, manic depressive disorder, autism as well as severe forms of other disorders such as major depression, panic disorder, and obsessive compulsive disorder.



Blue Cross
Blue Shield of Alaska
A PREMIER HEALTH PLAN
Independent Licensees of the Blue Cross and Blue Shield Association

RENEWAL BULLETIN SUMMARY OF CHANGES BestCare Program

Blue Cross Blue Shield of Alaska has made a number of changes to your program, which are shown in the new booklet you will receive for the upcoming contract year. The list below does not show all these changes, but it does show the material ones. For a full description of the terms and limits of each change, please refer to your new booklet. (The employer should also refer to the "Standard Provisions" of the new Group Contract.)

FEDERAL LEGISLATIVE CHANGES

Mental Health Parity Act of 1996 - Under the Mental Health Parity Act (MHPA), group health plans are not permitted to set aggregate lifetime dollar limits and calendar year dollar limits on mental health benefits that are lower than the limits applied to medical and surgical benefits. The law applies to both insured and self-insured groups of 51 or more employees and is effective for plan years beginning on and after January 1, 1998.

Upon renewal (or plan year if the renewal date does not coincide with the group's ERISA plan year), your group health plan's mental health benefit will be converted to an equivalent service limit benefit. This change will not affect rates.

<u>Current Benefit</u>			<u>1998 Revised Benefit</u>		
	Preferred	Nonpreferred		Preferred	Nonpreferred
Constant Benefit Level:	80%	50%	Constant Benefit Level	80%	50%
Calendar Year Inpatient Limit:	\$3,000		Calendar Year Inpatient Limit:	6 days	
Calendar Year Outpatient Limit:	\$1,000		Calendar Year Outpatient Limit:	12 visits	

STATE REGULATORY DIRECTIVES

Coverage for Newborns and Adoptive Children - Natural newborn dependent children born on or after the subscriber's effective date are covered for the first 31 days following the date of birth. If current subscription charges already include coverage for dependent children, coverage continues beyond the 31-day period.

The same holds true for adoptive children, both newly born and older dependent children. When adoptive children are adopted or placed for adoption on or after the subscriber's effective date, such dependent children are covered for the first 31 days following the date of adoption or placement for adoption. If current subscription charges already include coverage for dependent children, coverage will continue beyond the 31-day period.

However, if current subscription charges do not already include coverage for dependent children, the above dependent children must be properly enrolled within 60 days of birth, adoption, or placement for adoption in order for coverage to continue beyond the 31-day period.

We reserve the right to request additional information when necessary to establish eligibility of the dependent child.

less than \$500/mo/employee

**News and
Announcements**

- Calendar
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Media Advisory

For Immediate Release
Tuesday, March 24, 1998

Contact: Press Office
Phone: (301) 443-5052

New Study Examines Expansion Of Mental Health/Substance Abuse Insurance Benefits

Rockville, Md. -- A new study released today by the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that full parity for mental health and substance abuse services in private health insurance plans that tightly manage care would increase family insurance premiums less than one percent.

The premium increase for a composite of health plans that reflect insurance coverage nationwide (e.g. Fee For Service, Preferred Provider Organization, Health Maintenance Organization) would average 3.6 percent. In this composite, parity limited to substance abuse treatment only would raise premiums 0.2 percent, while parity for mental health services only would raise premiums by 3.4 percent.

The estimated premium increase varies greatly depending on the extent to which the plan utilizes managed care. For example, full mental health and substance abuse parity is estimated to increase premiums by 5.0 percent in fee for service plans.

"Mental and addictive disorders are among the most prevalent and most often neglected health problems in our Nation. Almost a third of all people ages 15-54 experience one or more mental or addictive disorders in a given year, and just under one half experience one or more during their lifetimes," said Nelba Chavez, Ph.D., SAMHSA's Administrator. "All Americans need to know that appropriate mental health services and drug and alcohol treatment programs improve lives and increase productivity. Yet, health insurance plans typically provide less coverage for mental health and substance abuse treatment than for general medical and surgical services. Equal access to these services is a sound, rational investment."

The study, The Cost and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits, provides a literature review on mental health and substance abuse parity, discusses state parity laws, includes case study reports from five states with parity laws, and estimates premium increases for full and partial parity options. The study was guided by an advisory panel consisting of representatives of the mental health and substance abuse fields, federal government agencies, employers, insurers and managed care organizations. A second expert panel consisting of actuaries and economists provided technical advice for the cost estimates.

In the study, "full parity" means that insurance benefits for any group of mental health and substance abuse diagnoses are the same as insurance benefits for medical/surgical diagnoses with respect to cost sharing, service limits, and annual or lifetime spending limits.

SAMHSA's Center for Mental Health Services (CMHS) Director, Bernard S. Arons, M.D., said: "We commissioned this study to learn more about the effects of state parity mandates, and to provide improved estimates of the costs of parity, based on recent data and the best advice of actuaries and economists. The new data will provide us, along with legislative staffs and others, a foundation for the development of future policies related to health insurance benefits.

Acting Director of SAMHSA's Center for Substance Abuse Treatment (CSAT) Camille Barry, Ph.D., R.N., noted that "seventy three percent of current drug users are employed. Treatment of drug and alcohol problems not only reduces drug use, but leads to increased productivity and better physical and mental health. Providing parity for substance abuse treatment in family health insurance coverage is both affordable and a very smart investment."

Key findings from the study are:

- State parity laws have had a small effect on premiums. The increases in cost have been the lowest in systems with tightly managed care and generous baseline benefits.
- Employers have not attempted to avoid parity laws by becoming self-insured. None of the employers studied identified their state parity laws as a consideration to self-insure.
- Based on an updated actuarial model, full parity for mental health and substance abuse services is estimated to increase premiums an average of 3.6 percent. Increases for mandates limited to parity in cost sharing or service limits will be lower. (See table below)

AVERAGE PREMIUM INCREASE DUE TO PARITY

<u>TYPE OF SERVICE</u>	<u>PARITY IN COST SHARING</u>	<u>PARITY IN SERVICE LIMITS</u>	<u>FULL PARITY</u>
MH/SA	0.4%	1.2%	3.6%
MH only	0.3%	1.1%	3.4%
SA only	0.1%	0.03%	0.2%

States and the Federal government have begun to require that mental health and substance abuse services are treated the same way as other medical care. The "Mental Health Parity Act," passed by Congress in 1996, and signed into law by President Clinton, became effective on January 1, 1998. The legislation requires health plans to provide the same annual and lifetime limits for mental health benefits as they do for other health care benefits. In addition to the federal legislation, 84 parity bills were introduced in 37 states during 1997, some of which included substance abuse services.

SAMHSA, a public health agency within the U.S. Department of Health and Human Services, is the federal government's lead agency for improving the quality and availability of substance abuse prevention, addiction treatment, and mental health services in the United States.

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A copy of this press release is available on the Internet via:
<http://www.samhsa.gov>

Anchorage Daily News
Tuesday, November 24, 1998

2 x 4 Ad

**Notice of Public Meeting
Mental Health Parity
Legislative Task Force**

The Legislative Task Force on Mental Health Parity will meet in Anchorage on Friday, December 4, 1998 to hold a regular meeting.

Place: Alaska Psychiatric Institute
Room 3123
2900 Providence Drive
Anchorage, Alaska

Time: 9:30 am – 4:30 pm

Persons with disabilities needing assistance should contact the Alaska Mental Health Board at (907) 465-3071.



MANAGEMENT ASSOCIATES

P.O. Box 34757 • Juneau, Alaska 99803-4757

November 2, 1998

Mental Health Parity Task Force

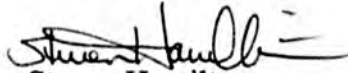
Dear Task Force Member:

I am enclosing the packet of materials for our December 7 meeting at API. In addition to the agenda, I have prepared some other materials for your review. Since the December meeting is the last face-to-face that we will have prior to my drafting the report, I have included a proposed table of contents for that report. Your review, revision and/or approval of this will help me in the preparation of the report. I have also included information on employer size/employees in Alaska as well as the data summary for lives covered in Alaska. I am still waiting for information from Aetna/NY Life that will increase the reliability the data, however, we received enough from other sources to make some initial estimates. Finally, I prepared a summary of the discrete mental health parity options that are independent of any pre-set models. This should help you in developing a package that is customized to Alaskan needs. In addition to these documents, I am also sending along copies of written testimony that we have received to date.

I am providing the enclosed information to Ron Bachman so that he can begin work on the actuarial analyses for Alaska. I intend to speak with him on Monday, November 30 and will try to gather additional information for you at that time. He previously indicated to me that he would attempt to have our estimates prepared by Christmas.

If you have any questions or concerns, you can contact me toll-free at (888) 803-3515. I look forward to seeing you on December 7.

Sincerely,



Steven Hamilton

Enclosure: (1) December 7 Meeting Agenda
 (2) Proposed Draft Report Contents
 (3) Alaskan Employer/Employee Information
 (4) Number of Lives Covered in Alaska
 (5) Mental Health Parity Discrete Options
 (6) Disability Law Center Written Testimony
 (7) Alaska State Hospital and Nursing Home Association Written Testimony
 (8) Anchorage Mental Health Consumer Transcribed Telephone Interview

Mental Health Parity Task Force

Monday, December 7, 1998

Meeting Agenda

**Alaska Psychiatric Institute, Room 3123
2900 Providence Drive
Anchorage, Alaska**

9:30 am – 4:30 pm

Morning Agenda Items

- I. Call to Order
- II. Review of Data
 - Alaska Employer/Employee Data
 - Insurance Coverage/Number of Lives Covered
 - Cost Information – General
- III. Report Format/Contents Proposal and Discussion

Lunch at API

- IV. Policy Issues Discussion
 - Different Options Available
 - Review of Previously Discussed Options (Federal Legislation Parity, Catastrophic Parity, Financial Parity)
 - Services Covered Under Parity
 - Mandatory versus Optional MH Coverage
- V. Implications for State Employee Health Insurance
- VI. Draft Report – Instructions to the Contractor/Distribution
- VII. The Next Step/Timetables
- VIII. Adjournment

Mental Health Parity Task Force

Proposed Draft Report Contents

- I. Introduction**
 - A. Background**
 - B. Scope of Work**
 - C. Methodology**
- II. Other MH Parity Legislation**
 - A. Federal Legislation**
 - B. Other States**
- III. Options/Elements of Parity**
- IV. Relevant Data/Information**
- V. Task Force Recommended Options for Consideration**

Mental Health Parity Task Force

Employer/Employee Information

Estimated 1997 Alaska Private Sector Employees: 200,000

Estimated 1997 Alaska Private Sector Small Business* Employees:

<u>Size of Firm</u>	<u>Total Number of Employees</u>
1 – 4 Employees	22,269
5 – 9 Employees	26,025
10 – 19 Employees	31,659
Total Small Business Employees	79,953

* Small Businesses are defined here as those businesses with less than 20 employees.

Data Source: Alaska Department of Labor

Employer Information

Number of Employees	Number of Companies
1 – 20	26,435
21 – 50	1,916
51 – 100	585
101 – 250	369
251 – 500	121
Over 500	77

Data Source: Alaska Department of Labor

Estimate of Small Business Employees Covered by Health Insurance

Based on reports from five states (which were, in turn, based on national data), the incidence of health insurance for specific size companies are estimated as follows:

<u>Size of Firm</u>	<u>Louisiana</u>	<u>Vermont</u>	<u>Delaware</u>	<u>Arizona</u>	<u>Georgia</u>
1 - 4 Employees	40%	37%	40%	40%	30-35%
5 - 9 Employees	61%	61%	60%	61%	50-55%
10 - 24 Employees	76%	76%	75%	76%	Unknown

Data Source: Coopers & Lybrand Actuarial Analyses

We would like to know the number of employees working small businesses (less than 20 employees) who are covered by health insurance. Coopers & Lybrand provided estimates of the number of firms offering insurance within the different segments. For purposes of this analysis, we will assume that the proportion of employers offering insurance is approximately the same as the proportion of small business employees covered by health insurance. We will use the following proportions: 1 - 4 employees - 40%; 5 - 9 employees - 60%; 10 - 19 employees - 75%.

<u>Size of Firm</u>	<u>Number of Employees</u>	<u>Percent Covered</u>	<u>Number Covered</u>
1 - 4 Employees	22,269	40%	8,908
5 - 9 Employees	26,025	60%	15,615
10 - 19 Employees	31,659	75%	23,744
Total Small Business Employees Covered by Health Insurance			48,264

This figure will be used to adjust the total number of lives covered to account for the fact that firms with less than 20 employees will be exempted.

