

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILES 8672
2590 SCOMM 112: AK TASK FORCE on PARITY FOR MENTAL HEALTH, 1998

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:

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 csmtgt@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

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

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					

^a 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

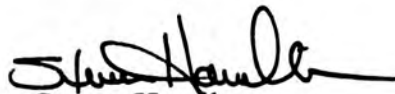
Re: Legislative Task Force on Mental Health Parity

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

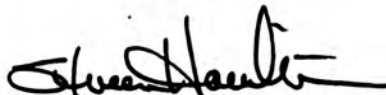
Re: Legislative Task Force on Mental Health Parity

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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(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.

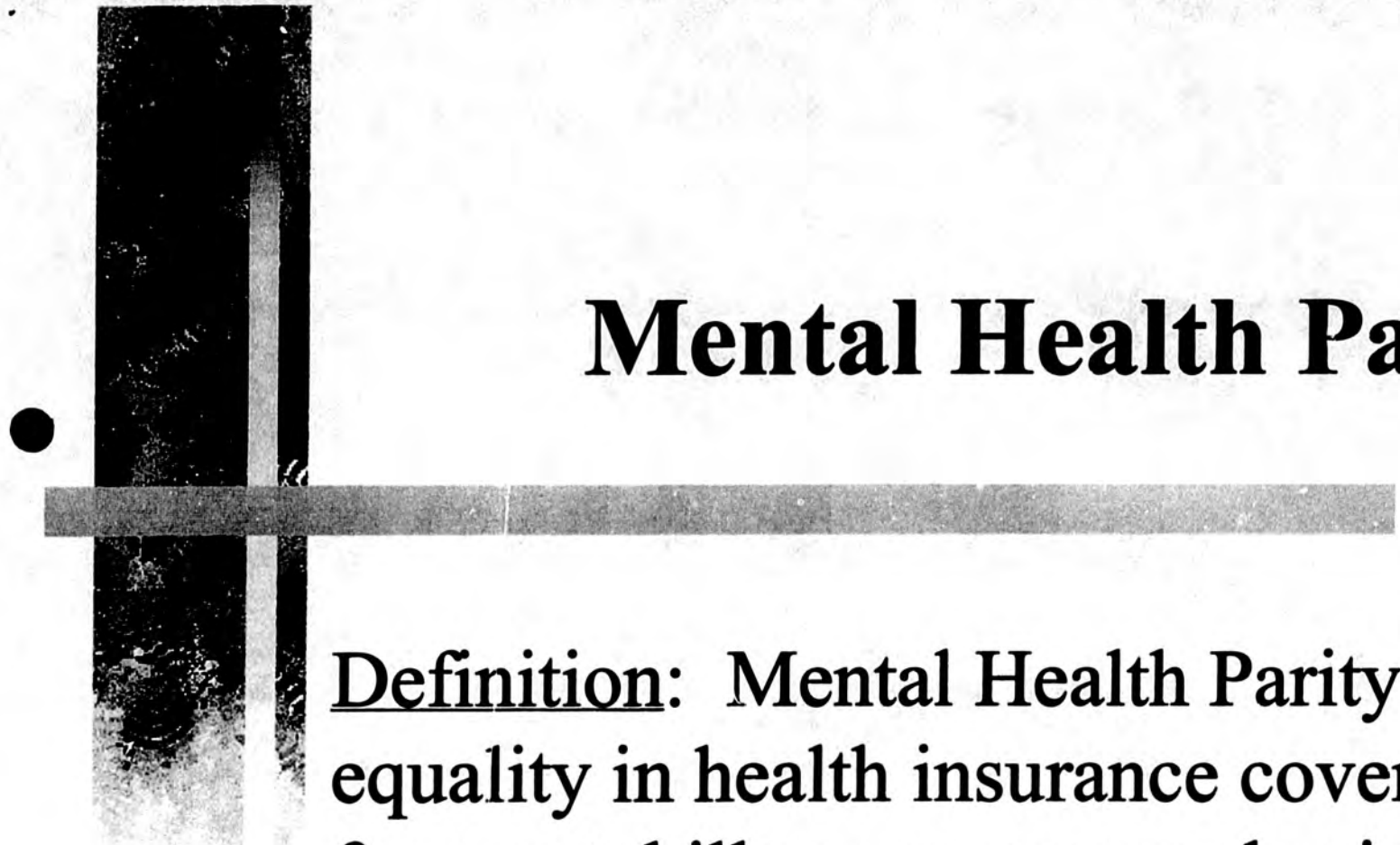
Steven Hamilton

Enclosure: Draft Mental Health Parity Report



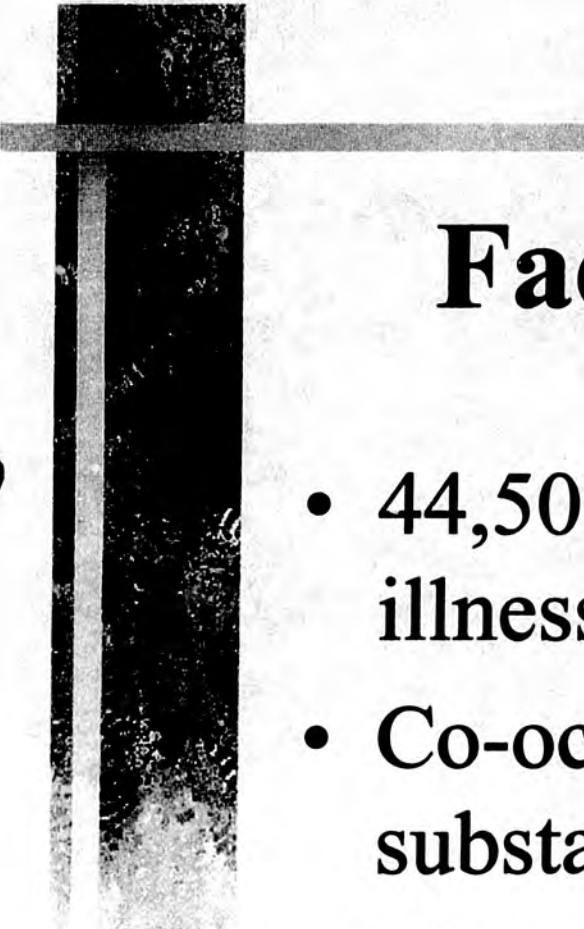
Legislative Task Force on Mental Health Parity

