

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILES 8672

2591 SCOMM 112: AK TASK FORCE ON PARITY FOR MENTAL HEALTH, 1998



RECORDS CERTIFICATION



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SCOMM 112: ALASKA TASK FORCE ON PARITY FOR MENTAL HEALTH, 1998

MEMBERS:

REPRESENTATIVE GARY DAVIS, CO-CHAIR
REPRESENTATIVE TOM BRICE
SENATOR JOHN TORGERSON, CO-CHAIR
SENATOR JOHNNY ELLIS
(plus 7 executive branch and public members)

Established by Legislative Resolve No. 63, 1998 (SCR 14).

Contents: 4 files. 6 cassettes are also available of meetings held 10/26 - 12/7/98.

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INFORMATION TO ASSIST STATES IN THE
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BY PRICE WATERHOUSE COOPERS. | |

SCOMM

112:5

Mental Health Parity Task Force 1998

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**Mental Health Parity Task Force
Draft Work Plan/Time Line
July 9, 1998**

Prior to First Meeting

- Finalize Task Force Membership
- Draft guiding principles for Task Force
- Initial research on information available from other states
- Arrange first face-to-face Task Force meeting

August

- Hold first in-person Task Force meeting. Agenda to include
 - review mission from legislation
 - provide background information on parity (federal legislation, etc.)
 - review/approve guiding principles
 - review work plan and time line
 - discuss budget and staffing
 - discuss opportunities for public testimony
- Develop specifications for contract(s) and/or staffing

September

- Selection of contractor(s) and/or staff
- Hold teleconference meeting (one or two). Agenda to include:
 - review definitions of "mental illness", "serious mental illness", "mental injury" and "mental health consumer"
 - review summary information from other states
 - select options for further consideration
 - public testimony?

October

- Hold teleconference meeting (one or two). Agenda to include:
 - summary information from contractor on various approaches to parity
 - begin to formulate potential actions/recommendations to Legislature
 - review outline/table of contents for final report
 - clarify additional information needed

November

- Hold in-person meeting. Agenda to include:
 - Review draft recommendations/actions for inclusion in final report
- Discuss menu of parity options and prioritize options for inclusion in final report

December

- Hold in-person or teleconference meeting(s) to review/adopt final report

Alaska State Legislature



Official Business

Speaker of the House of Representatives

State Capitol
Juneau, Alaska 99801-118:
(907) 465-3720

MEMORANDUM

TO: Rep. Norman Rokeberg, Co-Chair
Joint Committee on Electric Utility Restructuring
Rep. Pete Kelly, Co-Chair
Joint Committee on Military Bases in Alaska
Rep. Pete Kott, Co-Chair
Task Force on Census and Redistricting
Rep. Gary Davis, Co-Chair
Task Force on Parity for Mental Health
Rep. Con Bunde, Co-Chair
Long-Term Care Task Force

FROM: Speaker Gail Phillips *Gail*
SUBJECT Transcription of Committee Minutes

DATE: July 24, 1998

House Records is still in the process of transcribing minutes from the last regular session of the legislature. In order to have your special committee minutes transcribed in a timely fashion, I would suggest you have your staff do the work. House Records is making the backlog a priority and will not be able to transcribe anymore minutes at this time. Records should have their session minutes done by the first of October.



Official Business

Alaska State Legislature

State Capitol
Juneau, AK 99801-1182

July 28, 1998

Dear Task Force Member:

Thank you for agreeing to serve on the Mental Health Parity Task Force. We have many important things to discuss, and a limited time frame.

For that reason, we would like to schedule the Task Force's first meeting on August 19, from 10 a.m. until approximately 3 p.m. We will meet at the Alaska Psychiatric Institute in Anchorage. A working lunch will be provided.

The intent of the meeting will be to establish a work plan for the task force, and to receive some background information on the parity issue. A more detailed agenda will be forthcoming.

To assist you with travel arrangements and per diem, please contact Donna Zahina at the Alaska Mental Health Board, 907/645-3071.

Again, thank you for agreeing to work on this important issue. We have enclosed the resolution creating the task force, and a membership roster. Call us at 907/224-2051 if you have any questions.

Sincerely,

A handwritten signature in cursive script, appearing to read "Gary".

Gary Davis, Representative
Co-Chair Mental Health Parity Task Force

Mental Health Parity Task Force 1998

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Official Business

Alaska State Legislature

Post-it® Fax Note 7671		Date 8/17	# of pages 6
To Jerry Ritzer	From Julie T		
Co./Dept.	Co.		
Phone #	Phone # 224-2051		
Fax # 258-1642	Fax #		

State Capitol
Anchorage, AK 99801-1182

August 12, 1998

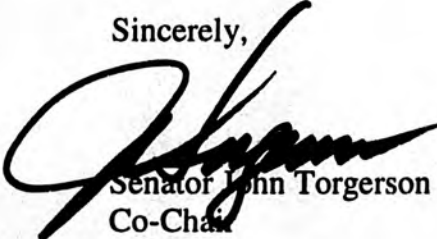
Dear Mental Health Task Force Members,

As you know, the Mental Health Parity Task Force will meet on Wednesday, August 19, 1998 from 10:00 a.m. to 3:00 p.m. at the Alaska Psychiatric Institute (API). Please plan on having lunch at API.

An agenda and meeting materials are attached for your review. A copy of SCR 14, the legislation establishing the Task Force, has already been sent to you under separate cover. If you have any questions about the meeting, you can contact Julie Tauriainen in Representative Gary Davis' office (224-2051), or Walter Majoros at the Alaska Mental Health Board (465-3072). Questions regarding travel arrangements should be directed to the Mental Health Board.

Thank you for your interest in serving on the Task Force; we look forward to seeing you in Anchorage.

Sincerely,


Senator John Torgerson
Co-Chair


Representative Gary Davis
Co-Chair

ALASKA STATE LEGISLATURE

News From The Senate and House Majorities

State Capitol
Juneau, AK 99801
Actuality line: 1-800-478-6540
For Immediate Release: August 18, 1998

Jerry Ritter (907) 258-8164
Wendy Lindskoog (907) 258-8184
web site: <http://www.akrepublicans.org>
Contact: Julie Tauriainen (907) 224-2051
Walter Majoros (907) 465-3072

Alaska Mental Health Parity Task Force to Meet

Goal is Parity for Insurance Coverage of Mental Illnesses

(ANCHORAGE) -- The Alaska Legislature's Mental Health Parity Task Force will hold its first meeting Wednesday, August 19, 1998, from 10 a.m. until 3 p.m. at the Alaska Psychiatric Institute (API), 2900 Providence Drive, Anchorage.

The Mental Health Parity Task Force was established by the 20th Alaska Legislature to examine how to achieve parity for mental illnesses in insurance coverage. This initial meeting will examine federal legislation regarding parity as well as how other states have implemented it. The task force will also organize itself and establish a work plan for establishing parity in Alaska.

The Mental Health Parity Task Force is composed of four legislators and seven members representing the Administration and the public. The 11-member task force is co-chaired by Rep. Gary Davis (R-Soldotna) and Sen. John Torgerson (R-Kasilof).

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Author: Jerry Ritter at LAA_HPHG

Date: 8/18/98 11:41 AM

Priority: Normal

TO: Andy Peterson at LAA_TRANS, Annette Deal at LAA_TRANS, Barbara Cotting at CC2MHS1, Bill Sykes at LAA_HBAR, Billie Rae Gillas, Bruce Campbell at LAA_TRANS, Cliff Stone at CC2MHS1, Dan Saddler at LAA_HBUN, Darwin Peterson at LAA_TRANS, David Pree at LAA_TRANS, David Stancliff at LAA_TRANS, Denny DeWitt (Dennis Dewitt) at LAA_CAP, Eddie Grasser at LAA_TRANS, Gary Cadd at CC2MHS1, Heather Sickafoose at LAA_HHAN, Jeff Logan at LAA_TRANS, Jennifer Florian at LAA_TRANS, Joel Lounsbury at LAA_TRANS, Judi Jordan at LAA_CAP, Julie Tauriainen at LAA_TRANS, Ken Erickson at CC2MHS1, Kip Knudson at LAA_HHAN, Kristie Keele at LAA_TRANS, Kyle Johansen at CC2MHS1, Larry Labolle at LAA_CAP, lsncckde@laa_mail.legis.state.ak.us at CC2MHS1, Marco Pignalberi at LAA_TRANS, Marieke Barnes, Mark Riehle at LAA_HBAR, Matt Gill at LAA_TRANS, Melinda Hofstad at LAA_CAP, Melissa Myers at LAA_TRANS, Mike Tibbles at CC2MHS1, Myrna Maynard, Myrna McGhie at CC2MHS1, Nicole Thibodeau at CC2MHS1, Noelle Brekke at CC2MHS1, Pat Carter at LAA_TRANS, Pat Springer, Patricia Walker at LAA_CAP, Peter Ecklund at CC2MHS1, Robert Walsh at CC2MHS1, Sara Fisher at CC2MHS1, Shirley Armstrong at LAA_TRANS, Tim Sullivan at LAA_TRANS, Tom Manninen at LAA_TRANS, Tom Wright at LAA_TRANS, Tracy Ashe at LAA_TRANS, Tricia Everson at LAA_CAP, Walter Wilcox at CC2MHS1, Wendy Lindscoog at CC2MHS1

Subject: Press Release 8/18/98

ALASKA STATE LEGISLATURE

News From The Senate and House Majorities

State Capitol

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For Immediate Release: August 18, 1998

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Subject: Legislative E-News 08-18-98

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Electric Utility Restructuring Committee Meets Again
Joint House-Senate Committee Hears from Public

Anchorage -- The Alaska Legislature's Joint Committee on Electric Utility Restructuring held the second of four meetings Tuesday in Anchorage. Co-chairs Senator Bert Sharp and Representative Norman Rokeberg say the committee is attempting to formulate written recommendations for the next Legislature on whether and how to implement electric utility restructuring in Alaska.