Mental Health Parity Task Force

Number of Lives Covered in Alaska **(All estimates exclude ERISA/Self Insured Lives)**

Blue Cross of Washington/Alaska 60,000
(Note: Blue Cross is not included in the Division of Insurance Market Share List)

<u>Company</u>	<u>Percent Market Share</u>	<u>Lives Covered</u>
Principal Mutual Life Insurance Co.	7.73%	7,378
Employers Health Insurance Company	3.53%	3,500
Guardian Life Insurance Company	3.52%	5,785
Great-West Life & Annuity Insurance Co.	2.12%	1,800
Total	19.6%	18,463

Lives Covered – Method 1

Total Lives = Sample Lives Covered / Market Share of Sample + Blue Cross Lives Covered

Total Lives Covered = $18,463 / 19.6\% + 60,000$

Total Lives Covered = $94,199 + 60,000$

Total Lives Covered = 154,199

Lives Covered – Method 2

According to Blue Cross Officials, the company believes that they have 38% of the non-ERISA lives covered. If we use this figure with the 60,000 lives covered by Blue Cross, we compute total lives covered as:

Total Lives Covered = Blue Cross Lives / Blue Cross Market Share

Total Lives Covered = $60,000 / 38\%$

Total Lives Covered = 157,894

The estimates from the two methods appear close enough to work with for our purposes. If we take the average of the two, we end up with an estimate of total non-ERISA lives covered in Alaska of **156,047**.

Data Source: Key Informant Interviews 11/98

Adjustment for Small Business Employees

Since the current thinking is to exempt businesses with less than 20 employees, we need to adjust the total lives covered to account for those numbers. Using the data derived in the analysis of

small businesses, we note that approximately 48,264 small business employees are likely to be covered by health insurance. Adjusting for this in the total number of lives covered we find:

Total Lives Covered:	156,047
Less Small Business Employees:	<u>48,264</u>
Total Impacted Lives Covered	107,783

Mental Health Parity Task Force

Mental Health Parity Discrete Options

In reviewing the various reports on mental health parity prepared by Coopers & Lybrand, the options have been grouped together into various models with descriptive titles such as Financial Parity, Partial Parity, Comprehensive Parity, etc. While these are useful in examining alternatives, it might also be helpful to look at each element of mental health parity standing alone. This is a useful exercise because the Task Force is not limited to the pre-determined models presented by Coopers & Lybrand.

<u>Element of Parity</u>	<u>Descriptions</u>
Days/Visits	Firms covered by federal legislation are not allowed to set annual and lifetime benefits (in dollar amounts) at different levels than physical health. What they can do, however, is place limits on the number of outpatient visits and inpatient days that policies will cover. Parity for this element would result in coverage in which any limits on days/visits are the same as for physical health.
Co-payments	Co-payment refers to the distribution of payment for covered expenses between the insurance company and the beneficiary. Common co-payment schemes are 90% - 10%, 80% - 20%, and 50% 50% (insurance company and beneficiary). Parity for this element would require the same co-payment for mental health benefits as for physical health benefits.
Deductibles	A deductible is that amount that the beneficiary must pay toward health care expenses before insurance begins to pay. Typical deductible amounts are \$100, \$250, \$500, and \$1,000. Parity can impact deductibles in two ways. First, it can require that the deductible for mental health services is identical (but separate) from the physical health deductible. It can also require that the deductible for mental health be a common deductible with physical health, that is, that a single deductible exists and payments toward either physical or mental health count toward the common deductible.
Max OOP Expenses	Some health insurance policies contain a feature that limits the amount of money that beneficiaries must spend in terms of deductibles and co-payments. This is called maximum out-of-pocket expenses. This feature is used to ease the financial burden on families when extraordinarily high expenses occur. Typical maximum OOP expense levels are \$1,250, \$2,500, and \$5,000. As

with deductibles, parity can impact maximum OOP expenses in two ways. First, it can require that the maximum OOP expense level be the same for mental health as physical health (although separate). It can also require that there be a single OOP expense level that expenses in both physical and mental health count towards.

Mandatory vs. Optional

Some states have required that all health insurance policies written contain coverage for mental health while it is optional in other states. While there seems to be no data indicating that companies are dropping mental health coverage as parity is implemented (and increasing costs), there is always the possibility that firms could opt out of mental health coverage if the costs become onerous. Making mental health coverage mandatory prevents companies from dropping coverage (which would serve to decrease the size of the risk pool).

Other Features

There are other tools available to insurance companies for controlling costs that are technically not elements of parity but impact parity by limiting the applicability. One such tool is limiting the services that may be covered under parity provisions. Mental Health services typically exempted under such provisions include marriage counseling, psychoanalysis or psychotherapy credited toward earning a degree, and services and supplies that are not considered medically necessary. Another tool used by some states to control costs is a limit on the provisions of parity based on diagnosis. Some have included all diagnoses included in DSM IV while some others have limited parity only to diagnoses of serious mental illness. Small business exemptions are also used in legislation to impact the costs of parity. Finally, there have been some instances in which provisions of mental health parity have applied only to certain types of providers such as psychologists, psychiatrists, etc.



Testimony before the

State of Alaska

Task Force on Mental Health Parity

October 26, 1998

ANCHORAGE

615 E. 82nd Avenue
Suite 101

Anchorage, AK 99518-3158

(907) 344-1002

FAX (907) 349-1002

1-800-478-1234

Members of the Task Force, thank you for this opportunity to appear before you to discuss the important subject of parity in mental health insurance benefits. My name is Robert Briggs. I am a staff attorney in the Juneau office of the Disability Law Center of Alaska, Inc. The Disability Law Center is a non-profit corporation dedicated to providing advocacy and legal representation for Alaskans with disabilities in legal matters relating to a disability. The Disability Law Center has been designated as the Protection and Advocacy Organization for the State of Alaska, in fulfillment of federal laws requiring each state to designate an independent agency to provide such protection and advocacy services.

My work involves representation of individuals in protection of rights and securing of benefits to which persons with disabilities are entitled. This work includes appeals of denials of Social Security and Alaska public benefits, proceedings regarding the federal Individuals with Disabilities Education Act (IDEA), and claims of discrimination under the federal Fair Housing Act, Americans with Disabilities Act (ADA), the federal Vocational Rehabilitation Act, and other laws.

Another important component of our work, beyond representation of individuals, is our advocacy for systems change. Within our organization, and in our contact with other organizations that represent the interests of persons with disabilities, we constantly seek to promote change that has the widest effect and the greatest benefit. We want to improve Alaska's laws and regulations, and help enact new legislation to improve the lives of Alaskans.

MEMBER OF THE
NATIONAL
ASSOCIATION OF
PROTECTION &
ADVOCACY
SYSTEMS

1. State parity legislation is needed to complement existing Alaska anti-discrimination law

State legislation to require parity in mental health insurance benefits is long overdue, and necessary. There are existing statutes that, it may be argued, already mandate parity in the provision of health insurance benefits by both private and public employers. Yet despite this law, disparity in health insurance benefits still exists in Alaska.

Alaska Statute 47.80.010 requires that a person with a disability "may not be excluded . . . from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity that receives public funds." A more explicit directive to State and local agencies is contained in Alaska Statute 18.80.255. This statute declares it to be unlawful "for the state or any of its political subdivisions . . . to refuse or deny to a person any local, state, or federal funds, services, goods, facilities, advantages, or privileges because of physical or mental disability." These statutes form the basis of the argument that state and municipal employees, at least, have a right to parity in mental health insurance benefits, as a matter of Alaska law.

For both public and private employers within this state, Alaska Statute 18.80.220 declares it to be unlawful "to refuse employment to a person, or to bar a person from employment, or to discriminate against a person in compensation or in a term, condition or privilege of employment because of the person's . . . physical or mental disability . . . when the reasonable demands of the position do not require distinction on the basis of . . . physical or mental disability . . ."

There is also the equal protection clause of the Alaska Constitution, which itself may be a source of law on this subject.

However, these laws are general and do not address the specific issues of parity in public and private employment insurance benefits. We believe you should strive to achieve legislation in this area that has the consensus of the business community, the insurance industry, mental health consumers, and health care providers. Legislation in this area will minimize the need for judicial interpretation through litigation, and will provide more certainty.

2. State parity legislation is not necessarily pre-empted

The law regarding pre-emption in the field of private health care benefits regulated

under the federal Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act) is complex. However, that is not to say that the complexity of this law automatically prevents state legislation regarding parity in mental health coverage. In a joint rulemaking statement made by three federal agencies that regulate in this area (the Internal Revenue Service, the Department of Labor, and the Department of Health and Human Services), it was pointed out:

Section 514(b)(2) of ERISA saves from preemption any State law that regulates insurance. However, section 731(a) of ERISA and section 2723(a) of the PHS Act preempt State insurance laws relating to health insurance issuers in connection with group health insurance coverage to the extent such laws 'prevent the application of' Part 7 of Subtitle B of Title I of ERISA or Part A of Title XXVII of the PHS Act, including the MHPA provisions. (There is no corresponding provision in the [Internal Revenue] Code.) *In this regard, the conference report to [the Health Insurance Portability and Accountability Act of 1996 (HIPAA)] states that the conferees generally intended the narrowest preemption of State laws with regard to health insurance issuers (not group health plans) with respect to the provisions of Part 7 of Subtitle B of Title I of ERISA and Part A of Title XXVII of the PHS Act. Further, the conference report to the [Mental Health Parity Act (MHPA)] states that the application of these preemption provisions should permit the operation of any State law or provision that requires more favorable treatment of mental health benefits under health insurance coverage than that required under the MHPA provisions.*

Thus, generally, a State law that requires more favorable treatment of mental health benefits under health insurance coverage offered by issuers would not be preempted by the provisions of MHPA and the interim rules.¹

In the only opinion we are aware of interpreting Section 514 of ERISA, the United States Supreme Court construed the section more narrowly than prior lower court decisions, noting that the starting point for any preemption analysis is a presumption *against* pre-emption. The Supreme Court opined that nothing in ERISA "indicates that Congress chose to displace general health care regulation, which historically

¹ 62 Fed. Reg. 66932, 66933 (Dec. 22, 1997)(emphasis added).

has been a matter of local concern." The Court proceeded to uphold New York's taxes on hospital rates and membership fees charged by HMOs against a claim that such state taxes were pre-empted by ERISA.²

In your deliberation on this subject, we believe you should take the same approach as the United States Supreme Court, and presume that no strategy or proposal is pre-empted, unless it is clearly and objectively demonstrated to you, with citation to specific legal authority, that federal law pre-empts state action.

3. Federal parity law is mixed, uncertain, limited, and of limited duration

The status of federal law on parity in mental health insurance is mixed. Court cases applying the federal Americans with Disabilities Act have split on the question whether Titles I and III of the ADA mandate parity in different aspects of mental health insurance coverage.

Recently, a federal district court judge in the Eastern District of Virginia found ADA claims were properly made against a national corporate employer under Title I of the ADA when the employee was offered disability insurance coverage of shorter duration for a mental disability than coverage offered for other types of disabilities.³

Yet in the United States Court of Appeals for the Sixth Circuit, an opinion was issued in August 1997 that Title III of the ADA afforded no protection against an insurance company who provided a private employment health insurance policy with a two-year cap on long-term disability insurance benefits for mental disabilities, while the same policy covered people with other disabilities until age 65.⁴

² New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Company, 514 U.S. 645 (1995).

³ Lewis v. Aetna Life Insurance Co. and K-Mart Corp., No. 97-1230-A, Memorandum Opinion (E.D.Va. June 1, 1998). A decision against K-Mart was entered after trial, on June 11, 1998. The court's prior ruling on October 24, 1997 declined to dismiss the case on the motion of K-Mart and Aetna, rejecting the defendants' arguments that the ADA Titles I and III did not apply. Aetna was subsequently granted summary judgment on other grounds. This case is currently being appealed to the United States Court of Appeals for the Fourth Circuit.

⁴ Parker v. Metropolitan Life Ins. Co., ___ F.3d ___ (No. 95-5269)(6th Cir. 1997)(en banc).

The federal Equal Employment Opportunity Commission (EEOC) has felt the issue of parity in mental health insurance so important that it is pursuing several cases around the country on behalf of employees who experience a mental disability. These cases are not decided yet.

The federal Mental Health Parity Act of 1996 (MHPA) provides some aspects of parity for employees working in companies with more than 50 employees, but that law expires on September 30, 2001, focuses only on lifetime and annual limits of coverage, and has several other loopholes that effectively allow disparity in coverage for persons with mental disabilities.

Therefore, it cannot be said at this time that federal law provides a complete prevention of disparity in treatment of persons who experience mental illness, and their families.

4. Mental Health Parity in Alaska by legislation

We believe that this Task Force should support mental health parity in work-related health insurance, and we hope you will be a potent advocate for passage of parity legislation by the Alaska Legislature. After you have examined the facts regarding the costs and savings of mandating across-the-board parity in insurance coverage, and after you have deliberated on the incalculable benefits that parity will provide to help people with mental disabilities to get employed, stay employed, and become re-employed more rapidly, we think you will urge Alaska's Legislature to join the growing ranks of states that have chosen to act in this area. This is too important to wait for the federal Congress and the federal courts.

