

SCOMM

112:3

Alaska Chamber of Commerce Business Survey

In 1998 the Alaska Legislature established a Task Force to look at the issue of parity between mental health insurance coverage and medical insurance coverage. This included looking at what, if any, disparities exist between levels of mental health and substance abuse coverage and levels of medical/surgical coverage. Issues where disparity could exist might be in deductibles, co-payments, policy limits, and out-of-pocket expenses. That Task Force is now completing its work and one of the possible outcomes might be legislation that creates new insurance mandates for companies. Before legislation is drafted, the Task Force would like to hear from more businesses. We would greatly appreciate it if you would be willing to give us your thoughts, as well as some basic information. The survey form below, when completed, will submit information to the contractors that will be passed on to Legislators and the Task Force. If you would like more information on this project as well as a copy of the initial report, you can follow the link below to the project page.

This survey should take 5 minutes or less. Thank you for taking the time and effort to complete this survey.

ZIP Code of Business:

Type of Business:

Retail
Manufacturing
Health/Medical/Social Services
Professional Services
Food Services
Transportation
Communications
Other

Number of Employees:

Do you offer health care insurance to employees?

If yes, does that insurance include

Mental health coverage?

Substance abuse coverage?

If you do offer health care insurance to employees, what is the average monthly premium per employee?

Comments:

<Link to MH Parity Project Page>

Business Owners – We need to hear from you!

In 1998 the Alaska Legislature established a Task Force to look at the issue of parity between mental health insurance coverage and medical insurance coverage. This included looking at what, if any, disparities exist between levels of mental health and substance abuse coverage and levels of medical/surgical coverage. Issues where disparity could exist might be in deductibles, co-payments, policy limits, and out-of-pocket expenses. The Task Force is now completing its work and one of the possible outcomes might be legislation that creates new insurance mandates for companies. Before legislation is drafted, the Task Force would like to hear from more businesses. We would greatly appreciate it if you would be willing to give us your thoughts, as well as some basic information.

If you have access to the Internet, you can sign on to www.csmgt.com and follow the link to the Alaska Chamber of Commerce Business Survey. This survey will take 5 minutes or less. This will also provide you with additional information on the issue. If you do not have access to the Internet, you can call Steve Hamilton of C & S Management Associates and provide the information by telephone. You can contact Steve toll-free at (888) 803-3515 or 789-0921 in Juneau. Thanks for the help!

Internet Data Capture Feedback

1. As a private not for profit, we want to provide medical coverage for our employees which covers basic needs but also allows for employees to choose additional coverage. At this same time, we only require a cursory employee contribution since our salaries and stability of employment are not as stable as state government (or even other private businesses). We struggle to achieve some balance with our benefits and premiums but I find it increasingly difficult. Particularly when federal and state governments begin to mandate certain benefit/requirements.
2. I'm not sure whether or not substance abuse is covered in my policy, but I know "mental illness" is not, meaning no counseling or coverage for anti-depressants. Given the connection between mind and body I find it difficult to understand why this disparity exists. There are also other issues, like certain meds and surgical procedures that are only marginally covered, whether or not the procedure was elective. This, despite the fact that my health insurance premium increases roughly 10% per year! :-)
3. I am not in favor of further mandates--it just costs businesses more (like an additional tax). Let the free market work--if enough potential employees ask for it, business will provide it.
4. Mandated health care programs forced on small business, and all rural Alaska businesses are small, places an economic burden on those businesses which tends to either destroy the business or results in no growth because the business owner will maintain a low level of employment that will avoid the insurance requirement. The proponents of this type of legislation, while they may be very well meaning, do not understand the economics of small business. This type of legislation will eventually destroy small rural businesses driving the business to the large towns leaving small rural Alaska communities without so much as a grocery store. I suggest that the proposers of this legislation travel through the small towns of this country and observe all of the empty buildings that used to house the core business of those communities.
5. Insurance coverage should be a matter of choice not mandatory. This would place undue economic and other liability requirements upon employers. I am totally against this from the limited information I have received. Perhaps additional information will be provided prior to any legislative action being taken.
6. Please do not pass on to the business community another unfunded mandate. Passing this bill may cause a good number of business to stop offering health care insurance to their employees all together or they may need to raise the deductible the employee pays in order to cover the increased premiums.
7. Do not hamper the engine that drives Alaska's economy, small business's, with another cost.

8. We pay 100% for the employees' health insurance coverage. This coverage includes a \$250 deductible/person, per year or \$500/family per year. Mental health is covered at 50%.

Also, every year for the past 5 years we have had an increase in our premiums. This is difficult on the budget, but we do not want to increase the employees' annual deductible or require the employee to pay for a percentage of their coverage.

9. Making employers provide mental health and substance abuse insurance is not reasonable, and would probably INCREASE drug problems.
What the hell....if I get hooked, I can take off work for 6 mos. paid.

Telephone Feedback

1. Currently offer medical insurance but no mental health coverage. 47 employees. If mental health coverage is mandated, we will discontinue medical insurance because of the added expense.

2. Currently offer health care insurance with mental health coverage but MH is not at parity with medical surgical. If parity is mandated, will discontinue all medical insurance because of expense. Why are firms that offer mental health coverage being punished?

3. Juneau firm, 46 employees, offers mental health and substance abuse coverage in its health insurance but mental health is not at parity with medical surgical. Opposes MH parity mandate because they feel it is too expensive. An additional burden to those companies that already provide health care insurance to their employees. Issues in disparity of coverage should be resolved at the insurance company level.



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 LIO

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 tht 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.

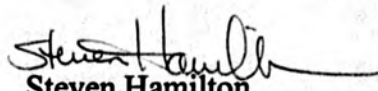
She was discharged from the hospital and continued in therapy. In July 1996, at the age of 15, she ran away from home for a brief period but returned. Upon returning she again expressed ideas of suicide. At this time, there was also a question of substance abuse although this was later ruled out. She 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 to the right.

Steven Hamilton
C & S Management Associates