"At our first meeting, we heard from invited participants, including utilities and unions," Rokeberg said. "Today it was the public's turn to tell us what they're feeling on this partial deregulation of the utility industry," Rokeberg said.

"We'll be holding at least two more meetings before we make any recommendations, one in Fairbanks in September and at least one more meeting in November," Sharp said. "The more sources we hear from the better the chances that we'll have a handle on what works and what doesn't work as we try to get the best results for individual Alaska consumers," Sharp said.

The full text of this press release is at
<http://www.akrepublicans.org/prrokeberg108181998.htm>

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The full text of this press release is at
<http://www.akrepublicans.org/prtorgerson108181998.htm>
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**Mental Health Parity Task Force
Meeting Agenda
Wednesday, August 19, 1998
Alaska Psychiatric Institute**

10:00 to Noon

Introductions

Review of SCR 14/Task Force Mission

Background Information on Mental Health Parity

- **Federal Legislation**
- **Facts About Mental Health Parity**
- **States That Have Passed Parity Legislation**

Draft Work Plan and Time Line for Task Force

Noon to 1:00 p.m.

Lunch at API

1:00 to 3:00 p.m.

Review/Approve Guiding Principles for Task Force

Budget and Staffing Issues

- **Mental Health Trust Appropriation**
- **Contracts to Facilitate Task Force Work**
- **Role of the Alaska Mental Health Board**

Opportunities for Public Testimony

Discuss/Set Future Meeting Schedule

Adjourn

THE MENTAL HEALTH PARITY ACT OF 1996 SUMMARY OF THE LAW

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

Key Provisions

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

What's Not Covered

The Mental Health Parity Act of 1996 does not provide:

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

Federal Regulations

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

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

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

Benefits for American Families

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

Mental Health Insurance Parity

Why Consider it?

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

Mental Health Insurance Parity

Fact Sheet

General

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

Mental Illnesses are Treatable

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

Costs of Mental Health Parity

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

A total of \$26.6 billion was spent on treating severe mental illness in the US in 1990. 57% of all treatment costs for severe mental illness was paid by federal and state entitlement programs at tax-payers expense, whereas, Tax-payers pay only 43% of the costs of all other illnesses. (3)

Alaska

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

References

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

States that have Passed Parity

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

**Mental Health Parity Task Force
Draft Work Plan/Time Line
July 9, 1998**

Prior to First Meeting

- Finalize Task Force Membership
- Draft guiding principles for Task Force
- Initial research on information available from other states
- Arrange first face-to-face Task Force meeting

August

- Hold first in-person Task Force meeting. Agenda to include
 - review mission from legislation
 - provide background information on parity (federal legislation, etc.)
 - review/approve guiding principles
 - review work plan and time line
 - discuss budget and staffing
 - discuss opportunities for public testimony
- Develop specifications for contract(s) and/or staffing

September

- Selection of contractor(s) and/or staff
- Hold teleconference meeting (one or two). Agenda to include:
 - review definitions of "mental illness", "serious mental illness", "mental injury" and "mental health consumer"
 - review summary information from other states
 - select options for further consideration
 - public testimony?

October

- Hold teleconference meeting (one or two). Agenda to include:
 - summary information from contractor on various approaches to parity
 - begin to formulate potential actions/recommendations to Legislature
 - review outline/table of contents for final report
 - clarify additional information needed

November

- Hold in-person meeting. Agenda to include:
 - Review draft recommendations/actions for inclusion in final report
- Discuss menu of parity options and prioritize options for inclusion in final report

December

- Hold in-person or teleconference meeting(s) to review/adopt final report

**Draft Guiding Principles
for the
Mental Health Parity Task Force
August, 1998**

1. Achieving greater parity between ^{comprehensive} mental health and physical health care coverage is an important public policy objective.
2. There needs to be a balance between private and public health care coverage for persons with mental disorders.
3. Whenever possible, mental health coverage should be included as part of comprehensive health care coverage in the public and private sectors.
4. Cost of mental health parity is an important consideration; mental health parity should not place an undue economic burden on employers.
5. Cost of mental health parity should be considered in comparison to costs for physical care coverage.
6. Lack of mental health insurance options needs to be recognized as an impediment to employment for persons with mental disorders.
7. A variety of options should be considered in developing recommendations for addressing mental health parity in Alaska.
8. Mental health parity should be recognized as a mechanism to help reduce reliance on Medicaid and Adult Public Assistance for persons with mental disorders.

Others?

TF recognizes stigma of mental ~~health~~ health



Official Business

Alaska State Legislature

State Capitol
Juneau, AK 99801-1182

August 25, 1998

Dear Parity Task Force Members,

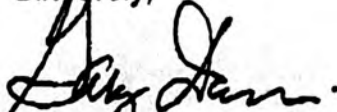
This is a reminder that the Mental Health Parity Task Force will meet on **Tuesday, September 1 from 10:30 a.m. to 3:00 p.m. at API** (check for meeting room location when you sign in).

The main purpose of the meeting will be to meet with Ron Bachman from Coopers and Lybrand to discuss the actuarial study he will be doing for us as well as background information on approaches that other states have taken with parity. We will also spend some time planning the logistics for our next Task Force meeting.

If you have any questions or concerns regarding the September 1 meeting, please contact Julie Taurainen in Representative Davis' office (224-2051) or Walter Majoros at the Alaska Mental Health Board (465-3072). Questions regarding travel arrangements should be directed to the Mental Health Board.

We believe that our first meeting went very well and look forward to continuing the work of the Task Force on September 1.

Sincerely,


Rep. Gary Davis
Co-Chair


Sen. John Torgerson
Co-Chair

ALASKA STATE LEGISLATURE

News From The Senate and House Majorities

State Capitol
Juneau, AK 99801
Actuality line: 1-800-478-6540
For Immediate Release: August 18, 1998

Jerry Ritter (907) 258-8164
Wendy Lindskoog (907) 258-8184
web site: <http://www.akrepublicans.org>
Contact: Julie Tauriainen (907) 224-2051
Walter Majoros (907) 465-3072

Alaska Mental Health Parity Task Force to Meet

Goal is Parity for Insurance Coverage of Mental Illnesses

(ANCHORAGE) -- The Alaska Legislature's Mental Health Parity Task Force will hold its first meeting Wednesday, August 19, 1998, from 10 a.m. until 3 p.m. at the Alaska Psychiatric Institute (API), 2900 Providence Drive, Anchorage.

The Mental Health Parity Task Force was established by the 20th Alaska Legislature to examine how to achieve parity for mental illnesses in insurance coverage. This initial meeting will examine federal legislation regarding parity as well as how other states have implemented it. The task force will also organize itself and establish a work plan for establishing parity in Alaska.

The Mental Health Parity Task Force is composed of four legislators and seven members representing the Administration and the public. The 11-member task force is co-chaired by Rep. Gary Davis (R-Soldotna) and Sen. John Torgerson (R-Kasilof).