Conclusion

Parity legislation adopted by the Alaska Legislature will make the environment more certain and predictable for employers and insurance companies doing business in Alaska. More refined legislation will minimize the necessity for judicial interpretation. Mental health insurance parity makes sense from the policy perspective of creating a favorable environment for outpatient treatment of mental health conditions, minimizing expensive acute care and lessening the demands on Medicaid and other public health programs. Insurance parity will lessen the strain on Alaskan families of dealing with mental illness. Thank you for this opportunity to present testimony, and for your dedication in absorbing what will be a large amount of complex information. I know you will do your task well.

ASLASKA STATE HOSPITAL AND NURSING HOME ASSOCIATION

Testimony to

MENTAL HEALTH PARITY TASK FORCE

**OCTOBER 26, 1998
Anchorage LHO**

Thank you for this opportunity to testify today. I am Gene O'Hara, Administrator of Providence Alaska Medical Center. I also serve as the Chair of the Mental Health Committee for the Alaska State Hospital and Nursing Home Association (ASHNHA). It is in this capacity, as spokesperson of ASHNHA, that I wish to address my remarks.

ASHNHA is committed to improve the health of Alaskans through public and private health care and address the critical challenges and issues affecting the health of the individuals we serve.

It is well documented that Alaska's number one health problem is substance abuse. It is also well documented that Alaska suffers from a very high suicide rate. Alaskans also are at risk of specific conditions such as Seasonal Affective Disorder (SAD), as well as the established rates of mental illnesses found in all communities throughout the U. S. In order to assure that the health care system can address the needs of mental illness, it is important for Alaskans to have coverage for their medically necessary treatment through their insurance coverage. To the degree that their insurance coverage does not provide care, Alaskans either go without treatment or are forced to rely on publicly funded programs.

Presently, Alaskans who have already impoverished themselves and have undergone determination of a disability may be covered by the State Medicaid Program. However, for the Alaskans who live in our communities, are employed and need help, the present coverage by some insurance policies is not adequate. The delineation between physical and mental illness is not longer a meaningful or relevant paradigm.

ASHNHA supports the work of this Task Force and hopes that you are able to develop an approach for equal coverage of mental illness to physical illness which is cost affective for all Alaskans and strengthens the ability of Alaskans to access mental health care.

November 4, 1998 Interview with Anchorage Mental Health Consumer

The individual interviewed was the mother of a girl suffering from mental illness. Mental illness (depression) was present in both sides of the family. The girl began to display symptoms at age 4 and, by the age of 15, had met her lifetime limits for mental health coverage. The girl is cognitively very bright with a high IQ.

The first symptom of a mental health problem at age 4 was a nervous tic that worsened with stress. At the time, no treatment was indicated. During the same time period, the young girl was involved in an automobile accident. When the girl was 6 ½ years old she began to display signs of depression with suicide ideation. At this time, the girl's grandparents had just died and her brother had become critically ill. She was assessed by a psychologist and ultimately treated by a child psychiatrist accessing insurance resources. During the duration of grade school, no other symptoms were noted although the family tried to keep the girl from high stress situations and often worked with the school psychologist.

During adolescence, the girl began to experience difficulties with peer relationships. In 1994 at age 13 ½, the girl was diagnosed with clinical depression and was in therapy from 1994 until April 1996. She began to "fall apart" in March 1996 and expressed thoughts of suicide. This was in conjunction with disclosure of previous sexual abuse. She was hospitalized for 12 days with a suicide watch. During this time, she received services from a primary physician, psychiatrist, and a gynecologist. She also received individual and teen group therapy and the family also received therapy. All of these services used insurance funding.

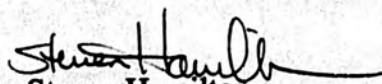
She was discharged from the hospital and continued in therapy. In July 1996, at the age of 15, she ran away from home for a brief period but returned. Upon returning she again expressed ideas of suicide. At this time, there was also a question of substance abuse although this was later ruled out. She received a tentative diagnosis of Bi-Polar Disorder. During this time, she was denied access to AYI services; her disability was not considered serious enough. She was again hospitalized but left against medical advice.

She was enrolled in a residential program in Utah. Her insurance benefits ran out in November 1996 although the family was able to piece together enough to cover expenses through January 1997. She left the Utah program in March 1997. Since returning home, she has continued in therapy although it is being paid for out-of-pocket. She attempted suicide in July 1998 at the age of 17 and was hospitalized. At this time, she disclosed that she had been raped at the age of 15.

At present, she is applying for the TEPRA option of Medicaid; a determination of eligibility is pending. The outstanding medical bills are continuing to mount. The mother cites three specific problems:

1. Access to appropriate mental health care in Alaska
2. Approval of payment for some types of services by insurance companies
3. Limits on insurance benefits

Interview was conducted via telephone with contractor Steven Hamilton on November 4, 1998.
The interviewee requested that, at present, her name not be disclosed.

A handwritten signature in black ink, appearing to read "Steven Hamilton", with a stylized flourish extending from the end.

Steven Hamilton
C & S Management Associates

Anchorage Daily News
Saturday, January 9, 1999

2 x 4 Ad

**Notice of Public Meeting
Mental Health Parity
Legislative Task Force**

The Legislative Task Force on Mental Health Parity will meet in Anchorage on Wednesday, January 13, 1999 to receive public comment on the draft Mental Health Parity Report.

Place: Legislative Information Office

Room 220

716 W. 4th Avenue

Anchorage, Alaska

Time: 8:00 am – 5:00 pm

Public comment will be taken:

By teleconference: 10:00 am – Noon

1-800-315-6338

Password – PARITY (727489)

In person: 1:30 – 3:30 pm

Persons with disabilities needing assistance should contact the Alaska Mental Health Board at (907) 465-3071.

Mental Health Parity Task Force
Wednesday, January 13, 1999
Meeting Agenda

Legislative Information Office
716 W. 4th Avenue, Room 220
Anchorage, Alaska

8:00 – 9:30 am	Task Force Discussions/Business
10:00am – Noon	Testimony – Priority given to telephone testimony
Noon – 1:30 pm	Lunch
1:30 – 3:30 pm	Testimony – Priority given to in-person testimony
3:45 – 5:00 pm	Task Force Discussions/Business
5:00 pm	Adjourn

Mental Health Parity Task Force

THE ALASKA TASK FORCE FOR MENTAL HEALTH PARITY IS PLEASED TO PRESENT

DRAFT REPORT

Following months of work by Task Force members, we are pleased to present our draft report, which contains findings as well as a tentative range of recommendations. The purpose of this draft report is to provide the stakeholders and the general public with an update on our efforts and a basis upon which to make comments and suggestions. As you read this draft, there are several things to keep in mind:

1. This is a draft; not a final document. We expect that there will be changes; both in form and substance. Changes will be made as a result of further refinement by the Task Force, receipt of cost analysis information, and based on comments received from stakeholders and the general public.
2. The final report, which will be developed after we have received public comment, will be presented to the Alaska Legislature and made available to the public around February 1, 1999.
3. Public testimony will be taken on January 13, 1999 in person at the Anchorage Legislative Information office. There will also be a portion of the meeting dedicated to telephone testimony (see attached agenda). Those desiring to testify by telephone can connect by dialing (800) 315-6338 and enter the password PARITY (727489).
4. Persons unable to offer testimony on January 13, may provide written or oral comments by contacting C & S Management Associates by telephone at (907) 789-0921, by fax at (907) 789-1667, or by e-mail at csmtg@alaska.net. We ask such comments be submitted prior to January 13 so that they may be considered by Task Force members at that meeting.
5. As this draft was prepared, we did not have the cost estimates. We expect these estimates to be available at the public testimony meeting on January 13, 1999.
6. Additional copies of this document may be obtained by contacting the Alaska Mental Health Board at (907) 465-3071.

Written comments may be submitted by mail to: C & S Management Associates
Attn: Steven Hamilton
PO Box 34757
Juneau, AK 99803

Thank you,
Mental Health Parity Task Force

Size of Firm	Number of Employees	Percent Covered	Number Covered
1 – 4 employees	22,269	40%	8,908
5 – 9 employees	26,025	60%	15,615
10 – 19 employees	31,659	75%	23,744

Total Small Business Employees Covered by Health Insurance 48,264

This figure will be used to adjust the total number of lives covered to account for the fact that firms with less than 20 employees will be exempted.

How many Non-ERISA Lives are Covered in Alaska?

Blue Cross of Washington/Alaska . 60,000

(Note: Blue Cross is not included in the Division of Insurance Market Share List)

Company	Percent Market Share	Lives Covered
Principal Mutual Life Insurance Co.	7.73%	7,378
Employers Health Insurance Company	3.53%	3,500
Guardian Life Insurance Company	3.52%	5,785
Great-West Life & Annuity Insurance Co.	2.12%	1,800
Total	16.9%	18,463

Lives Covered – Method 1

Total Lives = (Sample Lives Covered / Market Share of Sample) + Blue Cross Lives Covered

Total Lives Covered = (18,463 / 16.9%) + 60,000

Total Lives Covered = 109,248 + 60,000

Total Lives Covered = 169,248

Lives Covered – Method 2

According to Blue Cross Officials, the company believes that they have 38% of the non-ERISA lives covered. If we use this figure with the 60,000 lives covered by Blue Cross, we compute total lives covered as:

Total Lives Covered = Blue Cross Lives / Blue Cross Market Share

Total Lives Covered = 60,000 / 38%

Total Lives Covered = 157,894

The estimates from the two methods appear close enough to work with for our purposes. If we take the average of the two, we end up with an estimate of total non-ERISA lives covered in Alaska of **163,571**.

Data Source: Key Informant Interviews 11/98

Adjustment for Small Business Employees

Since the current thinking is to exempt businesses with less than 20 employees, we need to adjust the total lives covered to account for those numbers. Using the data derived in the analysis of small businesses, we note that approximately 48,264 small business employees are likely to be covered by health insurance. Adjusting for this in the total number of lives covered we find:

Total Lives Covered:	163,571
Less Small Business Employees:	48,264
Total Impacted Lives Covered	115,307

Impact on State of Alaska Employees Health Insurance. The health plan offered to the State of Alaska employees would not be legally subject to parity mandates recommended by this Task Force. In discussions with state officials, however, we learned that it is the policy of the State to implement any mandates placed on private insurance plans. In reviewing the various state employees health plans, we noted that most elements of parity are already in place as a function of the characteristics of the coverage. For example, the co-insurance (80%-20%) is the same for mental health and physical health. The deductibles for physical and mental health are a combined deductible. Since the federal legislation applies to ERISA programs, the State employees' health plans have already removed the annual and lifetime maximums. The State employees' plan currently places no limits on the number of visits and hospital days for mental health. Our observations were confirmed by the Division of Retirement and Benefits in a key informant interview with the Director, Guy Bell.

In light of the foregoing, it appears that, even if the State were to adopt any mental health parity mandate approved by the legislature, there would be no impact on costs for the State employees' health plans. The same is not true, however, for State employee retirees' plans, which do not have the same features as current employees' plans. The most immediate impact would likely be in the area of co-payments and co-insurance since retirees' plans require differential co-payment for mental health and physical health. There is no clear indication, however, of the extent to which the retirees' plan would be modified to comply with mental health parity mandates since there is no legal requirement to do so.

Mental Health Parity Task Force

**THE ALASKA TASK FORCE FOR MENTAL HEALTH PARITY
IS PLEASED TO PRESENT**

*Dec 30 Agenda
- Draft Report -*

DRAFT REPORT

Following months of work by Task Force members, we are pleased to present our draft report, which contains findings as well as a tentative range of recommendations. The purpose of this draft report is to provide the stakeholders and the general public with an update on our efforts and a basis upon which to make comments and suggestions. As you read this draft, there are several things to keep in mind:

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Written comments may be submitted by mail to: C & S Management Associates
Attn: Steven Hamilton
PO Box 34757
Juneau, AK 99803

Thank you,
Mental Health Parity Task Force

Mental Health Parity Task Force

Wednesday, January 13, 1999

Meeting Agenda

Legislative Information Office

716 W. 4th Avenue, Room 220

Anchorage, Alaska

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3:45 – 5:00 pm	Task Force Discussions/Business
5:00 pm	Adjourn

D R A F T

Alaska Task Force on Mental Health Parity

Draft Report

December 1998

D R A F T

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Introduction

Background. In 1996, the Congress passed the Mental Health Parity Act of 1996 that became effective on January 1, 1998. As of April 30, 1998, 15 other states had passed mental health parity legislation in one form or another while another 25 states had introduced such legislation¹. In 1998, the Twentieth Alaska State Legislature passed Senate Concurrent Resolution 14 (SCR 14) that established the Alaska Task Force on Parity for Mental Health. The purpose of the Task Force was to examine the issues related to parity in health insurance coverage between mental health and physical health.