A Report to the Legislature



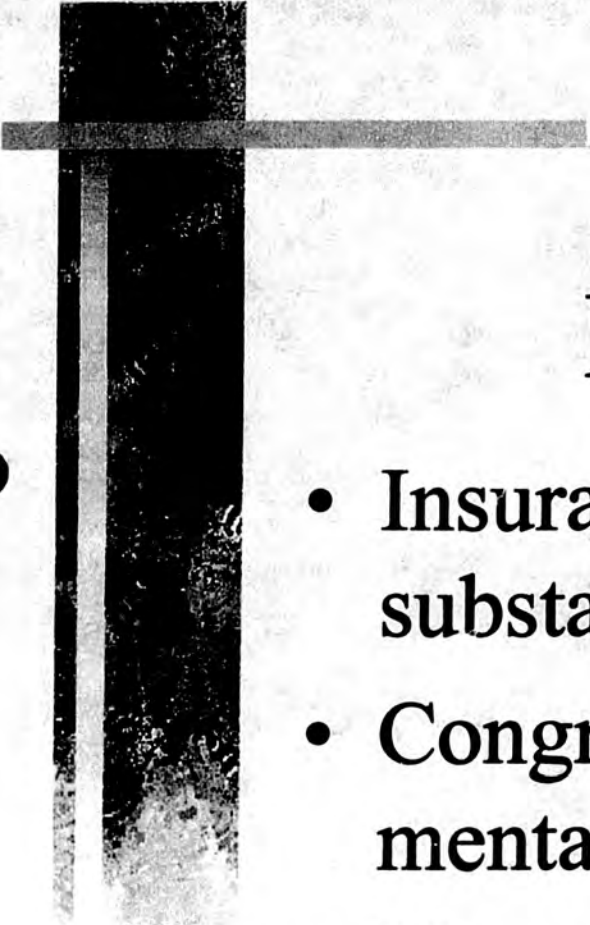
Mental Health Parity

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



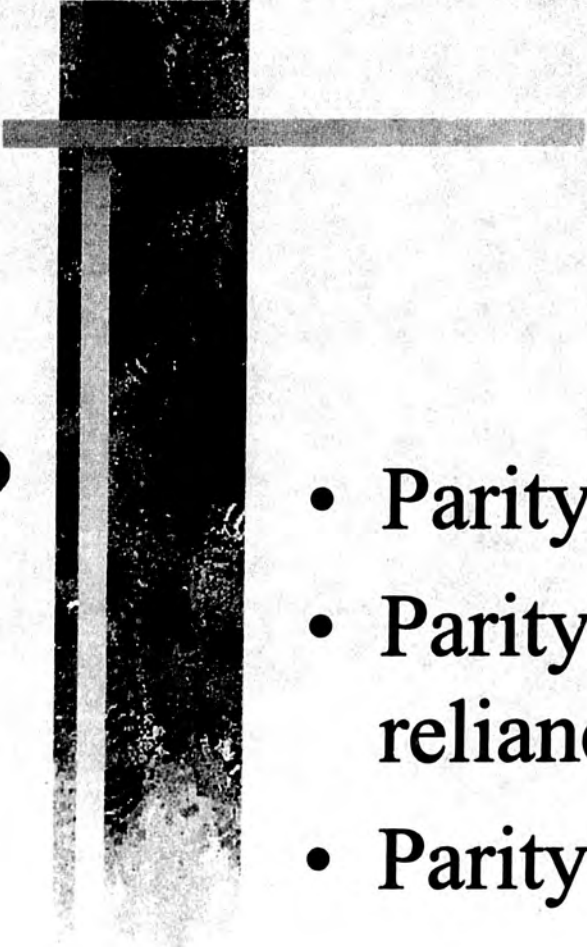
Facts About Mental Illness

- 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.



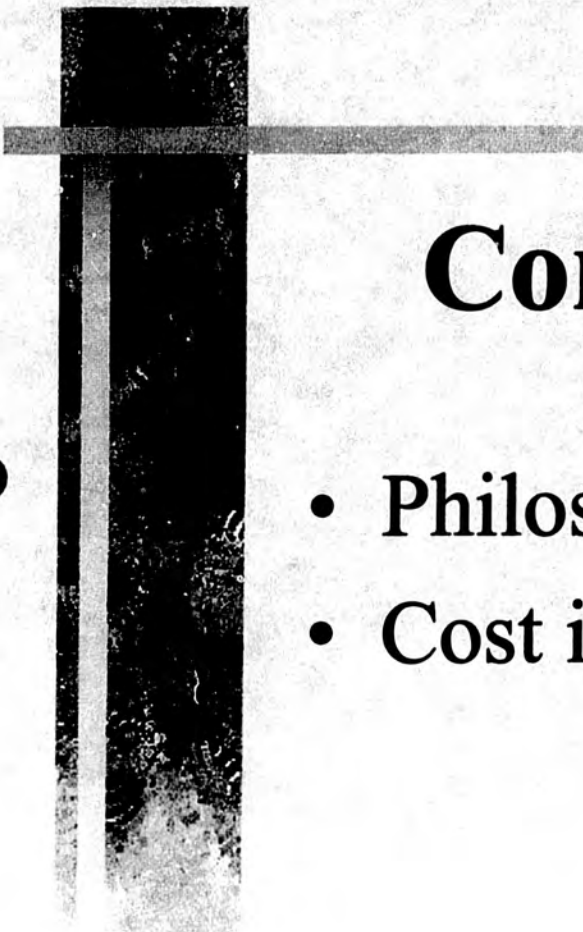
Facts About Mental Health Parity

- 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.