###

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

- Agenda 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

ALASKA MENTAL HEALTH BOARDTony Knowles, Governor
STATE OF ALASKA431 N. Franklin Street, #101
Juneau, Alaska 99801
Office: 907-465-3071
Fax: 907-465-3079**Facsimile Cover Sheet**Date: 9/4 Number of Pages 4 including cover sheet

Time: _____

To: Rep Gary Davis
Sen John TorgersonFrom: Walter ☒ Majoros Donna _____ Richard _____ Margo _____
Zahina Rainery Waring**Comments:**

Here are the draft background/
workscope for the staffing
contract & draft Task
Force budget. I will call
at 9:00 am on Tues.
Sept 8 for our teleconference
Thanks Walter

DRAFT

Background Statement and Work Scope for Parity Task Force Procurement

Background Information

The purpose of this contract is to provide staffing and consultation services to the Mental Health Parity Task Force. The Task Force was established by the 1998 Legislature to study the differential treatment of mental disorders versus physical disorders in health insurance coverage, and make recommendations to the 1999 Legislature on how this issue should be addressed within Alaska (see attached copy of SCR 14 which establishes the Task Force). The Task Force is composed of 11 members including representatives from the Legislature, insurance industry, the Department of Health and Social Services, State advisory boards for mental health and alcoholism/drug abuse, and the mental health provider and consumer community.

The issue of mental health parity is also being addressed by the federal government and other states. Recognizing that 90% of health insurance plans provide less mental health than physical health coverage, Congress passed the Mental Health Parity Act of 1996, which equalizes annual and lifetime benefits for mental health and physical health for affected health plans. Primarily due to limitations in the scope and provisions of the federal law, 19 states have passed parity laws ranging from very limited to comprehensive coverage. Each state's approach has been unique regarding such issues as the mental health conditions covered, the scope of coverage, and the pool of affected health plans.

The Alaska Task Force has held two in-person meetings to date. The purpose of the first meeting was to review the task force legislation, hear background information on mental health parity, review a draft work plan and guiding principles, and discuss budget and staffing issues. The purpose of the second meeting was to hear from a national expert who will be conducting an actuarial study on the cost of implementing mental health parity legislation in Alaska. It is anticipated that the Task Force will hold approximately 3 more in-person meetings and periodic teleconferences between September and January. A final Task Force report is expected by mid-January, 1999.

Work Scope

The contractor will be responsible for the following tasks:

- 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, as well as reports on the impact of implementing parity legislation.
- Analyzing and summarizing information gained through research for consideration by Task Force members in developing its recommendations.
- Staffing approximately three in-person Task Force meetings (averaging 6 hours per meeting), and periodic teleconference meetings. This includes agenda development and preparation of background materials for all meetings. Meeting logistics (travel and meeting room arrangements, copying, etc.) will be covered by State of Alaska staff.

DRAFT

- Revising the Task Force's draft work plan and time line to ensure that all essential tasks are completed.
- 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.
- 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.
- Writing a final report which includes the Task Force recommendations on parity and other pertinent information.
- 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.

Contract Type and Budget

This is a firm fixed price contract. The total funding anticipated for this contract is \$20,000.

Draft**Parity Task Force Budget****September 4, 1998****DRAFT**

Personal Services	
AMHB Staff Time	5.0
Travel	
5 meetings @ 3.3	16.5
Contractual	
Bachman 9/1 trip	2.5
Staffing Contract	20.0
Teleconferences	1.2
Meeting Advertising	1.5
Report Printing	3.3
TOTAL	50.0

ALASKA MENTAL HEALTH BOARD

FAX MEMORANDUM

To: Mental Health Parity Task Force: **Date:** Oct. 14, 1998

Sen. John Torgerson
Sen. Johnny Ellis
Marianne Burke
Dr. Cynthia Dodge
Katsumi Kenaston
Elmer Lindstrom

Rep. Gary Davis
Rep. Tom Brice
Joe Heueisen
Banarsi Lal
Pat Murphy

From: Walter Majoros *Walter*
Executive Director

Phone: 465-3072

Subj.: 10/26/98 Task Force Meeting

A full agenda and any back up materials for the Monday, October 26, 1998 Task Force meeting will be sent to you next week. In the meantime, I wanted to give you some basic information about the meeting so you can all schedule it into your calendars and make any necessary travel arrangements.

Date: Monday, October 26, 1998

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

Time: 9:30 a.m. to 2:45 p.m. Task Force Meeting with Working Lunch
3:00 p.m. to 5:00 p.m. In-person Public Testimony
7:00 p.m. to 9:00 p.m. Call-in and In-person Testimony

Please feel free to contact me if you have any questions. I hope you all are well and look forward to seeing you on the 26th.

ALASKA MENTAL HEALTH BOARD**FAX MEMORANDUM****To: Mental Health Parity Task Force:****Date: Nov. 17, 1998**

Sen. John Torgerson

Rep. Gary Davis

Sen. Johnny Ellis

Rep. Tom Brice

Marianne Burke

Joc Heueisen

Dr. Cynthia Dodge*

Banarsi Lal

Katsumi Kenaston

Pat Murphy

Elmer Lindstrom

From:Walter Majoros *Walter*
Executive Director**Phone: 465-3072****Subj.:****December 7, 1998 Task Force Meeting**

I am writing to confirm that the Mental Health Parity Task Force meeting has been changed from Friday, December 4 to **Monday, December 7, 1998**. The meeting will run from 9:30 a.m. to 4:30 p.m. and will take place at API; please make your travel arrangements accordingly. Steve Hamilton will mail an agenda and any necessary back-up materials as we get closer to the meeting date. Thanks and I look forward to seeing you all on December 7.

cc. Steve Hamilton

To: Julie From: Darwin
224-5067

ALASKA MENTAL HEALTH BOARD

Tony Knowles, Governor
State of Alaska

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

forwarded to Julie
9-14-98

MEMORANDUM

DATE: September 4, 1998
TO: Mental Health Parity Task Force
THRU: Walter Majoros *W Majoros*
Executive Director, Alaska Mental Health Board
FROM: Barbara Magnusson *B Magnusson*
Secretary
SUBJECT: Task Force Travel

The Alaska Mental Health Board will be reimbursing members of the Mental Health Parity Task Force for travel to Task Force meetings. This memo will serve to clarify the Board's travel practices as outlined in their Policies and Practices.

Task Force members are encouraged to have their respective agencies pay travel expenses if at all possible. If agencies are unable to provide funding for travel, members should follow the procedures listed below.

- Travel reservations should be made with the travel agency of their choice. Travel agencies should be instructed to call the Alaska Mental Health Board for approval and to obtain the Business Travel Account number (BTA). All travel per state regulations is to be purchased through the BTA.
- Travelers are encouraged to travel at flight specific times to cut down on travel costs and are asked to stay in reasonably priced hotels. When making travel reservations indicate to your travel agent that Avis is the state contract car rental agency.

- Travel authorizations will be generated in the Alaska Mental Health Board office and signed off by the Executive Director.
- Upon completion of travel, please submit the following receipts/backup within 1 week of travel to the Boards office in order to expedite your reimbursement.

Travel Itinerary

Final Airline Ticket Stub

Original Hotel receipts if any

Original Car Rental Agreement

Original Receipts for incidentals such as Gas, Parking, Copying

Telephone calls etc.

If you have any questions regarding travel please feel free to call me at the Board's office at 465-3071.

ALASKA MENTAL HEALTH BOARD

FAX MEMORANDUM

To: Mental Health Parity Task Force: Date: Sept. 16, 1998

Sen. John Torgerson
Sen. Johnny Ellis
Marianne Burke
Dr. Cynthia Dodge
Katsumi Kenaston
Elmer Lindstrom

Rep. Gary Davis
Rep. Tom Brice
Joe Heueisen
Banarsi Lal
Pat Murphy

4 pages total

From: Walter Majoros *Walter* Phone: 465-3072
Executive Director

Subj.: Staffing contract and meeting information

As directed by the Task Force, a subcommittee met on September 8 to develop the work scope and framework for a contractor to provide staffing/consultation services for the Task Force. Highlights of the meeting and information on the contract procurement process are presented below:

- The background statement, work scope, budget and time frame for the contract were reviewed and approved. A copy of this information is attached.
- Proposals are due on September 22 and we will hold a Proposal Evaluation Committee (PEC) meeting (teleconference) on Friday morning, September 25. The subcommittee is proposing that the PEC consist of: Senator Torgerson, Representative Davis, Cynthia Dodge, Pat Murphy, Joe Heueisen and Walter Majoros. If you have any concerns regarding this composition, please contact me (465-3072) or Julie Tauriainen (224-2051) in Representative Davis' office.
- The subcommittee recommends that we hold a full Task Force teleconference immediately following the PEC meeting. The tentative time for this meeting is 11:00 a.m. on Friday, September 25. The purpose of the teleconference would be the following:
 - reviewing the PEC recommendations for the consultation contract (I will check with the State procurement specialists to make sure this is allowable).
 - revisiting our meeting schedule. The subcommittee thought we should consider postponing our next in-person meeting until we can have the contract consultant on board to prepare for and attend the meeting.

We will send you updated information on the procurement process and teleconference meeting by the middle of next week. In the meantime, please pencil in 11:00 a.m. on Friday, September 25 for a full Task Force teleconference. Thank you all for your involvement.