In SCR 14, the Legislature recognized that mental health disorders cost the Alaska economy \$187,272,000 in 1996, and that approximately 44,000 Alaskans suffer from mental illness or emotional disorders. Data from the National Institute of Mental Health (NIMH) provides some additional statistics relevant to this issue:

- On a national level, mental illness costs are estimated to be more than \$150 billion for treatment, costs of social service and disability payments, lost productivity, and premature mortality.
- Schizophrenia alone accounts for \$30 billion of those costs.
- While costs are staggering, there is clear evidence that early and appropriate treatment can significantly reduce the costs. For example, lithium therapy for manic depressive illness is estimated to have saved the U. S. economy more than \$145 billion since 1970.
- Clozapine treatment for schizophrenia saves an average of \$23,000 per patient annually, largely by reducing the need for hospitalization.
- An analysis conducted for the U. S. Senate Appropriations Committee projected that appropriate and timely treatment for severe mental disorders would produce a 10 percent reduction in the use and cost of medical services by people with these illnesses, yielding a savings greater than the cost of providing the treatment.
- A new type of medication combined with appropriate therapy has been shown to reduce symptoms in 80 percent of individuals suffering from obsessive compulsive disorder².

These illustrate both the magnitude of the problem we face as a state and also the return on investment in early and appropriate treatment. Addressing the issue of parity in health coverage with regard to mental health care is one way of helping to assure this early and appropriate care.

The Legislature directed the Task Force to examine the disparities in health care insurance between mental health and physical health and make recommendations for reducing those disparities. The make-up of the Task Force was specified in SCR 14 and is included in this report as Appendix A.

Scope of Work. As directed by SCR 14, the duties of the Task Force include studying the issue of differential insurance coverage, particularly as it relates to parity between mental and physical health. The Task Force was charged to develop recommendations and associated costs and to identify the positive and negative effects of any recommendations. The results of this study as well as recommendations from the Task Force are contained in this report. Legislation to implement these recommendations will be developed and submitted separately.

Methodology. The Task Force was supported administratively by the staff of the Alaska Mental Health Board as well as a contractor/consultant, C & S Management Associates. In accomplishing its objectives, the Task Force and supporting staff used the following methods:

Public Input. The Task Force held public meetings on:

August 19, 1998 – Alaska Psychiatric Institute, Anchorage, Alaska
September 1, 1998 – Alaska Psychiatric Institute, Anchorage, Alaska
October 1, 1998 – Teleconference
October 26, 1998 – Legislative Information Office, Anchorage, Alaska
December 7, 1998 – Alaska Psychiatric Institute, Anchorage, Alaska
December 30, 1998 – Teleconference
January 15, 1998 – Legislative Information Office, Anchorage, Alaska (Planned)

At the October 26 meeting, a specific two-hour time period was set aside for in-person public comment and an additional two-hour slot for telephone testimony. At this meeting, a total of 21 people testified and an additional 10 people attended but did not testify.

Research. The contractor conducted research using key informant interviews, Internet searches, consumer surveys, traditional literature searches, and analysis of existing legislation. Key informant interviews focused on consumers and advocates, insurance industry representatives, and officials from other states that have addressed the parity issue. Information available from the federal government addressed parity options and cost estimates.

Publicity. To inform the public of the proceedings, all meetings of the Task Force were publicized in the Anchorage Daily News. In addition, a project description and schedule as well as the Task Force membership directory were published on the contractor Internet web site. Advocacy groups from consumers, providers, and the insurance industry also helped to publicize the process.

Actuarial Analysis. The cost information for the options contained in this report was developed through actuarial analyses performed by Mr. Ron Bachman of PricewaterhouseCoopers, a national expert of mental health parity options and costs.

Glossary of Terms

Note: Unless otherwise noted, the following definitions are taken from the U. S. Department of Health and Human Services publication The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits.

Annual Limits. The term "annual limits" refers to the maximum amount of covered health care expenses paid by an insurance policy for covered care annually (definition developed by Task Force).

Baseline Benefits Package. For each type of health plan, the typical benefit package is the benefit package that has the highest percentage of enrollees (the statistical "mode"). Also referred to as the typical benefit package.

Benefit Package. Services covered by a health insurance plan and the financial terms of such coverage. These include cost sharing, limitations on the amounts of services, and annual or lifetime spending limits.

Chemical Dependency. Physiological or physical dependence on a psychoactive substance.³

Co-Insurance. A type of cost sharing where the insured party and insurer share payment of the approved charge for covered services in a specified ratio after payment of the deductible. Most fee-for-service plans require a 20 percent co-insurance for covered inpatient and outpatient medical/surgical services.

Co-Payment. The type of cost sharing where the insured party is responsible for paying a fixed dollar amount per covered service. For example, an HMO could require a \$10 co-payment for every visit to a network physician.

Cost Increase. The term "cost increase" as referred to in this study, means the increase in the cost of claims to the insurance carrier (experienced or anticipated). This does not equate to an increase in the cost of premiums to employers (definition developed by Task Force).

Cost Sharing. A health insurance policy provision that requires the insured party to pay a portion of the costs of covered services. Deductibles, co-insurance, and co-payment are types of cost sharing.

Coverage Decision. A decision by a health plan whether to pay for or provide a medical service for particular clinical conditions.

Deductible. The type of cost sharing where the insured party pays a specified amount of approved charges for covered medical services before the insurer will assume liability for all or part of the remaining covered services.

ERISA. The Employee Retirement Income Security Act of 1974 (ERISA). Health plans that are self-insured are exempt from state regulation under ERISA.

FFS. Fee-for-Service. A type of health care plan where health care providers are paid for individual medical services rendered.

Financial Requirements. The term "financial requirements" refers to co-payments, deductibles, out-of-pocket contributions, fees, annual limits, and lifetime aggregate limits imposed on covered individuals.⁴

Gatekeeper. A primary care physician in a managed care plan (such as HMO or POS plan) who oversees the care of enrollees in the plan.

HMO. Health maintenance organization. A type of managed care plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Services are furnished through a network of providers (such as physicians and hospitals).

Health Plan. An organization that acts as insurer for an enrolled population. Types of health plans include fee-for-service (FFS), preferred provider organization (PPO), point-of-service (POS), and health maintenance organizations (HMO).

Lifetime Limits. The term "lifetime limits" refers to the maximum amount of covered health care expenses paid by an insurance policy for covered care over the life of the policy (definition developed by Task Force).

Managed Care. A system of health care delivery where the health plan attempts to control or coordinate the use of health services by enrolled members to contain health care expenditures and/or improve quality. Types of managed care plans include HMOs, point-of-service (POS) plans, and preferred provider organizations (PPOs).

Maximum Out-of-Pocket Expenses. The maximum amount, including deductible and co-payments/co-insurance that an insured is required to pay before the insurance policy begins to pay all costs for covered care.

Mental Illness. The term "mental illness" includes mental disorders defined in the Diagnostic and Statistical Manual IV (DSM IV) or subsequent editions published by the American Psychiatric Association, except those codes defining substance abuse disorders (291.0 to 292.9 and 303.0 to 305.9) and the "V" codes.⁵

Mental Health Benefits. Benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.⁶

Parity. The term "parity" as used in this study refers to equal treatment in terms of financial limits, limits on visits and days, deductibles, co-payments, etc. In this study, the types of coverage under consideration are for physical health and mental health (definition developed by Task Force).

POS. Point-of-service. Point-of-service plans are managed care plans that cover both in-network and out-of-network services. To encourage use of network providers, patient out-of-

pocket costs are higher when non-network providers are used. POS generally manage in-network services more tightly than PPOs manage services because POS plans use gatekeepers.

PPO. Preferred provider organization. A PPO is a managed care plan that contracts with providers to furnish services to plan enrollees. PPO providers are paid according to a discounted fee schedule. Enrollees may lower out-of-pocket costs when they use network ("preferred") providers. Services they receive from non-network providers, however, are also covered. Enrollees pay higher out-of-pocket costs when they use non-network providers for covered services.

Premium. The amount an insurer charges for a health insurance policy. The premium amount is computed to pay for the expected costs of all health insurance expenses. Health insurance expenses include medical/surgical services, MH/SA services, and administrative costs and profits.

Primary Care Physician. Primary care physicians generally include physicians with the following specialties: general medicine, family practice, internal medicine, obstetrics/gynecology, and pediatrics.

Severe Mental Illness. The National Advisory Mental Health Council defines serious mental illness (SMI) to include disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, and autism, as well as severe forms of other disorders such as major depression, panic disorder, and obsessive compulsive disorder.

Self-Insured Plan. Employer-provided health insurance in which the employer, rather than an insurer, is at risk for its employees' medical expenses.

Service Limits. Limits on the amount of services covered by a health plan. For example, a health plan can limit the number of covered outpatient visits or inpatient hospital days.

Substance Abuse. Use of alcohol, other drugs, or inhalants in a way that is illegal or deviates from medically accepted use.⁷

Typical Benefits Package. For each type of health plan, the typical benefit package is the benefit package that has the highest percentage of enrollees (the statistical "mode"). Also referred to as the baseline benefit package.

Existing Legislation: Federal/Other States

Federal Legislation: Mental Health Parity Act of 1996. Congress passed the Mental Health Parity Act of 1996 (P.L. 104-204) which President Clinton signed into law on September 26, 1997. The law became effective January 1, 1998. This law, which sunsets on September 30, 2001, contains limited elements of parity and had a number of exemptions. The major provisions of the federal legislation are:

- The law requires parity between mental health and physical health for insurance coverage purposes with regard to aggregate lifetime and annual limits. It allows differential treatment with regard to limits on days/visits.
- The law covers mental illness; it does not cover substance abuse.
- The law exempts small businesses with 50 employees or less.
- The law applies to both fully insured state-regulated health plans and self-insured plans that are exempt under ERISA.
- The law applies only to employers who offer mental health coverage; it does not mandate such coverage.
- State laws which require equal or greater parity are not prohibited or preempted by this law.
- 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.
- The law does not place restrictions on businesses' ability to manage care.

The main weakness in this law is that the only real element of parity that is addressed is the annual and lifetime limits differential. The elimination of this differential is offset by the fact that employers can set restrictions on the number of hospital days or outpatient visits annually, which has the same effect as differential annual dollar limits. While the law does allow businesses that experience a one percent increase in costs due to parity to exempt themselves, it is unclear how much impact this will have since the law only went into effect on January 1, 1998.

Other States' Legislation. As of April 30, 1998, 15 states have enacted mental health parity legislation. There are 25 other states in which similar legislation has been introduced. In some cases, it has passed. In others it has not, and in at least two cases (California and Oklahoma), legislation passed but was subsequently vetoed by the Governor. The legislation that was enacted in the 15 states varies widely from state to state, both in terms of applicability and elements of parity included. The following table represents a summary of the existing state legislation and features included:

Table 1
Characteristics of Mental Health and Substance Abuse Parity Legislation by State

Element of Parity	State Legislation											
	AR	CO	CT	IN	ME	MD	MN	NH	NC	RI	TX	VT
Defines Mental Illness	X	X	X		X			X	X	X	X	X
Covers only "serious mental illness"		X	X		X			X		X	X	
Covers substance abuse	X					X	X		X			X
Provides specific elements of parity	X			X	X	X	X		X	X	X	X
Specifies minimum benefit requirements					X	X			X			
Specifies providers who are covered					X				X			X
Mentions managed care	X		X		X	X	X	X	X	X		X
Contains medical necessity clauses	X				X	X	X			X		
Only applies to government employees				X					X		X	
Exempts small businesses	X				X	X	X					

⁸ Data Source: U.S. Dept of Health and Human Services

Note: Specifics for Arizona, Missouri, and South Carolina, all of which have newly enacted legislation, are not included in the above table.

Experiences of Other States.

Arizona

Arizona passed mental health parity legislation in the second regular session of their 43rd Legislature (1997-1998). Having had the benefit of observing other states' efforts during period following the passage of federal mental health parity legislation, Arizona crafted a comprehensive package of parity elements. Although the legislation did not apply to ERISA health plans, it did apply to small businesses; there were no exemptions. Another feature of the legislation is that it mandated the inclusion of the mental health and substance abuse coverage in any health care plan written in the state. The legislation mandated the model of parity that Mr. Bachman labeled as "Comprehensive Parity." This model specifies that there can be no difference in co-insurance, co-payments, deductibles, day/visit limits, annual or lifetime limits, or out-of-pocket expenses. For Arizona, the equating of financial requirements required

combined limits rather than "separate but equal." Finally, it includes both mental health and substance abuse.