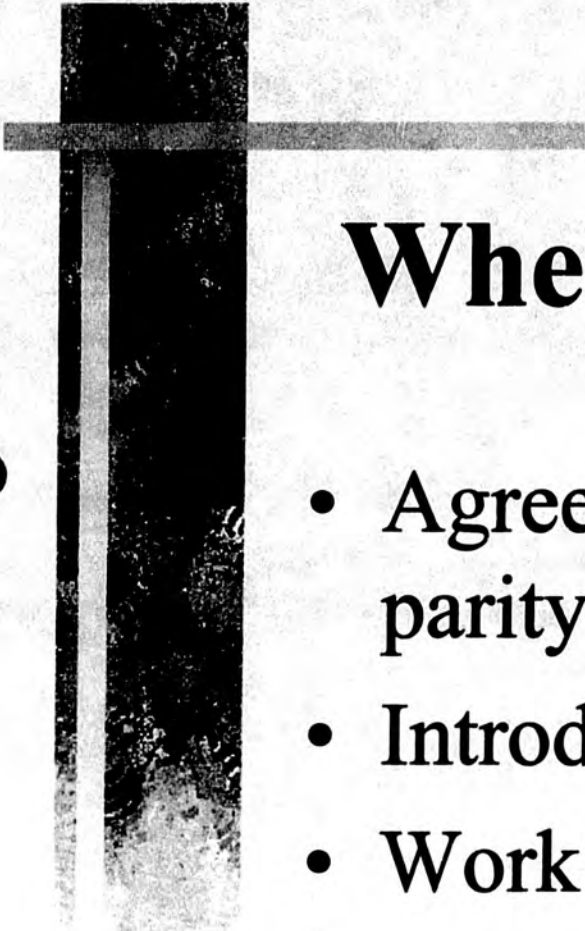
Benefits of Parity

- 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					

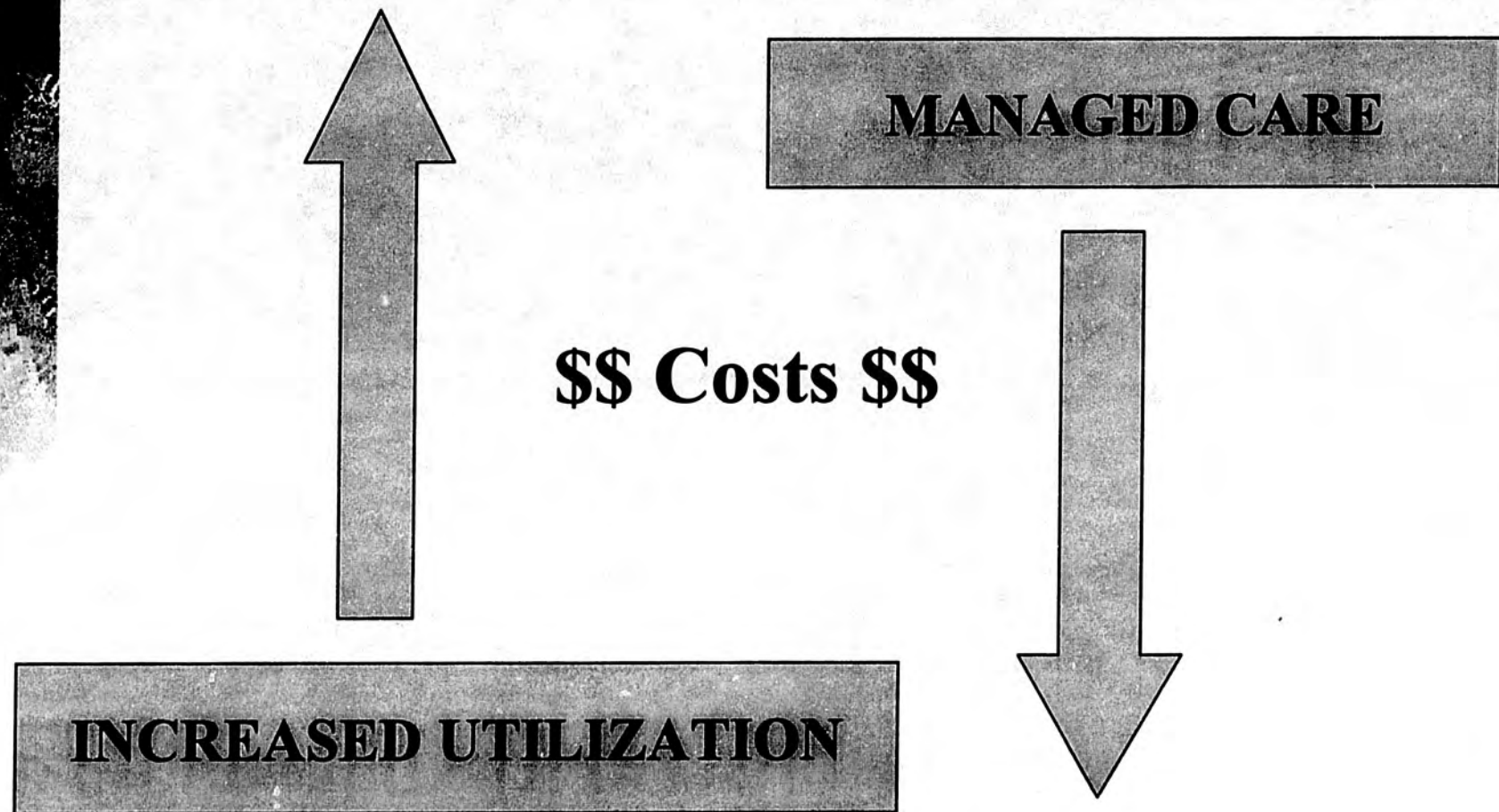
U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits, Chapter 1, Washington D.C., 1998.

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**