Section 1 Program Background Information and Purpose of contract

The purpose of this contract is to provide staffing and consultation services to the Mental Health Parity Task Force. The Task Force was established by the 20th Legislature to study the differential treatment of mental disorders versus physical disorders in health insurance coverage, and make recommendations to the 21st Legislature on how this issue should be addressed within Alaska (see attached copy of SCR-14 which establishes the Task Force). The Task Force is composed of 11 members including representatives from the Legislature, insurance industry, the Department of Health and Social Services, State advisory boards for mental health and alcoholism/drug abuse, and the mental health provider and consumer community.

The issue of mental health parity is also being addressed by the federal government and other states. Recognizing that 90% of health insurance plans provide less mental health than physical health coverage, Congress passed the Mental Health Parity Act of 1996, which equalizes annual and lifetime benefits for mental health and physical health for affected health plans. Primarily due to limitations in the scope and provisions of the federal law, 19 states have passed parity laws ranging from very limited to comprehensive coverage. Each state's approach has been unique regarding such issues as the mental health conditions covered, the scope of coverage, and the pool of affected health plans.

The Alaska Task Force has held two in-person meetings to date. The purpose of the first meeting was to review the task force legislation, hear background information on mental health parity, review a draft work plan and guiding principles, and discuss budget and staffing issues. The purpose of the second meeting was to hear from a national expert who will be conducting an actuarial study on the cost of implementing mental health parity legislation in Alaska. It is anticipated that the Task Force will hold approximately 3 more in-person meetings and periodic teleconferences between September and January. A final Task Force report is expected by mid-January, 1999.

Section 2 Scope of Work, Schedule and Budget

The contractor will be responsible for the following tasks:

- 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.).
- Analyzing and summarizing information gained through research for consideration by Task Force members in developing its recommendations.
- Staffing approximately three in-person Task Force meetings (averaging 6 hours per meeting), and periodic teleconference meetings. This includes agenda development and preparation of background materials for all meetings. Meeting logistics (travel and meeting room arrangements, copying, etc.) will be covered by State of Alaska staff.
- Revising the Task Force's draft work plan and time line to ensure that all essential tasks are completed.
- Presenting for the Task Force's consideration, the pros and cons of all major policy-related issues that 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.
- Acting as liaison to the Pricewaterhouse Coopers, 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.
- Writing a final report, which includes the Task Force recommendations on parity and other pertinent information.
- 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.

Work Schedule

The dates below represent the State's time frame. If there are any delays, the rest of the dates will be adjusted accordingly. The estimated contract schedule is as follows;

Issue date of Request for Informal Proposal (RFIP):	September 15, 1998
Questions about RFIP received by:	September 16, 1998
Proposals due by:	September 22, 1998
Evaluation done on:	September 25, 1998
Award made on:	September 29, 1998
Contract begins:	September 29, 1998
Final Task Force report:	January 15, 1999
Contract ends:	May 15, 1999

Amendments to or withdrawals of proposals will only be allowed if acceptable requests are received prior to the deadline set for receipt of proposals. No amendments or withdrawals will be accepted after the deadline unless they are in response to State's request in accordance with 2 AAC 12.290.

Contract Type and Budget

This is a firm fixed price contract. The total funding budgeted for this contract is \$20,000.

The State will make payments based on a negotiated payment schedule. Each billing must consist of an invoice and progress report. No payment will be made until the progress report and invoice has been approved by the project director. The State is not responsible for and will not pay local, state, or federal taxes. All costs associated with the contract must be stated in U.S. currency.

SEP-25-98 FRI 13:26
SEP-25-98 FRI 14:23

KENAI LIO
ALASKA MENTAL HEALTH BRD

FAX NO. 2833075
FAX NO. 919074653079

P. 02
P. 02/02

ALASKA MENTAL HEALTH BOARD **FAX MEMORANDUM**

To: Mental Health Parity Task Force: Date: Sept. 22, 1998
Sen. John Torgerson Rep. Gary Davis
Sen. Johnny Ellis Rep. Tom Brice
Marianne Burke Joe Heuseisen
Dr. Cynthia Dodge Banarsi Lal
Katsumi Kenaston Pat Murphy
Elmer Lindstrom

From: Walter Majoros *Walter* Phone: 465-3072
Executive Director

Subj.: 1. Contractor proposal
2. 11/1/98 teleconference

Contractor Proposal

The winning proposal for the contract to provide staffing/consultation services to the Task Force was C & S Management Associates. A copy of the C & S proposal is attached for all those Task Force members who did not sit on the Proposal Evaluation Committee. If you have any questions about the proposal evaluation process, please contact me at 465-8072. I expect to have the contract on-line by the middle of next week.

11/1/98 Teleconference

The full Task Force will hold a teleconference meeting on Thursday, October 1, 1998 from 11:00 a.m. to 1:00 p.m. - please put this date on your calendar. To connect with the teleconference, you will need to call 1-800-315-6338 followed by PARITY# (or 7274894). I will work with the new contractor to develop an agenda for the meeting and will fax this to you all by next Wednesday.

Thanks again for your ongoing involvement and please contact me if you have questions or need additional information.

Tom Englehart
273-9232
258-3966 fx
800/982-5968

2490 fx

Mental Health Board
431 N Franklin
Rm 101 Juneau
99801



Official Business

Alaska State Legislature

State Capitol
Juneau, AK 99801-1182

September 30, 1998

Dear Parity Task Force Members:

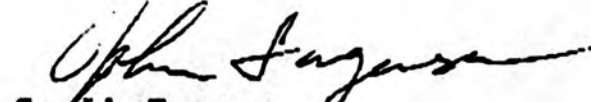
This is a reminder that the Mental Health Parity Task Force will meet by teleconference on Thursday, October 1, 1998 from 11:00 a.m. to 1:00 p.m. To connect with the teleconference, please call 1-800-815-6338 followed by **PARITY#** (or 727489#).

The main purpose of the meeting will be to meet with Steve Hamilton and Matt Felix from C & S Management Associates, the firm that was recently selected to provide staffing and consultation services to the Task Force. An agenda for the meeting and a description of the services to be provided by C & S Management Associates are attached.

Your participation at the October 1 meeting is strongly encouraged since we will be discussing our meeting schedule and work priorities for the upcoming months. Thank you for your ongoing involvement.

Sincerely,


Rep. Gary Davis
Co-Chair


Sen. John Torgerson
Co-Chair



MANAGEMENT ASSOCIATES

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

October 5, 1998

Mental Health Parity Task Force

Dear Task Force Members:

Enclosed please find the proposed minutes for our October 1 teleconference. Please let me know if these meet your expectations with regard to form and content. Is this the level of detail that you expect? I will have out the packets for our October 26 meeting around the 19th. Please let me or Walter Majoros know if there are particular issues (other than the ones identified during the teleconference) that you would like added to the agenda.

I look forward to meeting all of you on the 26th.

Sincerely,

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

Steven Hamilton

Enclosure: October 1 Teleconference Minutes

Mental Health Parity Task Force

Thursday, October 1, 1998

Teleconference Meeting

Minutes

1. **Call to Order.** The teleconference meeting of the Mental Health Parity Task Force was called to order at 11:09 am by Representative Gary Davis, Co-Chair.

2. **Attendance.** Attending the teleconference were:

Representative Gary Davis, Co-Chair

Representative Tom Brice

Joe Heueisen – Insurance Industry

Elmer Lindstrom – DHSS

Katsumi Kenaston – Consumer

Steven Hamilton – C & S Management Associates

Julie Tauriainen – Rep Davis Staff

Matt Felix – C & S Management Associates

Senator Johnny Ellis

Dr. Cynthia Dodge – Provider

Pat Murphy – AMHB

Walter Majoros – AMHB

Banarsi Lal – ABADA

Sharon Macklin – Bridges Campaign

Pat Ryan Clasby – ASHNA

3. **Introductions.** Members of the task force, staff, and contractors introduced themselves briefly before taking up items on the agenda.

4. **Review of Services.** Steven Hamilton, owner and principal of C & S Management Associates, reviewed the scope of work and services to be provided under the contract. Several points of direction were given by the Task Force:

- Avoid duplication and reinventing; there are many studies that can provide excellent information and insight. Use existing studies and verify the experiences of other states to the extent possible.
- Once the Task Force has arrived at a recommendation or series of recommendations from which legislation can be developed, the contractor will be expected to support those positions through testimony before legislative committees.
- In addition to gathering data, special effort should be made by the contractor to contact providers, consumers, and advocates to obtain qualitative information regarding the impacts of mental illness and insurance limitations on people's lives.
- The contractor will examine the issue of inclusion or exclusion of substance abuse in any parity recommendations and present information and data to address parity both with and without substance abuse.
- Coordination with PricewaterhouseCoopers, who are conducting the national actuarial study, should begin as early as possible to ensure that the Alaska-specific information and assumptions are conveyed in time for a meaningful analysis to take place.