Like Alaska, Arizona has a relatively high number of health plans that are subject to ERISA and therefore not impacted by this legislation. In contrast, however, Arizona has a relatively strong presence of managed care. The legislation specifically allows mental health and substance abuse care to be delivered in a managed care setting although it does not provide any greater detail or guidance about what this might look like.

Mr. Bachman conducted an actuarial analysis of the legislation and made the following cost projections:

Type of Delivery System	Distribution	Percentage Increase in Base Medical Plan			
		Partial	SMI *	Full	Comprehensive
Fee-for Service	20%	1.3%	2.8%	3.5%	4.3%
Managed Indemnity	25%	1.1%	2.3%	2.8%	3.6%
PPO & POS	25%	0.7%	2.1%	2.6%	3.0%
HMO & Gatekeeper	30%	0.7%	1.2%	1.5%	2.2%
Composite - Gross		0.9%	2.0%	2.5%	3.2%
Composite - Net		0.4%	0.8%	1.0%	1.3%

* SMI is Full Parity that applies only to persons diagnosed with Serious Mental Illness

The composite gross figure is the expected increase before any additional cost containment actions by employers and/or insurers. The composite net is the expected increase taking anticipated cost containment measures into account. Because this is new legislation (1998) there are not quantitative data on actual experience.⁹

Maryland

Unlike Arizona, Maryland has had mental health parity legislation since 1995. The Maryland legislation applies to all insurers, non-profit health service plans, or HMOs on a group or individual basis that provide benefits or services for diseases. This mandate applied to mental and addictive disorders that professional practitioners determined to be medically necessary and treatable. Additionally, mental health coverage was mandated for all health care plans. Some of the main elements of parity present in the Maryland legislation are:

- Equal inpatient day coverage; at least 60 days of partial hospitalization.
- No visit limits for outpatient visits; with co-insurance amounts increasing with the number of visits.
- Benefits may be delivered in a managed care setting.
- Parity of maximum out-of-pocket expenses.
- Parity for deductibles and co-insurance.

This legislation went into effect on July 1, 1995. During the years after transition, several rigorous studies were conducted using data from major managed care companies in the state. The first set of data examined represented the common experience of 650,000 members using a

combination of delivery systems. In terms of utilization, the study noted that the number of mental health inpatient admissions increased slightly during the first year but the cost was more than offset by significantly lower lengths of stay. Overall, mental health outpatient utilization decreased. In terms of cost increases, the premium costs increased slightly during the transition but then returned to pre-parity levels. A different managed care company confirmed that their cost increases were less than one percent during the first seven months following the transition to parity.¹⁰ We were not able to locate reliable data for the periods after the year following transition to parity.

Rhode Island

Rhode Island is a contrast to the two previously reviewed states in that the application of parity is much more limited. First, parity is limited to treatment for serious mental illness only. It does not cover mental disorders outside of this category nor does it cover substance abuse. Finally, it applies only to "medical treatment" which is defined as inpatient hospitalization and outpatient medication visits. There is also a medical necessity clause. For those plans covered by the legislation, it mandates parity for days/visits, amount limits, deductibles, and co-insurance.

Cost increases experienced in Rhode Island following the implementation of mental health parity legislation was less than one percent. A notable result of implementing limited mental health parity in Rhode Island was a marked shift toward greater managed care. As expected, premiums for the tradition fee-for-service plans increased and, as a result, subscriptions in the lower cost managed care plans increased five-fold.¹¹

Other States – General

Every study that we examined stressed that each of the states that have implemented mental health parity has done so in slightly different ways. We found different criteria for applicability and different levels of parity. In key informant interviews with the different state representatives ranging from Insurance Division officials to mental health advocacy representatives, we repeatedly heard that the final form of the legislation was shaped by a myriad of factors. Some of the factors include (but are not limited to):

- Presence and strength of advocacy groups on each side of the issue;
- State demographics;
- Characteristics of the health care delivery systems; and
- Economic issues.

Mental Health Parity Options

General. Mental health parity can be pursued on a number of different levels depending on the elements of parity that are included in the effort. The following is a discussion of the individual elements of parity as well as presentation of several "models" that have been developed and implemented in other states.

Elements of Parity. While it is useful to examine different packaged "models" of mental health parity, it is essential to understand the different elements that are included in these models. The following is an overview of the discrete elements of parity that are present in the various models that will be discussed in the next subsection.

Element of Parity	Descriptions
Days/Visits	Firms covered by federal legislation are not allowed to set annual and lifetime benefits (in dollar amounts) at different levels than physical health. What they can do, however, is place limits on the number of outpatient visits and inpatient days that policies will cover. Parity for this element would result in coverage in which any limits on days/visits are the same as for physical health.
Co-payments	Co-payment refers to the distribution of payment for covered expenses between the insurance company and the beneficiary. Common co-payment schemes are 90% - 10%, 80% - 20%, and 50% - 50% (insurance company and beneficiary). Parity for this element would require the same co-payment for mental health benefits as for physical health benefits.
Deductibles	A deductible is that amount that the beneficiary must pay toward health care expenses before insurance begins to pay. Typical deductible amounts are \$100, \$250, \$500, and \$1,000. Parity can impact deductibles in two ways. First, it can require that the deductible for mental health services is identical (but separate) from the physical health deductible. It can also require that the deductible for mental health be a common deductible with physical health, that is, that a single deductible exists and payments toward either physical or mental health count toward the common deductible.
Max OOP Expenses	Some health insurance policies contain a feature that limits the amount of money that beneficiaries must spend in terms of deductibles and co-payments. This is called maximum out-of-pocket expenses. This feature is used to ease the financial burden on families when extraordinarily high expenses occur. Typical maximum OOP expense levels are \$1,250, \$2,500, and \$5,000. As with deductibles, parity can impact maximum OOP expenses in two ways. First, it can require that the maximum OOP expense

level be the same for mental health as for physical health (although separate). It can also require that there be a single OOP expense level that expenses in both physical and mental health count towards.

Mandatory vs. Optional

Some states have required that all health insurance policies written contain coverage for mental health while it is optional in other states. While there seems to be no data indicating that companies are dropping mental health coverage as parity is implemented (and increasing costs), there is always the possibility that firms could opt out of mental health coverage if the costs become onerous. Making mental health coverage mandatory prevents companies from dropping coverage (which would serve to decrease the size of the risk pool).

Substance Abuse

The definition of mental illness specifically excludes those diagnoses related to substance abuse and chemical dependency. Some states have elected to include substance abuse in parity legislation while others have elected to specifically exclude it. If included, the elements of parity that apply to mental health would also apply to substance abuse.

Other Features

There are other tools available to insurance that are technically not elements of parity but impact parity by limiting the applicability. One such tool is limiting the services that may be covered under parity provisions. Mental Health services typically exempted under such provisions include marriage counseling, psychoanalysis or psychotherapy credited toward earning a degree, and services and supplies that are not considered medically necessary. Another tool used by some states to control costs is a limit on the provisions of parity based on diagnosis. Some have included all diagnoses included in DSM IV while some others have limited parity only to diagnoses of serious mental illness. Small business exemptions are also used in legislation to impact the costs of parity. Finally, there have been some instances in which provisions of mental health parity have applied only to certain types of providers such as psychologists, psychiatrists, etc.

Existing Parity Models.¹² The following models each contain certain elements of parity that are described above. These models were developed by Mr. Ron Bachman, a national consultant with PricewaterhouseCoopers, who has considerable experience working with the mental health parity issue.

Mental Health Parity Act Model. The federal act prevents differing lifetime or annual dollar limitations between mental health and non-mental health insurance coverage. The MHPA is not a mandate. It does not require or mandate that health coverage be provided under any plan. If mental health coverage is provided, however, the plan cannot impose annual or lifetime

dollar limitations on mental health coverage that are not imposed on coverage for non-mental health conditions. This model, when enacted at the state level, applies these limitations to whatever population that the individual state selects. The estimated cost, at the national level, for implementation of this model is 0.13 percent of total plan costs.

Limited Parity Model. This model extends the MHPA model to outpatient visits and inpatient days limits. Following the approach of MHPA, there is no mandated coverage. That is, while no mental health coverage is required, if mental health coverage is provided, the plan cannot impose day or visit limits on mental health coverage that are not imposed on coverage for non-mental health conditions. The estimated cost, at the national level, for implementation of this model, is 0.7 percent assuming that all other elements of the mental health coverage remain the same.

Catastrophic Parity Model. This model includes the features of Limited Parity listed above and adds maximum out-of-pocket (OOP) limit. Maximum OOP limits are common features for non-mental health coverages provided by many insurance plans (particularly indemnity plans). This feature protects an individual or family from the financial ravages of a catastrophic cost where even the traditional 20 percent co-insurance paid by the patient can accumulate to an amount that threatens the family's financial resources. The maximum OOP limit is the total amount of eligible expense cost sharing for which a covered member is responsible. The maximum OOP can be separate and distinct from any non-mental health maximum OOP. Again, the MHPA approach, there is no mandated coverage. If mental health coverage is provided, however, the plan cannot impose a maximum OOP limit on mental health greater than any imposed on other coverages. The estimated cost, at the national level, for implementation of this model, is 1.1 percent assuming that all other elements of the mental health coverage remain the same.

Significant Parity Model. This model includes all of the elements listed in the MHPA, Limited, and Catastrophic models and extends parity to the co-insurance and co-payment features of an insurance plan design. With the introduction of this model, Mr. Bachman maintains that "anti-selection" begins to play a role in costs. It is at this point, he says, that small employers (if they are included) will begin to opt out of mental health coverage if it is not mandated. The estimated costs of implementation at the national level, if coverage is mandated, is 1.6 percent, assuming that all other elements of the coverage remain the same.

Financial Parity Model. This model represents the point at which all plan reimbursement features for existing plan-eligible expenses are made on the same basis as non-mental health eligible expenses. In addition to the features of the previously listed models, this brings parity to the issue of deductibles. The estimated costs of implementation at the national level, again assuming that coverage is mandated, is 2.4 percent, if other elements of the coverage remain the same.

In the previous models, Mr. Bachman also notes that the increases will likely be mitigated significantly by available cost controls within each model and the increased use of managed care. According to the U. S. Department of Health and Human Services, this is a realistic expectation.¹³

In preparing actuarial reports for the various states that have enacted legislation, Mr. Bachman provides cost estimates for three basic models which combine many of the elements of the previously listed models:

Partial Parity. This model is the same as the Limited Parity Model listed above.

Full Parity. This model provides for parity in terms of cost sharing such as deductibles, maximum OOP expenses, and annual or lifetime maximums. In this model, such cost sharing is "separate but equal."

Comprehensive Parity. This model is the same as Full Parity described above, however, the cost sharing features are common. For example, if the plan had a \$250 deductible, initial expenses in physical health and mental health would count toward the same deductible.

Note: The above discussion on models of parity were taken from Mr. Bachman's publication Mental Health: Parity Issues and Costs, February 1998.

Inclusion/Exclusion of Substance Abuse. Substance abuse is specifically excluded from the definition of mental illness. Likewise, it is not included in the Mental Health Parity Act of 1996. Some states have elected to include substance abuse in their parity legislation while others have excluded it. Basically, any mental health parity model can accommodate the inclusion of substance abuse. The cost of inclusion of substance abuse, at a national level, has been estimated at between 0.5 and 1.0 percent.

In 1988, the Alaska Legislature passed Alaska Statute 21.42.365 dealing with substance abuse and health insurance. Among other elements of the legislation, the following points are relevant to the topic of mental health parity:

- This legislation mandated substance abuse coverage be included in health insurance policies written in Alaska.
- The benefits must be at least \$7,000 over two consecutive benefit years.
- The lifetime benefits must be at least \$14,000.
- The benefits specified above must be adjusted for inflation every three years.
- The legislation provided for parity for substance abuse insurance in terms of co-payments and deductibles.
- The legislation provided for parity in terms of claim payment methodology, second opinion or pre-notification policies, or other coverage issues.
- The statute applies to employers with 20 or more employees only.

As a result of this legislation being in place, we could reasonably expect the cost of including substance abuse in any Alaska initiative to be less than projected nationally.

Impact of Delivery Systems on Costs of Parity. When describing models of mental health parity and the associated implementation costs, it is necessary to include a discussion of health care delivery systems since they have a significant impact on costs. Cost estimates are provided in terms of increased cost of claims; not increased cost of premiums and were obtained from PricewaterhouseCoopers principal Ron Bachman in his publication Mental Health: Parity Issues

and Costs and from the SAMHSA publication The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits. While we present a discussion of all models of delivery, Alaska has what can be described as primarily a fee-for-service delivery system. We have seen little penetration of HMOs or Point-of-Service plans.