- In addition to public comments on the draft report, public testimony will take place at the first face-to-face meeting, following the completion of business. This will allow interested members of the public, consumers, providers, and other stakeholders to comment at the earliest stages of the project. During this public meeting, priority will be given to those individuals who have not been contacted and interviewed as key informants.

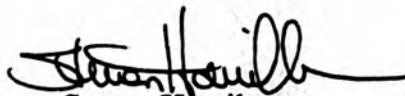
5. **Communications with Contractor.** Walter Majoros agreed to act as primary liaison to the contractors, C & S Management Associates. Walter will provide contact information for other key individuals, such as legislative aides, to the contractor. Steve will distribute both meeting minutes (target 7 days following meetings) and meeting packets (7 to 10 days prior to meetings) by mail.

6. **Verification of Key Policy Issues.** Based on the prior two Task Force Meetings, a set of key policy issues has been developed and was included as part of the issues to be addressed by the contractor. The Task Force again reviewed and, in some cases amplified, these issues during the teleconference:

- (a) **Definition of Mental Illness** – Pat Murphy expressed the hope that the group not get bogged down in the details of mental illness definitions; the true issue is parity.
- (b) **Inclusion or Exclusion of Substance Abuse** – Banarsi Lal reiterated the expectation that the contractor would examine the issue of parity both with and without substance abuse included and present information to cover both possibilities to the Task Force.
- (c) **Definition of Eligible Expenses** – Representative Brice asked for amplification on this issue. Does this define who is a provider? What services are provided?
- (d) **Definition of Existing Employer Pool** – Considerable discussion took place regarding potential employers who may or may not be covered under any proposed parity legislation in Alaska. Examples of such organizations include State of Alaska employees or municipalities who are self-insured. Steve indicated that his first step would be to begin to identify and categorize employers and try to identify insurance coverage for the various groups.
- (e) **Mandatory versus Voluntary Coverage**
- (f) **Continuum of Options from Partial to Comprehensive Parity**
- (g) **Analysis of Actuarial Data, including Alaska-specific Information**
- (h) **Consideration of Public Input**
- (i) **Review/Approval of Final Report** – Steve recommended a time line that calls for completion of a draft report by December 31. The working draft would be distributed to Task Force members during the third week of December. Upon their direction, the contractor would then distribute the draft for public comment. The Committee would receive such comment in written, oral, or testimony format (mid-January meeting). Comments from the all of the relevant groups and the Task Force would then be integrated into the report and the final edition distributed.
- (j) **Development of any Proposed Legislation**

- (k) **Others** – Walter indicated that he had added this to ensure that there were no other major issues not included. With the short time available for the completion of work, it will be critical to have the relevant issues identified at the beginning.
7. **Options for Public Input.** The concept of public testimony at the next face-to-face meeting was approved. Walter and Steve will make arrangements.
8. **Determination of Future Meetings:**
- (a) October 26, 1998, 9:30 am (Business Meeting and Public Testimony)
 - (b) November 24, 1998, Time TBA
 - (c) January 13, 1999, Time TBA
 - (d) Teleconference late December; date to be announced
9. **Next Meeting Agenda; Details.** Walter suggested that he and Steve work on meeting details and agenda. The Task Force agreed with this approach.
10. **Adjournment.** The meeting was adjourned at 12:50 pm.

Respectfully Submitted



Steven Hamilton
C & S Management Associates

CITY/BOROUGH OF JUNEAU
★ ALASKA'S CAPITAL CITY

Juneau Recovery Hospital
3250 Hospital Drive
Juneau, Alaska 99801 (907) 585-9508

October 16, 1998

Representative Gary Davis
145 Main Street Lp. Suite 223
Kenai, Alaska 99611

Dear Rep. Davis:

I understand that you are involved in the process of evaluating possible legislation aimed at establishing parity for the provision of mental health/substance abuse treatment services in Alaska. I believe that a parity law would be good for Alaskans, and encourage your support in enacting such legislation. As you are aware, some states, the federal government, and some employers already require that mental health and/or substance abuse treatment be covered in the same manner as other medical care services.

It is critical to support parity for substance abuse treatment services in Alaska, for the overall health and productivity of our State and its' citizens. This makes sense from a fiscal point of view as well as from a humanitarian perspective. As a substance abuse treatment provider, I am aware that our high rate of alcoholism has had devastating effects on our families and our State.

It pleases me that both Mental Health and Chemical Dependency are working together in a fact-finding process since mental illness and substance abuse are so closely linked in their impact on one another. If Chemical Dependency were excluded from parity, a very significant portion of mentally ill individuals would not be eligible for treatment of a condition affecting their overall health and thus, affect their ability to benefit from mental health services.

Other Reasons to Support Parity Include:

- **Fiscal Impact** - The amount of money we spend in Alaska on medical costs, law enforcement, child welfare investigations and foster placement, care of FAS and other alcohol-affected children, as well as other problems directly linked to substance abuse, is staggering and well-documented. According to the U.S. Department of Health and Human Services (DHHS) report, "The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits" June, 1998, "parity for substance abuse treatment is estimated to raise insurance premiums only 0.2 percent".
- **Impact on Businesses** - Costs of parity for mental/health substance abuse treatment differ with methods of delivery such as managed care and indemnity

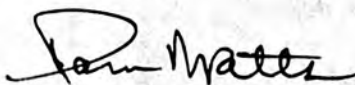
plans. Three states (Arkansas, Maine, and Maryland) exempt small businesses from parity provisions. Alaska could choose, for example, to exempt individual plans or businesses with 25 or fewer employees while offering parity provisions as an option. The DHHS study indicates that "state parity laws have had a small effect on premiums... and that employers have not attempted to avoid parity laws by becoming self-insured, and they do not tend to pass on the costs of parity to employees...due to low costs of adopting parity." Also, "costs have not shifted from the public to private sector because most recipients of public services are not insured".

- > **Treatment Works** - Public treatment programs, once criticized for "revolving door" treatment of chronic alcoholics, have proven that on average, only 15% of client admissions are repeat admissions during the year (1997 Annual Report, State Advisory Board on Alcoholism and Drug Abuse). Individuals with Private insurance often are employed, have adequate housing and support systems, all of which increase the likelihood of an even greater chance of successful recovery.

For these reasons and others, I again encourage your support of legislation to enact a parity law for substance abuse treatment in Alaska. I would be happy to speak with you by telephone or meet with you in Juneau to discuss this matter. If you haven't already received a copy of the U.S. Dept. of Health and Human Services report, "The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits", June, 1998, I suggest it as an excellent reference. It is available through the Center for Substance Abuse Treatment (CSAT), and can be found on the Internet at <http://www.mentalhealth.org.Whatsnew/parity/prtyexsm.htm>

Thank you for your attention to this very important issue.

Sincerely,



Pam Watts, Administrator
Juneau Recovery Hospital

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**

*Call-in # for public testimony
1-800-315-6338 followed by 727489#*

SUMMARY OF ACTUARIAL COST ANALYSES OF FEDERAL AND STATE MENTAL HEALTH PARITY

I. FEDERAL MENTAL HEALTH PARITY LEGISLATION

Actuarial studies estimate the cost of mental health parity at between 3 and 4% increase in individual premiums.

According to an actuarial analysis conducted by the firm of Coopers & Lybrand, the full mental health parity as proposed for in the original Domenici-Wellstone amendment, would have *increased premiums in the private sector by only about 3.2%.*

Additional government and private industry studies have reached similar actuarial conclusions. In a letter to Senator Nancy Kassebaum (R-KS) dated April 23, 1996, the Congressional Budget Office (CBO) estimated the *cost impact of the Domenici-Wellstone amendment at 4%.* Results of a Milliman & Robertson study found that *parity for mental illness would increase plan premiums by only 3.9%.*

II. STATES WITH MENTAL HEALTH PARITY LAWS IN EFFECT

Actual state experiences have resulted in an increase in individual premiums of between 1 and 2.2%, consistent with federal actuarial studies.

MARYLAND

In 1993, Maryland enacted parity for mental illness and drug abuse. Maryland has shown a continuing *decline in the length of inpatient stays in both psychiatric hospitals and psychiatric units of general hospitals.*

MINNESOTA

Minnesota's full mental health parity legislation became effective August 1, 1995. According to John Gross, director of Health Care Policy-Insurance Federation, "No one has cited rising mental health costs as reasons for premium increases." The Minnesota Department of Commerce, the state agency that regulates indemnity insurance, *estimated costs of 1% of total premium dollars for mental health parity.* Medica, an independent consulting organization, estimated Minnesota costs for mental health parity is *\$.26 per member per month (pmpm).*

per mo. per member

NEW HAMPSHIRE

For New Hampshire, mental illness is defined by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. New Hampshire Blue Cross Blue Shield has indicated that while they do not have final data, the data they have collected gives them no reason to believe that their original estimate of a 1.5% increase in premium costs is inaccurate.

NORTH CAROLINA

In 1992, the North Carolina State Employee Health Plan established mental health and substance abuse benefits with full comprehensive parity of coverage. Since that time, mental health payments as a portion of total health payments have *decreased from 6.4% to 3.7% of total health care costs for the fiscal year ending June 30, 1995.*

RHODE ISLAND

Rhode Island requires all health insurers to provide coverage for the medical treatment of serious mental illness under the same terms and conditions as coverage for other illnesses and diseases. In Rhode Island, preliminary data indicate that the *increased premium costs amounts to only 30 cents pmpm.*

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In Texas, a parity requirement for the state employees' plan resulted in new initiatives to create a managed behavioral health care benefit, which resulted in a 47.9% decrease in the cost of behavioral health care for the 170,000 enrollees in the managed fee for service, point of service and preferred provider option.

III. COOPERS & LYBRAND ACTUARIAL ANALYSIS OF ADDITIONAL STATES WITH PROPOSED OR PENDING PARITY LEGISLATION.

Projected mental health parity costs of between 1.9 and 3.9% in additional states are consistent with federal actuarial studies and actual state experiences.

ARKANSAS

The projected impact of full parity legislation originally proposed in Arkansas would have *increased costs by 2.3% or \$2.61 pmpm.*

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Actuarial analysis of comprehensive parity legislation proposed in Delaware would have *increased costs by 3.9% or \$5.16 pmpm.*

GEORGIA

Actuarial analysis of full parity legislation originally proposed in Georgia projected an *increase in costs of only 2.4% or \$3.10 pmpm.*

MASSACHUSETTS

Massachusetts proposed a comprehensive parity bill utilizing the SAMHSA definition for functional impairment. This legislation would *increase costs by only 1.9% or \$2.72 pmpm.*

NORTH CAROLINA

The proposed North Carolina mental illness and chemical dependency parity bill would *increase costs by only 3% or \$3.34 pmpm.*

PENNSYLVANIA

Comprehensive mental health legislation currently proposed in Pennsylvania would *increase costs by only 3.1% or \$4.26 pmpm.*

UTAH

Utah's full parity legislation was projected to *increase costs by 2.4% or \$2.69 pmpm.*

VERMONT

Actuarial analysis projected that a comprehensive parity and substance abuse bill would *increase costs by 3.4% or \$3.45 pmpm.*

PRICEWATERHOUSECOOPERS

January 8, 1999

Steve Hamilton
C&S Management Associates
P.O. Box 34757
Juneau, AK 99803

PricewaterhouseCoopers LLP
1100 Campanile Building
1155 Peachtree Street
Atlanta GA 30309-3630
Telephone (404) 870 1100
Facsimile (404) 870 1239

Dear Steve,

I have made preliminary calculations for the impact of the potential Mental Health and Substance Abuse legislation in Alaska. Actual legislative language, when developed, may alter the results up or down. Cost estimates shown are for Mental Health Only and MH & SA together. The cost projections are higher than national averages due to three key factors specific to Alaska. One, the current coverage levels of MH and SA are low. This is true in spite of the SA mandate that requires more upfront reimbursements through equalized deductible and coinsurance rates. The \$7,000 over two consecutive years; \$14,000 lifetime limit is less than generally available elsewhere. Second, the current level of managed care in Alaska is very low. Most of my weighted pricing is on managed indemnity. Third, mental health and substance abuse utilization rates are high in Alaska. Expanded benefits will cost more than similar expansions in other states.

Extraordinary → The four delivery systems assumed are:

Delivery System 1. Indemnity plans with utilization review found on typical medical plans. There is no special mental health or substance abuse focus and the review (preadmission certification and continued stay review) generally only applies to inpatient care.

Delivery System 2. Indemnity plans with specialized mental health and substance abuse utilization review. The utilization review applies to inpatient care, but may also apply to intensive or lengthy outpatient treatments.

Delivery System 3. Preferred Provider (PPO) and Point of Service (POS) plans that have specialized mental health and substance abuse networks. These are not carve-out programs, but act with similar attention to negotiated rates, utilization controls, and limited provider access. There is no gatekeeper mechanism. Plan design and costsharing are primarily used to channel members to network providers.

Delivery System 4. HMO/Gatekeeper plans and carve-out mental health and substance abuse programs. Access to mental health and substance abuse providers is through a primary care gatekeeper or other similar intensive utilization controls. Provider reimbursements are highly negotiated. HMO POS plans are also included.

A summary of the current and four parity options priced within the four delivery systems is:

1. **Current** - typical mental health and substance abuse benefit design as in current market.
2. **MHPA** - limited parity for mental health and substance abuse for annual/lifetime dollar limits. Consistent with the federal Mental Health Parity Act of 1996 (MHPA) except is applicable to groups with 20 or more lives and is mandated.
3. **Catastrophic Parity** - requires parity for any lifetime/annual/episode limits, day and visit limits, and maximum out-of-pocket provisions. Does not require parity for deductibles, copayments, or coinsurance (except after any maximum out-of-pocket limit). *stop/loss*
4. **Comprehensive Parity** - financial parity with mental health and substance abuse benefits reimbursed under health insurance plans on the same basis as medical/surgical benefits.

Table 1
Mental Health Only

<u>Type of Delivery System</u>	<u>#</u>	<u>Distribution</u>	<u>Percentage Increase in Base Medical Plan for Change to Type of Parity</u>		
			<u>MHPA</u>	<u>Cat</u>	<u>Comprehensive</u>
Fee-for-Service	1	20%	0.1%	2.6%	3.7%
Managed Indemnity	2	55%	0.1	2.0	3.1
PPO & POS	3	20%	0.1	1.6	3.4
HMO & Gatekeeper	4	5%	0.1	1.8	2.3
Composite Market Analysis			0.1%	2.0%	3.2%
Composite PMPM			\$0.15	\$3.10	\$4.87
Net Market Impact			0.04%	0.8%	1.3%
Net PMPM Impact			\$0.06	\$1.24	\$1.95

Similar values were run for mental health and substance abuse parity. Certain assumptions were made as to the impact on parity relative to the existing SA mandate. We assumed under the MHPA that a 20 day and 20 visit limit would replace the current dollar limit. We further assumed that a plan's coinsurance coverage would be decreased to 50%, generally. In spite of these tradeoff limitations, we estimate the cost of the SA coverage to increase slightly.

Under the catastrophic option, the equalized deductible and coinsurance is replaced with unlimited days and visits and a maximum out-of-pocket cost. This tradeoff is substantial and results in increased costs since many of the inpatient stays will exceed the maximum out-of-pocket costs with the excess covered at 100%. However, the deductible and coinsurance value of the existing SA legislation is particularly important to those using outpatient and very short term inpatient (detox) care.

Table 2
Mental Health and Substance Abuse

<u>Type of Delivery System</u>	#	<u>Distribution</u>	<u>Percentage Increase in Base Medical Plan for Change to Type of Parity</u>		
			<u>Partial^{MM}</u>	<u>Cat</u>	<u>Comprehensive</u>
Fee-for-Service	1	20%	0.3%	4.1%	5.4%
Managed Indemnity	2	55%	0.2	3.0	4.1
PPO & POS	3	20%	0.2	2.1	4.1
HMO & Gatekeeper	4	5%	0.3	2.2	2.7
Composite Market Analysis			0.2%	3.0%	4.3%
Composite PMPM			\$0.36	\$4.51	\$6.55
Net Market Impact			0.08%	1.2%	1.7%
Net PMPM Impact			\$0.14	\$1.80	\$2.62

- no effects

Employer offsets

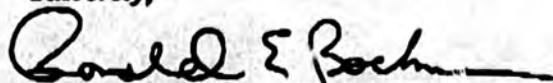
The PwC modeling assumes a reasonable, but conservatively low managed care penetration for Alaska. The assumptions were established conservatively to account for the impact of fewer small groups currently using managed care. PwC did not find data available to determine the split of managed care for behavioral health plans in Alaska solely for insured plans.

The "Net Market Impact" reflects how employers respond to any potential increase in benefit costs in a variety of ways including, competitively marketing the plan to obtain lower premiums, intensely negotiating lower provider costs, cutting plan administrative costs, increasing plan costsharing by members, increasing premium contributions by members, reducing other benefits, and in the extreme, dropping plan coverages and reducing wages (or wage increases).