Fee-for-Service (FFS). FFS delivery systems are the most expensive because there is relatively little systematic emphasis on cost control. Providers of services are paid on a per-service basis for any services they deliver. Enrollees can typically use any provider they choose with the provider being paid for the services either based on charges or on some determination of customary fees. Mr. Bachman estimates costs for implementation of mental health parity are the highest for this delivery model with those costs ranging from 0.9 percent to 1.3 percent for partial parity (see discussion above), and from 2.7 percent to 4.9 percent for comprehensive parity (see discussion above). SAMHSA, using several different models, suggests that FFS systems faced with implementation of mental health parity will evolve and witness a much greater penetration of managed care, which will serve to dampen costs. They cite several experiences where, following implementation of parity and subsequent penetration of managed care, mental health costs actually declined.¹⁴

Managed Indemnity. The FFS system can be modified somewhat by the introduction of managed care principles. This typically involves pre-notification and case reviews of lengthy courses of treatment, typically inpatient stays. Because care delivered in the most expensive and/or protracted situations (inpatient or extended outpatient) are subject to greater control by the employer and/or insurer, the costs associated with the system are slightly lower than the FFS system. Mr. Bachman estimates that implementing parity in the managed indemnity delivery system would result in cost increases of between 0.7 percent and 0.9 percent for partial parity and between 2.2 percent and 3.6% for comprehensive parity.

Preferred Provider Organizations (PPO) and Point-of-Service (POS) Systems. PPOs and POSs represent a further intensification of managed care that we are told will evolve. These systems involve a much higher degree of cost control with employers and insurers establishing networks of providers who are paid at negotiated prices as well as gatekeepers. Estimates of costs for implementing parity under these types of delivery systems range from 0.3 percent to 0.6 percent for partial parity and from 2.3 percent to 3.8% for comprehensive parity.

Health Maintenance Organizations (HMO). The HMO delivery system, combined with intensive gatekeeping, is the most aggressive delivery system model for which costs estimates were provided. In these systems, the organization is a combination of the insurer and the provider so that there is maximum incentive to decrease costs. Estimates for implementing parity in these systems range from 0.4 percent to 0.5 percent for partial parity and 1.2 percent to 1.8 percent for comprehensive parity.

While these four models are presented here as discrete systems, they will likely exist in some combination, the ratio of which varies from state to state. With the implementation of mental health parity, there would most likely be some movement toward the more rigorously managed systems and away from the FFS system.

Estimates of Cost: Actuarial Studies

To be added upon completion of analyses by Mr. Bachman.

The Potential Impact of Mental Health Parity Legislation

General. Implementing any level of parity for mental health insurance, with or without substance abuse, will impact organizations and individuals differently. The following discussion is intended to identify those groups that will be impacted and what that impact will be. We will also quantify the size of the groups to the extent possible.

Who is exempt?

ERISA. Under the terms of ERISA, employers who offer self-insured health plans will be exempt from any mental health parity legislation. In Alaska, this accounts for a significant portion of the lives covered under health insurance plans. For example, health insurance for state employees as well as federal and local governments would be exempt. Likewise, all large private companies who are self-insured would be exempt.

Some Alaskan operations are companies with headquarters and offices in other states. Employees health plans for these types of operations are typically written outside Alaska and, therefore, they would also be exempt.

Small Businesses. A major concern in implementing any changes in health insurance mandates in Alaska is the impact on small businesses. The federal legislation applies only to companies with more than 50 employees. Alaska Statute 21.42.365, the legislation that addresses substance abuse, exempts businesses with less than 20 employees. According to the Alaska Department of Labor, there were 26,435 small businesses with less than 20 employees in 1997. There were 1,916 firms that employed between 20 and 50 employees. The numbers begin to fall off dramatically for firms with more than 50 employees.

Number/Size of Employers

Number of Employees

Number of Firms

1 – 19	26,435
20 – 50	1,916
51 – 100	585
101 – 250	369
251 – 500	121
Over 500	77

Data Source: Alaska Department of Labor

In viewing the data on the number of employers in each size category, one of the major concerns is how to balance the need to exempt small businesses from onerous mandates against the need to insure that a sufficient sized risk pool exists to make changes feasible. With most large employers exempt because of ERISA, and small businesses exempted due to size, the risk pool becomes very small.

To test the impact of changes on concerned groups, the Task Force set a tentative cutoff for small businesses at those with 20 or more employees. Consequently, employers with 19 or less employees would be exempt. Based on this, we determined the number employees who would be excluded from any count. The following is an analysis based on Department of Labor data.

Employer/Employee Information

Estimated 1997 Alaska Private Sector Employees: 200,000

Estimated 1997 Alaska Private Sector Small Business* Employees:

<u>Size of Firm</u>	<u>Total Number of Employees</u>
1 – 4 employees	22,269
5 – 9 employees	26,025
10 – 19 employees	31,659
Total Small Business Employees	79,953

* Small Businesses are defined here as those businesses with less than 20 employees.

Data Source: Alaska Department of Labor

Estimate of Small Business Employees Covered by Health Insurance

Based on reports from five states (which were, in turn, based on national data), the incidence of health insurance for specific size companies are estimated as follows:

Size of Firm	Louisiana	Vermont	Delaware	Arizona	Georgia
1 – 4 employees	40%	37%	40%	40%	30-35%
5 – 9 employees	61%	61%	60%	61%	50-55%
10 – 24 employees	76%	76%	75%	76%	Unknown

Data Source: Coopers & Lybrand Actuarial Analyses

We would like to know the number of employees working small businesses (less than 20 employees) who are covered by health insurance. PricewaterhouseCoopers provided estimates of the number of firms offering insurance within the different segments. For purposes of this analysis, we will assume that the proportion of employers offering insurance is approximately the same as the proportion of small business employees covered by health insurance. We will use the following proportions: 1 – 4 employees – 40%; 5 – 9 employees – 60%; 10 – 19 employees – 75%.

Size of Firm	Number of Employees	Percent Covered	Number Covered
1 – 4 employees	22,269	40%	8,908
5 – 9 employees	26,025	60%	15,615
10 – 19 employees	31,659	75%	23,744

Total Small Business Employees Covered by Health Insurance **48,264**

This figure will be used to adjust the total number of lives covered to account for the fact that firms with less than 20 employees will be exempted.

How many Non-ERISA Lives are Covered in Alaska?

Blue Cross of Washington/Alaska 60,000
(Note: Blue Cross is not included in the Division of Insurance Market Share List)

Company	Percent Market Share	Lives Covered
Principal Mutual Life Insurance Co.	7.73%	7,378
Employers Health Insurance Company	3.53%	3,500
Guardian Life Insurance Company	3.52%	5,785
Great-West Life & Annuity Insurance Co.	2.12%	1,800
Total	19.6%	18,463

Lives Covered – Method 1

Total Lives = (Sample Lives Covered / Market Share of Sample) + Blue Cross Lives Covered

$$\text{Total Lives Covered} = (18,463 / 19.6\%) + 60,000$$

$$\text{Total Lives Covered} = 94,199 + 60,000$$

Total Lives Covered = 154,199

Lives Covered – Method 2

According to Blue Cross Officials, the company believes that they have 38% of the non-ERISA lives covered. If we use this figure with the 60,000 lives covered by Blue Cross, we compute total lives covered as:

$$\text{Total Lives Covered} = \text{Blue Cross Lives} / \text{Blue Cross Market Share}$$

$$\text{Total Lives Covered} = 60,000 / 38\%$$

Total Lives Covered = 157,894

The estimates from the two methods appear close enough to work with for our purposes. If we take the average of the two, we end up with an estimate of total non-ERISA lives covered in Alaska of 156,047.

Data Source: Key Informant Interviews 11/98

Adjustment for Small Business Employees

Since the current thinking is to exempt businesses with less than 20 employees, we need to adjust the total lives covered to account for those numbers. Using the data derived in the analysis of small businesses, we note that approximately 48,264 small business employees are likely to be covered by health insurance. Adjusting for this in the total number of lives covered we find:

Total Lives Covered:	156,047
Less Small Business Employees:	<u>48,264</u>
Total Impacted Lives Covered	107,783

Impact on State of Alaska Employees Health Insurance. The health plan offered to the State of Alaska employees would not be legally subject to parity mandates recommended by this Task Force. In discussions with state officials, however, we learned that it is the policy of the State to implement any mandates placed on private insurance plans. In reviewing the various state employees health plans, we noted that most elements of parity are already in place as a function of the characteristics of the coverage. For example, the co-insurance (80%-20%) is the same for mental health and physical health. The deductibles for physical and mental health are a combined deductible. Since the federal legislation applies to ERISA programs, the State employees' health plans have already removed the annual and lifetime maximums. The State employees' plan currently places no limits on the number of visits and hospital days for mental health. Our observations were confirmed by the Division of Retirement and Benefits in a key informant interview with the Director, Guy Bell.

In light of the foregoing, it appears that, even if the State were to adopt any mental health parity mandate approved by the legislature, there would be no impact on costs for the State employees' health plans. The same is not true, however, for State employee retirees' plans, which do not have the same features as current employees' plans. The most immediate impact would likely be in the area of co-payments and co-insurance since retirees' plans require differential co-payment for mental health and physical health. There is no clear indication, however, of the extent to which the retirees' plan would be modified to comply with mental health parity mandates since there is no legal requirement to do so.

Task Force Recommendations

General. The Task Force, having studied the various issues and elements of mental health parity, developed a set of three different models for initial consideration. All three models have some common features:

- Mandates would apply only to plans that are not covered by ERISA. Employers with less than 20 employees would be exempt.
- The conditions to which any of the models would apply would be those conditions listed in DSM IV, except that conditions defined in "V" codes would not be covered.
- Consideration would be given, in all models, to both inclusion and exclusion of substance abuse.
- There would be a mandate to provide mental health coverage in any health care plan provided by an employer covered by the parity mandate.

Model 1: Federal Legislation Extended. The first model presented for consideration would be the extension of the terms of MHPA of 1996 (federal legislation) to Alaskan firms with 20 or more employees. This would involve equating annual and lifetime dollar limits between mental and physical health. As noted above, it would also mandate that mental health coverage be provided in health care plans provided by firms subject to the mandate. It would also be considered with and without substance abuse inclusion.

Model 2: Catastrophic Model. The next model would add, in addition to the elements of MHTA noted above, parity with regard to days and visit limits and maximum out-of-pocket expenses.

Model 3: Financial Parity. This model would add, in addition to the elements of the two models noted above, parity with regard to co-insurance, co-payments, and deductibles.

Appendices

Appendix A: Task Force Membership

Appendix B: Resources and Suggested Readings

Appendix C: Senate Concurrent Resolution 14

Appendix A: Task Force Membership

Name	Representing
Senator John Torgerson	Alaska Senate
Representative Gary Davis	Alaska House of Representatives
Senator Johnny Ellis	Alaska Senate
Representative Tom Brice	Alaska House of Representatives
Marianne Burke	Alaska Division of Insurance
Joe Heueisen	Insurance/Shattuck & Grummett
Dr. Cynthia Dodge	Mental Health Provider
Banarsi Lal	Advisory Board on Alcoholism and Drug Abuse
Katsumi Kenaston	Consumer
Patrick Murphy	Alaska Mental Health Board
Elmer Lindstrom	Alaska Department of Health and Social Services
Task Force Support	
Steven Hamilton	C & S Management Associates (Contractor)
Matt Felix	C & S Management Associates (Contractor)
Walter Majoros	Alaska Mental Health Board

Appendix B: Resources and Suggested Readings

To be added later...

Appendix C: Senate Concurrent Resolution 14

To be attached later...

Endnotes

- ¹ U.S. Department of Health and Human Services, National Institute of Mental Health, Parity in Financing Mental Health Services: Managed Care Effects on Costs, Access, and Quality, p 57, Washington, D.C., 1998.
- ² U.S. Department of Health and Human Services, National Institute of Mental Health, Mental Illness in America: The National Institute of Mental Health Agenda, pp 1-2, Washington, D.C., 1998.
- ³ Alaska Advisory Board on Alcoholism and Drug Abuse, Results Within Our Reach: Alaska State Plan for Alcohol and Drug Abuse Services 1999 – 2003, Juneau, Alaska 1998.
- ⁴ Ronald E. Bachman, F.S.A., M.A.A.A., Mental Health: Parity Issues and Costs, p I-1, Atlanta, Georgia, 1998.
- ⁵ ibid.
- ⁶ ibid.
- ⁷ Alaska Advisory Board on Alcoholism and Drug Abuse, Results Within Our Reach: Alaska State Plan for Alcohol and Drug Abuse Services 1999 – 2003, Juneau, Alaska 1998.
- ⁸ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits, Chapter 1, Washington D.C., 1998.
- ⁹ Ronald E. Bachman, F.S.A., M.A.A.A., An Actuarial Analysis of Comprehensive Mental Health Benefits and Other Options for Improved Coverages in the State of Arizona, p 17, Atlanta, Georgia, 1998.
- ¹⁰ U.S. Department of Health and Human Services, National Institute of Mental Health, Parity in Coverage of Mental Health Services in an Era of Managed Care: An Interim Report to Congress by the National Advisory Mental Health Council, p 19, Washington, D.C., 1997
- ¹¹ ibid. p 20
- ¹² Ronald E. Bachman, F.S.A., M.A.A.A., Mental Health: Parity Issues and Costs, pp IV-1 – IV-4, Atlanta, Georgia, 1998.
- ¹³ U. S. Department of Health and Human Services, National Institute of Mental Health, Parity in Financing Mental Health Services: Managed Care Effect on Cost, Access, and Quality, p 45, Washington, D.C., 1998.
- ¹⁴ U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits, Chapter 1, Washington D.C., 1998.



MANAGEMENT ASSOCIATES

P.O. Box 34757 • Juneau, Alaska 99803-4757

December 18, 1998

Pam LaBolle, President
Alaska State Chamber of Commerce
217 2nd, Suite 201
Juneau, AK 99801

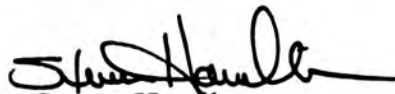
Re: Legislative Task Force on Mental Health Parity

Dear Ms. LaBolle:

We spoke some weeks back about the Alaska Legislative Task Force on Mental Health Parity. The Task Force was formed as a result of Senate Concurrent Resolution 14 in the last Legislature. The co-chairs of the Task Force are Senator Torgeson and Representative Davis. The group has met face to face four times and by teleconference once. We have one remaining face to face meeting in mid-January to hear more public testimony before finalizing recommendations. The current plan is to meet in Anchorage, either at the Legislative Information Office or at the Alaska Psychiatric Institute.

I am enclosing all of the materials generated by the project since I became involved (October 1). If you have any questions or would like to offer any input or comment outside the public testimony process, please feel free to contact me. You can reach me by phone at 789-0921, by fax at 789-1667, or by e-mail at Steve@csmgt.com.

Sincerely,


Steven Hamilton

Enclosures: (1) October 1 Teleconference Minutes
(2) Packet for October 26 Meeting
(3) October 26 Minutes and Related Materials
(4) Packet for December 7 Meeting
(5) Input offered by HIAA



MANAGEMENT ASSOCIATES

P.O. Box 34757 • Juneau, Alaska 99803-4757

December 18, 1998

Thyes Shaub
Shaub & Associates
217 2nd, Suite 206
Juneau, AK 99801

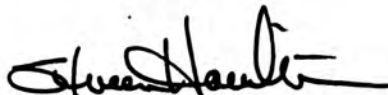
Re: Legislative Task Force on Mental Health Parity

Dear Ms. Shaub:

We spoke some weeks back about the Alaska Legislative Task Force on Mental Health Parity. The Task Force was formed as a result of Senate Concurrent Resolution 14 in the last Legislature. The co-chairs of the Task Force are Senator Torgeson and Representative Davis. The group has met face to face four times and by teleconference once. We have one remaining face to face meeting in mid-January to hear more public testimony before finalizing recommendations. The current plan is to meet in Anchorage, either at the Legislative Information Office or at the Alaska Psychiatric Institute.

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Sincerely,


Steven Hamilton

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(3) October 26 Minutes and Related Materials
(4) Packet for December 7 Meeting
(5) Input offered by HIAA



MANAGEMENT ASSOCIATES

P.O. Box 34757 • Juneau, Alaska 99803-4757

January 5, 1999

Tom Englehart
Human Affairs Account Management
4300 B Street, Suite 202
Anchorage, AK 99503-5926

Re: Mental Health Parity Draft Report

Dear Tom:

Here is the draft report for Mental Health Parity that I mentioned in my e-mail. Sorry for the delay getting it to you; it seems like everything happens at once around here, especially during the holidays. Please bear in mind that this is a draft and will likely change in both form and substance as a result of public testimony.

I hope you had a wonderful holiday season and I look forward to seeing you on the 13th. Please give me a call (toll free 888-803-3515) if you have any questions.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Steven Hamilton'.

Steven Hamilton

Enclosure: Draft Mental Health Parity Report



MANAGEMENT ASSOCIATES

P.O. Box 34757 • Juneau, Alaska 99803-4757

January 10, 1999

Gordon Evans, Esq.
211 Fourth Street, Suite 305
Juneau, AK 99801

Re: Mental Health Parity Study

Dear Gordon:

The Legislative Task Force on Mental Health Parity published its draft report on December 30, 1998 and I am enclosing a copy for your review. If the folks at HIAA want, they can also download a copy from our web site, www.csmgt.com. The Task Force is meeting again on Wednesday, January 13, 1999 to take public comment on the draft copy; they will likely develop their final recommendations following that meeting.

Give me a call if you have questions or concerns. The cover sheet for the report gives instructions for dialing in to the teleconference portion of the public testimony. Best wishes for a wonderful New Year and luck in the coming session.

Sincerely,

A handwritten signature in black ink, appearing to read 'Steven Hamilton', with a long, sweeping horizontal line extending to the right.

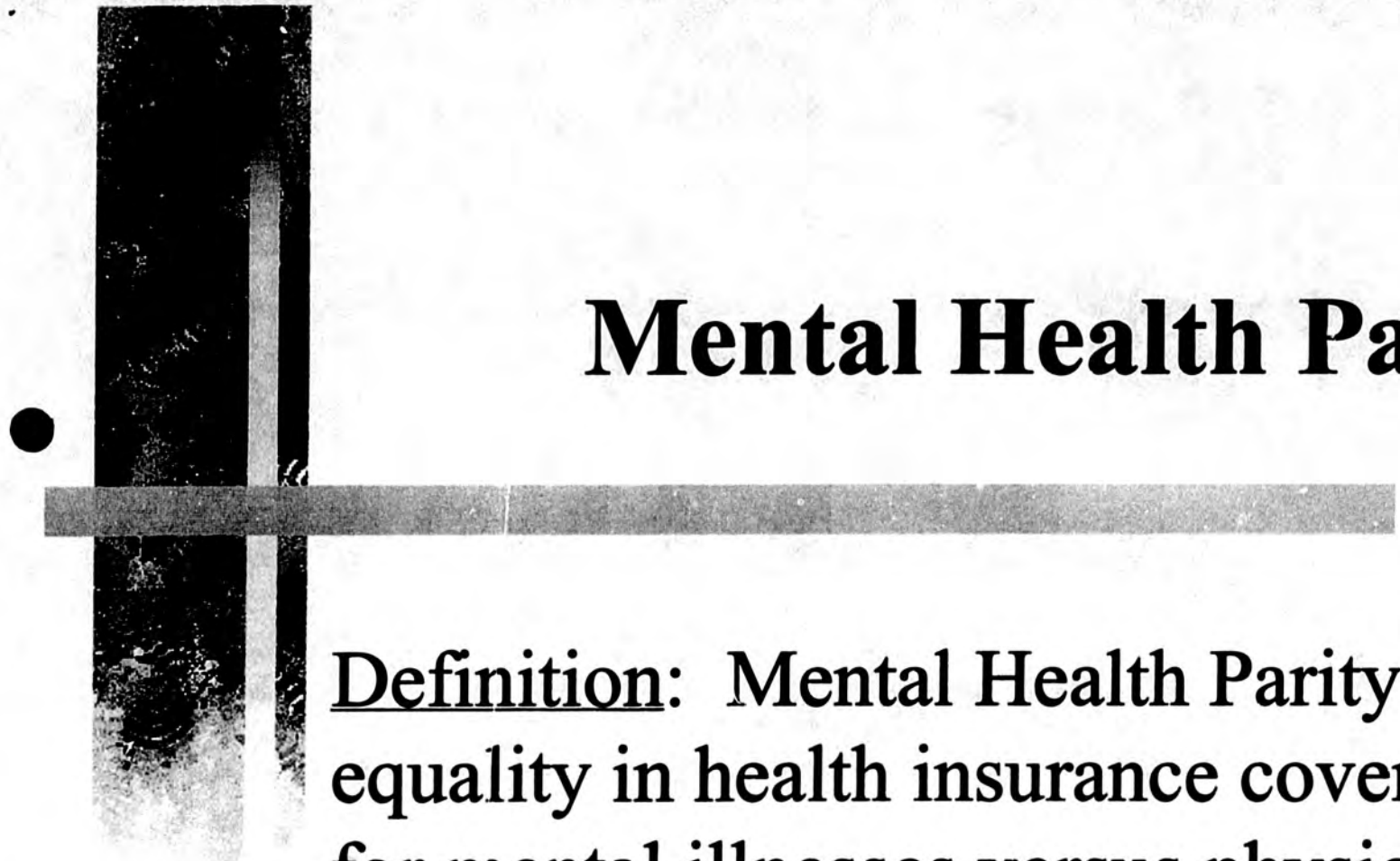
Steven Hamilton

Enclosure: Draft Mental Health Parity Report



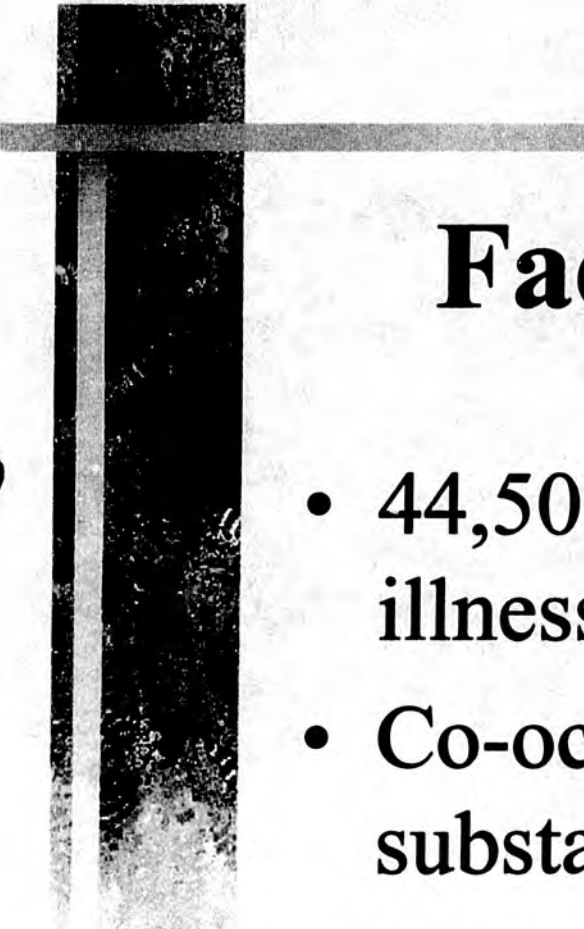
Legislative Task Force on Mental Health Parity

A Report to the Legislature



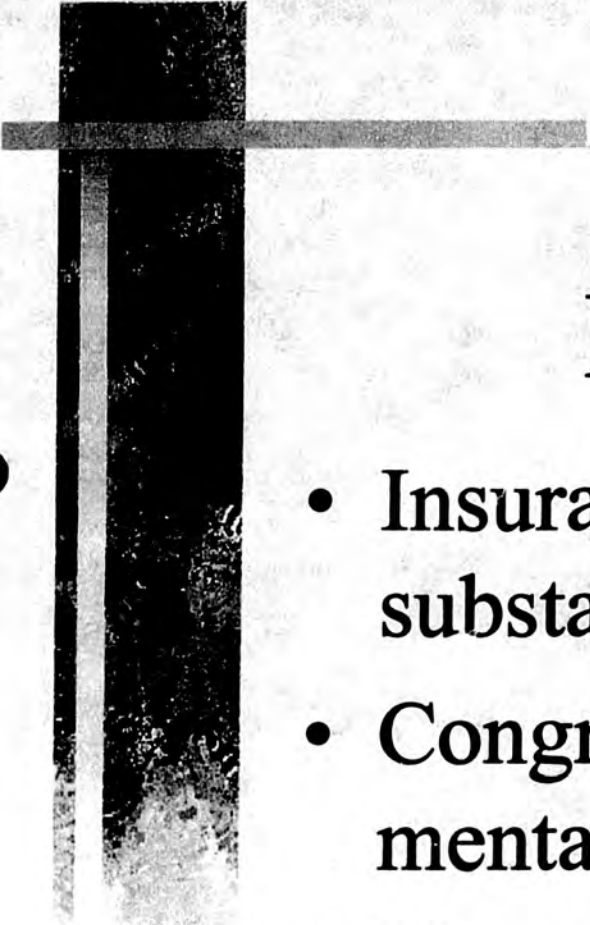
Mental Health Parity

Definition: Mental Health Parity is equality in health insurance coverage for mental illnesses versus physical illnesses.