Based upon a preliminary analysis using generally accepted actuarial practices, the total gross impact of the Alaska Catastrophic Parity Option for mental health and substance abuse parity bill is equal to 3.0% of current employer claims or about \$4.51 per member per month. However, the employer will respond in various ways to partially offset any potential cost increases. Therefore, the expected net employer contributions for health costs will rise about 1.2% or \$1.80 per member per month. Assuming an average of 3 members per family this translates into an equivalent wage increase of \$.031 per hour.

I am prepared to develop a full actuarial study with all the pricing details and coverage descriptions once the final legislation is developed and I can review the proposed language.

Sincerely,



Ronald E. Bachman FSA, MAAA
Principal, Health care Solutions
PricewaterhouseCoopers L.L.P.



MANAGEMENT ASSOCIATES

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

February 12, 1999

Senator John Torgerson
State Capitol Room 514
Juneau, AK 99801-1183

To Julie
MHPTF

Re: Employer Size/Employee Data

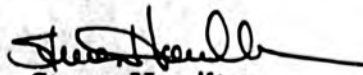
Dear Senator Torgerson:

Here is the data on the numbers of employees in each employer size group that you requested. The Department of Labor was able to provide the information for the months of April, May, and June 1998.

Size of Employer	Number of Employees		
	April 98	May 98	June 98
1 - 4 employees	13,716	14,546	15,139
5 - 9 employees	18,129	19,513	20,806
10 - 19 employees	21,971	23,989	26,332
20 - 49 employees	31,544	34,235	36,637
50 - 99 employees	24,538	26,020	27,540
100 - 249 employees	34,631	35,978	35,784
250 - 499 employees	30,468	31,081	31,336
500 - 999 employees	29,712	30,634	30,579
1000 and over	62,346	61,169	58,604

We do not know how many of the large company employees are covered under ERISA policies. Please let me know if there is other information that you need.

Sincerely,


Steven Hamilton

Cc: Alaska Mental Health Board
Representative Gary Davis



MANAGEMENT ASSOCIATES

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

March 25, 1999

Re: Mental Health Parity; Business Owner Survey

Dear Task Force Members:

As we finished the work on the Mental Health Parity Report, I was directed to work with the Alaska State Chamber of Commerce to try and gather some input from Alaska business owners. With the Chamber's cooperation, we put up a survey on-line and publicized it in the Chamber's newsletter. Over the course of about a month and a half, we had nine surveys completed on-line and another three telephone responses.

I am attaching a verbatim copy of the comments received. Because of the small numbers, we are not able to draw any quantitative conclusions from the other information they sent (type of business, location, number of employees, etc.). I have also provided a copy of these comments to Pam LaBolle, the Executive Director of the Alaska State Chamber of Commerce.

As always, if you have questions or concerns you can reach me by telephone at (907) 789-0921 ((888) 803-3515 toll-free outside Juneau), by fax at (907) 789-1667 and by e-mail at Steve@csmgt.com.

Sincerely,

A handwritten signature in black ink, appearing to read 'Steven Hamilton'. Below the signature, the name 'Steven Hamilton' is printed in a standard font.

Steven Hamilton

Attachment: Comments of Business Respondents

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.

SCOMM

112:6

OVER ALL

COST OF PARITY

SUMMARY OF ACTUARIAL COST ANALYSES OF FEDERAL AND STATE MENTAL HEALTH PARITY

I. FEDERAL MENTAL HEALTH PARITY LEGISLATION

Actuarial studies estimate the cost of mental health parity at between 3 and 4% increase in individual premiums.

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Actual state experiences have resulted in an increase in individual premiums of between 1 and 2.2%, consistent with federal actuarial studies.

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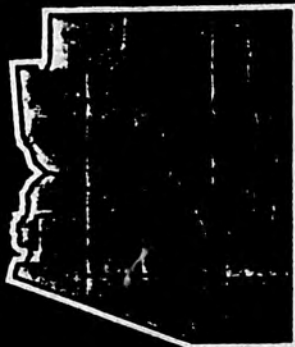
PENNSYLVANIA Comprehensive mental health legislation currently proposed in Pennsylvania would *increase costs by only 3.1% or \$4.26 pmpm.*

SOUTH DAKOTA Actuarial analysis of full parity legislation originally proposed in South Dakota projected an *increase in costs of 4.1% or \$4.03 pmpm.*

UTAH Utah's full parity legislation was projected to *increase costs by 2.4% or \$2.69 pmpm.*

VERMONT Actuarial analysis projected that a comprehensive parity and substance abuse bill would *increase costs by 3.4% or \$3.45 pmpm.*

ARIZONA



***An Actuarial Analysis
of
Comprehensive Mental Health Benefits
and
Other Options for Improved Coverages
in the State of Arizona***

February 1998

***Ronald E. Bachman, FSA, MAAA
Principal
(404) 870-1388***

RECEIVED
AUG 10 1998
ALASKA MENTAL
HEALTH BOARD



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Coopers
& Lybrand

Coopers & Lybrand LLP.
a professional services firm
Human Resources Advisory

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te requirement is the only real option that will allow implementation of comprehensive parity to all
ds at a minimum cost. A state-wide requirement creates a level playing field for all insurers and
; for an appropriate spreading of risks across a large population. Optional requirements are
ative as selection of optional coverages is usually minimal and anti-selection drives up the cost of
the option.

The proposed bill for Arizona requires mental health and substance abuse parity for insured policies regulated under the Arizona Insurance Commissioner's authority. The bill covers all insured individual and group policies. State law cannot affect most large employers because their plans are self-insured and governed under federal ERISA laws rather than State law. Many ERISA plans have already moved in the direction of expanded mental health benefits, usually in conjunction with a managed care carve-out.

While the C&L cost analysis is appropriate for all categories of required coverage, the variation from expected costs is greatest for small groups and individual plans of coverage. However, Arizona requires modified community rating in the small group market through the use of rating bands. Therefore, a state-wide requirement for parity creates a level playing field for all insurers and should provide adequate risksharing over a large population to minimize any cost increase applicable to the experience of any one group.

Coopers & Lybrand developed a matrix of plan options to estimate the range and impact of legislation on the employer market. Four delivery systems of varying intensity of managed mental health care are used in the modeling. Mental Health costs and associated cost increases are stated as a percentage of a typical underlying plan of medical/surgical benefits. In this way, a percentage impact on employer health care plans is determined.

The four delivery systems assumed are:

Delivery System 1. Indemnity plans with utilization review found on typical medical plans. There is no special mental health or substance abuse focus and the review (preadmission certification and continued stay review) generally only applies to inpatient care.

Delivery System 2. Indemnity plans with specialized mental health and substance abuse utilization review. The utilization review applies to inpatient care, but may also apply to intensive or lengthy outpatient treatments.

Delivery System 3. Preferred Provider (PPO) and Point of Service (POS) plans that have specialized mental health and substance abuse networks. These are not carve-out programs, but act with similar attention to negotiated rates, utilization controls, and limited provider access. There is no gatekeeper mechanism. Plan design and costsharing are primarily used to channel members to network providers.

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Delivery System 4. HMO/Gatekeeper plans and carve-out mental health programs. Access to mental health and substance abuse providers is through a primary care gatekeeper or other similar intensive utilization controls. Provider reimbursements are highly negotiated. HMO POS plans are also included.

Plan design modeling assumptions are established with commonly found benefit limits within each delivery system.

A summary of the current and four parity options priced within the four delivery systems is:

1. **Current** - typical mental health and substance abuse benefit design as in current market.
2. **Partial Parity** - as used in this paper partial parity means mental health and substance abuse equality with medical care for inpatient days and outpatient visit limits only.
3. **SMI Parity** - mental health benefits equal to medical benefits when diagnosis identifies a serious mental disorder. SMI Parity includes costsharing provisions that are separate but equal to medical plan costsharing. *Major medical policies - unfair to those w/ less severe illnesses*
4. **Full Parity** - mental health and substance abuse benefits equal medical care benefits with separate but equal costsharing provisions. For example, a plan can have a medical deductible of \$250 and a separate but equal \$250 deductible for mental health and substance abuse expenses.
5. **Comprehensive Parity** - same as full parity except that the insured plan has composite costsharing provisions. That is, a single deductible and maximum out-of-pocket limit applicable to all eligible expenses.

The following table summarizes the actuarial modeling results for mental health and substance abuse combined. The composite impact on the health insurance market ranges from 0.9% for Partial Parity to 3.2% for Comprehensive Parity. The cost increase for Fee-for-Service plans range from 1.3% to 4.3%. The lowest cost impact occurs under HMO & Gatekeeper programs where the cost impact of the parity options range from 0.7% to 2.2%.