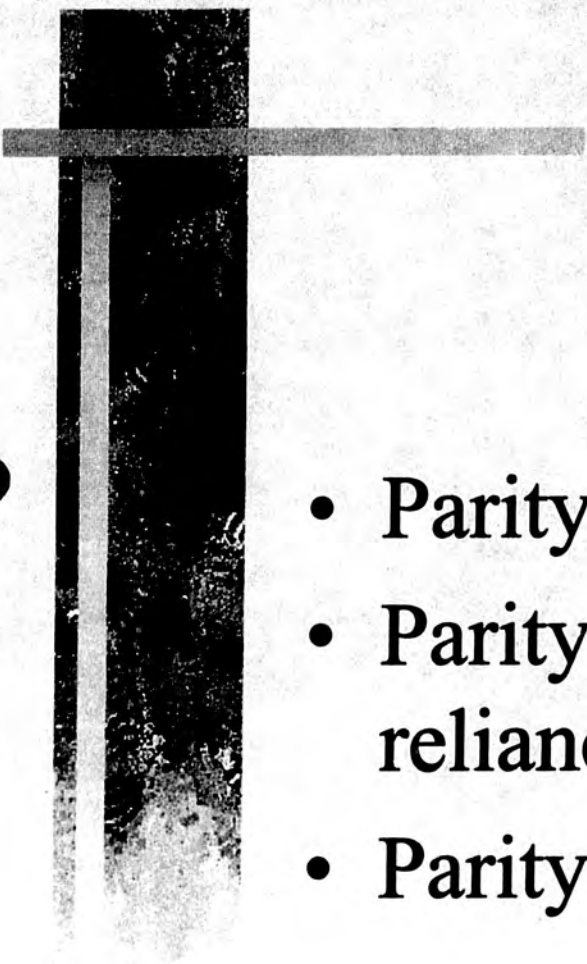
Facts About Mental Illness

- 44,500 Alaskans suffer from mental illnesses and emotional disorders.
- Co-occurrence of mental illness and substance abuse.
- Mental illness and substance abuse are treatable.
- Many people with mental illness want to work but can't.



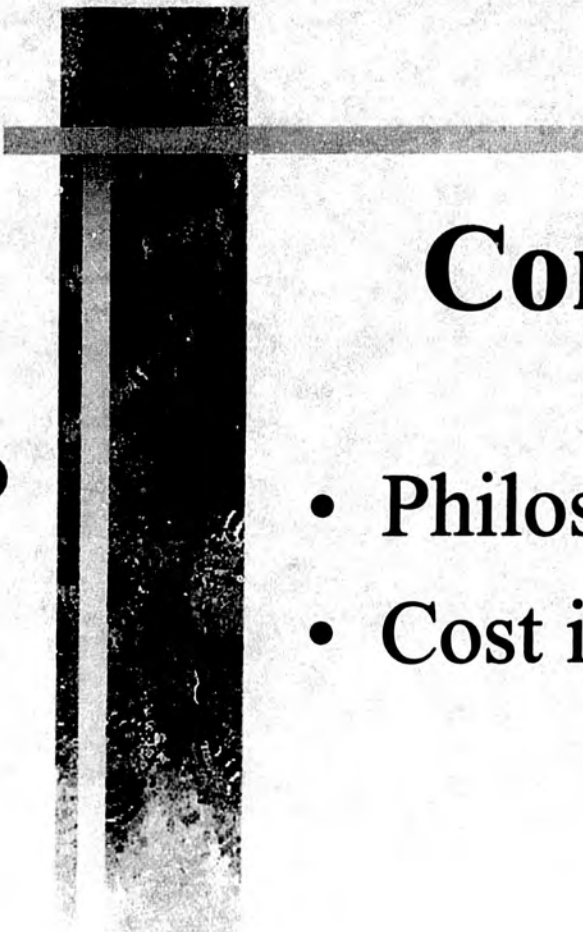
Facts About Mental Health Parity

- Insurance policies limit mental health and substance abuse benefits.
- Congress has taken the first step toward mental health parity.
- Many states are addressing parity now.
- There is no single approach to address parity.



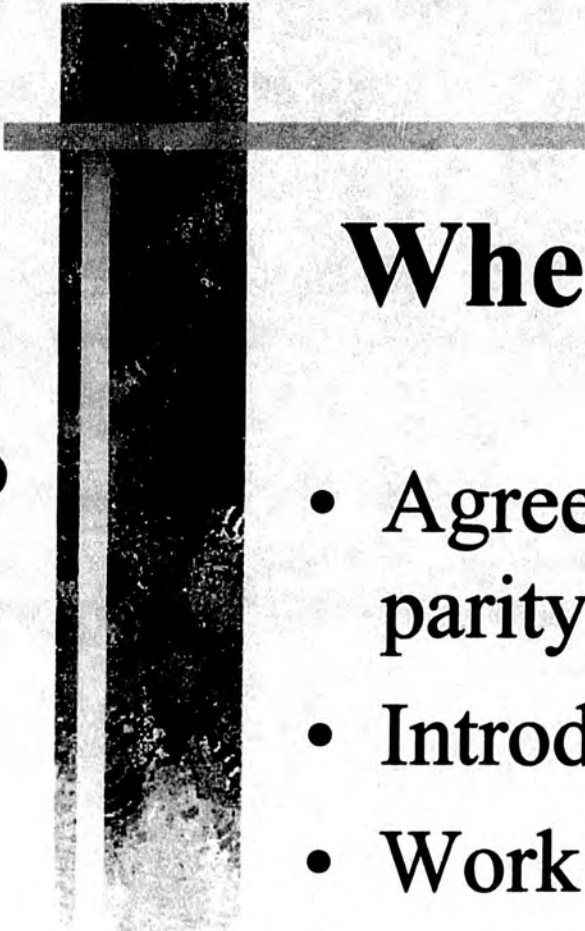
Benefits of Parity

- Parity is cost-effective.
- Parity increases productivity and self-reliance.
- Parity reduces reliance on public welfare.



Concerns Regarding Parity

- Philosophy on mandates
- Cost impact on small businesses



Where Do We Go From Here?

- Agree on the ultimate goal--achieving full parity
- Introduce legislation
- Work together to build consensus
- Pass legislation that moves towards full parity

Mental Health Parity Act of 1996

- Effective January 1, 1998
- Includes:
 - Firms with more than 50 employees including ERISA
 - Parity for Lifetime/Annual Dollar Limits
 - Does not prohibit disparity in days/visits limits
- Allows Increased Cost Exemption - 1%
- Does not include substance abuse
- Does not mandate coverage
- Sunsets September 30, 2001

Element of Parity	State Legislation											
	AR	CO	CT	IN	ME	MD	MN	NH	NC	RI	TX	VT
Defines Mental Illness	X	X	X		X			X	X	X	X	X
Covers only "serious mental illness"		X	X		X			X		X	X	
Covers substance abuse	X					X	X		X			X
Provides specific elements of parity	X			X	X	X	X		X	X	X	X
Specifies minimum benefit requirements					X	X			X			
Specifies providers who are covered					X				X			X
Mentions managed care	X		X		X	X	X	X	X	X		X
Contains medical necessity clauses	X				X	X	X			X		
Only applies to government employees				X					X		X	
Exempts small businesses	X				X	X	X					

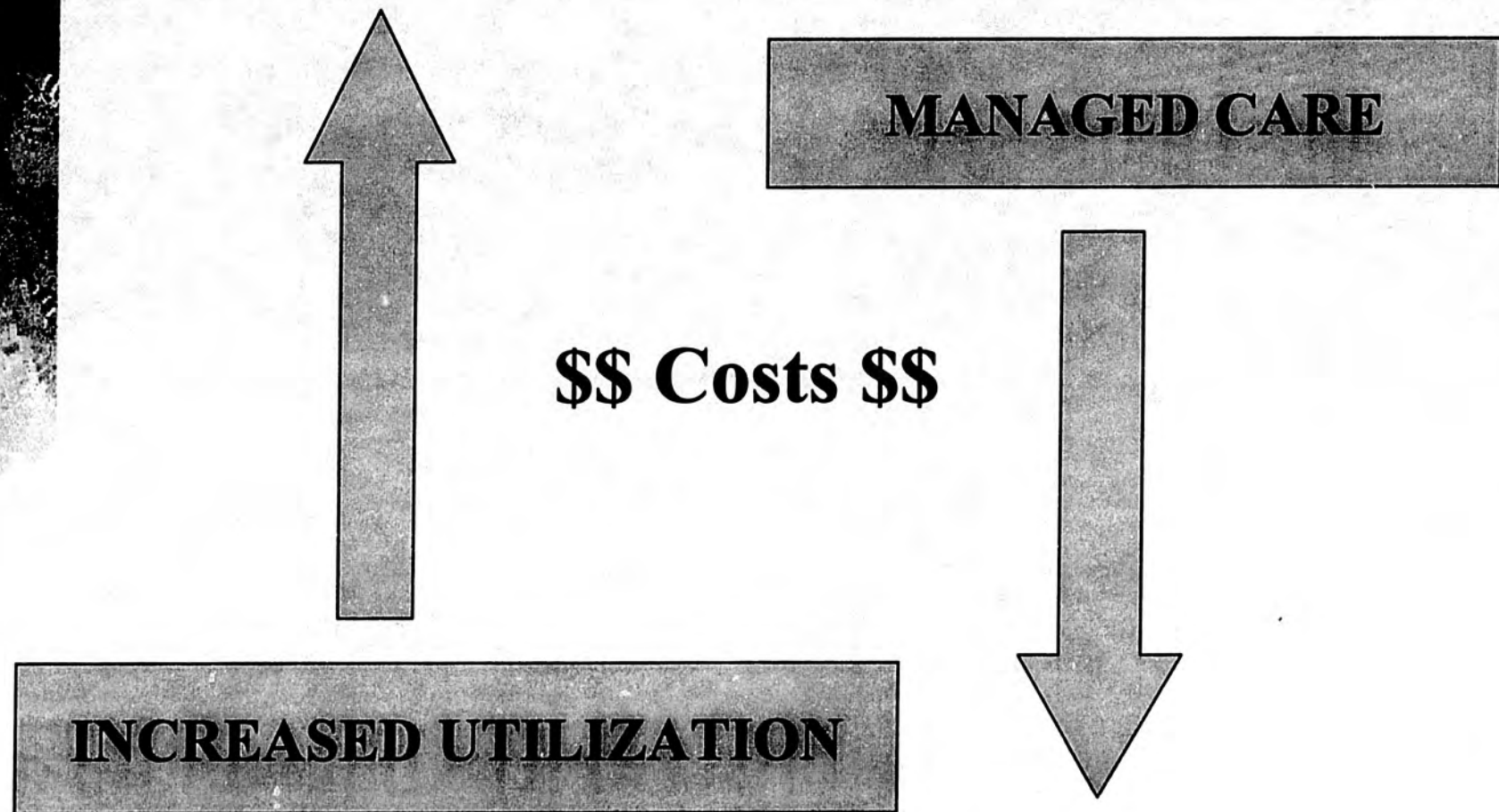
U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits, Chapter 1, Washington D.C., 1998.

Alaska Substance Abuse Statute

- A.S. 21.42.365 passed 1988
- Applicability:
 - ERISA Exempted
 - Firms under 20 employees exempted
- Parity for deductibles, Co-payments, Co-insurance
- Mandated Coverage
- Adjusted for inflation every three years

COST DYNAMICS:

Two Opposing Forces



Models Considered

- MHPA Extended
 - Parity for annual/lifetime dollar limits
- Catastrophic
 - Same as above plus
 - Parity for days/visits limits
 - Maximum out-of-pocket expenses
- Financial
 - Same as above plus
 - Parity for co-payments and co-insurance
 - Parity for deductibles

Cost Estimates

- Assuming:
 - Exempts companies with less than 20 employees
 - Firms covered by ERISA/Governments not included
 - Approximately 115,000 covered lives impacted
 - Coverage for mental health is mandatory
 - All diagnoses contained in DSM IV (except “V” codes) are covered and

Assumed Delivery System

- 20% Fee for Service
- 55% Managed Indemnity
- 20% PPO/POS
- 5% HMO

Cost Estimates - Claims

	MHPA	Catastrophic	Financial
MH Only	0.04%	0.8%	1.3%
MH/SA	0.08%	1.2%	1.7%

Represents the estimated increase in the cost of claims accounting for managed care.
Source: Ronald Bachman, PricewaterhouseCoopers, LLC

Estimate Costs - Premiums

	MHPA	Catastrophic Financial	
MH Only	\$0.06	\$1.24	\$1.95
MH/SA	\$0.14	\$1.80	\$2.62

Represents the estimated per member per month premium cost increase accounting for managed care.
Source: Ronald Bachman, PricewaterhouseCoopers, LLC

Task Force Recommendations

- **Financial Parity**
 - Annual/Lifetime limits
 - Days/Visits limits
 - Maximum out-of-pocket expenses
 - Co-payments/co-insurance
 - Deductibles
- **Inclusion of substance abuse**
- **Mandatory coverage**
- **All diagnoses in DSM IV except “V” codes**