The percentage impact in Arizona is consistent with national estimates for mental health and substance abuse illness costs. We assumed a \$25,000 annual maximum for a typical current mental health benefit. This provides a conservative (high) cost increase, since the cost impact analysis is determined from the current market costs. The Mental Health Parity Act of 1996 will remove that limit for plans above 50 employee lives. Therefore, this analysis includes the cost of implementing the federal act for employers above 50 lives. National data indicates a typical current plan maximum of \$40,000 lifetime limit. Since the impact of this legislation is on fully insured groups, we chose the lower limit to reflect the more limited mental health plan designs of this market segment.

Table 1
Mental Health & Substance Abuse Combined

<u>Type of Delivery System</u>	<u>#</u>	<u>Distribution</u>	<u>Percentage Increase in Base Medical Plan for Change to Type of Parity</u>			
			<u>Partial</u>	<u>SMI</u>	<u>Full</u>	<u>Comprehensive</u>
Fee-for-Service	1	20%	1.3%	2.8%	3.5%	4.3%
Managed Indemnity	2	25%	1.1	2.3	2.8	3.6
PPO & POS	3	25%	0.7	2.1	2.6	3.0
HMO & Gatekeeper	4	30%	0.7	1.2	1.5	2.2
Composite Market Analysis			0.9%	2.0%	2.5%	3.2%
Composite PMPM			\$1.12	\$2.46	\$3.08	\$3.90
Net Market Impact			0.4%	0.8%	1.0%	1.3%
Net PMPM Impact			\$0.45	\$0.98	\$1.23	\$1.56

Similar values were run for mental health parity only. All assumptions were held constant as to plan design for medical benefits, managed care impacts, and percentage distribution of the various delivery systems. Values for mental health only are shown below.

The Arizona proposal strongly endorses and requires parity for mental health and substance abuse. The attached analysis calculates parity for the proposed bill (Table 1) and mental health only (Table 2). The purpose of this analysis is to frame the cost discussions with facts related to the cost of various options that might come under debate.

Table 2
Mental Health Only

<u>Type of Delivery System</u>	<u>#</u>	<u>Distribution</u>	<u>Percentage Increase in Base Medical Plan for Change to Type of Parity</u>			
			<u>Partial</u>	<u>SMI</u>	<u>Full</u>	<u>Comprehensive</u>
Fee-for-Service	1	20%	0.9%	2.0%	2.5%	3.1%
Managed Indemnity	2	25%	0.7	1.7	2.1	2.7
PPO & POS	3	25%	0.6	1.7	2.2	2.5
HMO & Gatekeeper	4	30%	0.5	0.8	1.0	1.1
Composite Market Analysis			0.6%	1.5%	1.9%	2.3%
Composite PMPM			\$0.84	\$1.95	\$2.44	\$2.95
Net Market Impact			0.24%	0.6%	0.8%	0.9%
Net PMPM Impact			\$0.34	\$0.78	\$0.98	\$1.18

The C&L modeling assumes a reasonable, but conservatively low managed care penetration for Arizona. The assumptions were established conservatively to account for the impact of fewer small groups currently using managed care. C&L did not find data available to determine the split of managed care for behavioral health plans in Arizona solely for insured plans.

Employers respond to any potential increase in benefit costs in variety of ways including, competitively marketing the plan to obtain lower premiums, intensely negotiating lower provider costs, cutting plan administrative costs, increasing plan costsharing by members, increasing premium contributions by members, reducing other benefits, and in the extreme, dropping plan coverages and reducing wages (or wage increases).

The Congressional Budget Office (CBO) typically estimates that these employer responses to required coverages will result in cost offsets of about 60% of the gross cost estimates. Using the standard CBO economic modeling approach, employer contributions for health costs would rise about 40% of the estimate or only 1.3 percent.

Based upon an analysis using generally accepted actuarial practices, the total impact of the proposed Arizona mental health and substance abuse parity bill is equal to 3.2% of current employer claims or about \$3.90 per member per month. However, the employer will respond in various ways to partially offset any potential cost increases. Therefore, the expected employer contributions for health costs will rise about 1.3% or \$1.56 per member per month. Assuming an average of 3 members per family this translates into an equivalent wage increase of \$.027 per hour.

**An Actuarial Analysis
of
Comprehensive
Mental Health and Substance Abuse Benefits
and
Other Options for Improved Coverages in
the State of Arizona**

I. Introduction

The Arizona Psychological Association, the Mental Health Association of Arizona, the Arizona Alliance for the Mentally Ill, and the American Psychological Association engaged Coopers & Lybrand (C&L) to provide actuarial analysis and consulting advice on the mental health benefit proposal being developed for the 1998 Arizona legislative session. This report presents a detailed discussion and cost analysis of the primary proposal -- **Comprehensive Parity**, defined as coverage of insured mental health and substance abuse on the same basis as medical care coverage (parity). This report presents cost estimates for "mental health only" and "mental health and substance abuse combined." This report also includes analyses of other parity options to improve mental health benefits. The purpose of including other options is to more accurately frame the broader discussion of mental health and substance abuse benefits and to provide a complete documentation of costs as legislative questioning and debate develops in Arizona.

This report was commissioned by the Arizona Psychological Association, the Mental Health Association of Arizona, the Arizona Alliance for the Mentally Ill, and the American Psychological Association. No mental health organization (including those mentioned) or any other outside entity inappropriately influenced the choice of assumptions. The assumptions made in this report are made from independent analysis and research, proprietary C&L data bases, and, where needed, professional experience and judgment. The actuarial modeling is sufficiently complex to appropriately simulate the multitude of mental health and substance abuse disorder benefits offered by employers and represents a fair and accurate analysis of mental health and substance abuse costs. The modeling reflects Arizona specific data where available and appropriate.

This report includes a discussion regarding the existing legislative language and the need for clarifications to assure proper implementation of the above understandings. This report reflects the language of H.B. 2580, current legislative understandings, and proposed amendments to H.B. 2580 that have been described to C&L. At the time of developing this report such amendments have not been finalized.

The pricing and cost methods follow generally accepted actuarial practices. The modeling results are then compared to similar analyses performed by the Congressional Budget Office and the Congressional Research Services involving similar mental health and substance abuse parity proposals made at the national level. Coopers & Lybrand L.L.P. takes no responsibility for inappropriate use of this report or the actual impact of any legislation passed by the State of Arizona.

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II. Comprehensive Parity & Legislative Issues

The proposed 1998 Arizona legislation (the Bill) is referred to as H.B. 2580 and would amend the State of Arizona Code relating to health insurance. Under the proposed Bill all policies "that provide health benefits and services for physical illnesses shall provide benefits for the diagnosis and treatment of mental disorders and drug and alcohol abuse disorders under the same terms and conditions that apply to covered benefits under the contract for the diagnosis and treatment of physical illnesses." The bill applies to individual policies, group indemnity policies, and HMOs.

There is one year transition period from effective date of the bill, July 1, 1999 to June 30, 2000, where inpatient and partial hospitalization benefits are set at a minimum of 60 days. Full parity is applicable from July 1, 2000 forward.

Legislative language is subject to regulatory clarification and judicial interpretations. There is often uncertainty during the period of implementation and during the development of case law. In some instances, original intent is changed through that process. The Arizona Bill (as with any bill) could encounter problems due to uncertain language, undefined terms, and potential unintended consequences.

Based upon our experience with other state and federal mental health and substance abuse legislation, it may be helpful for the Arizona legislation to clarify areas that are not affected by the bill and how the bill should not be construed. Several areas of clarification are needed by the framers of the legislation before the cost impact as described in this legislation can be considered appropriate:

1. H.B. 2580 states, "*Benefits ...may be delivered under a managed care system.*" Clarifying language may be helpful to state that the bill should not be construed to prevent preadmission screening, continued stay reviews, case management, and other managed care techniques to assure that only medically necessary services are reimbursed under the contract.

2. Similarly, clarification may be helpful assuring continuation of current market plans that provide for mental health carve-out plans, specialty mental health and substance abuse provider networks, and the use of specialty criteria for medical necessity. For example, we assume under managed care arrangements (PPOs and HMOs), mental health and substance abuse providers can be capitated even if medical providers are not. C&L assumed that separate managed care mental health carve-out programs with differing reimbursements and risksharing arrangements are possible under the Arizona proposal. However, clarification may be needed to assure proper interpretation and implementation.

3. Clarifying legislation or regulation may assist in determining how a plan should handle multiple medical/surgical limits. Exceptions from wellness benefits (generally paid at 100%) are sometimes specifically excluded from parity comparisons.

4. Substance abuse parity should be reviewed to assure it does not prevent benefit differences that reflect practical considerations, such as day restrictions on detox programs. C&L assumes that medical necessity and medical management will be extended to control costs for substance abuse parity.

Changes are suggested only to improve clarity and prevent misinterpretations. These clarifications can be handled through legislation, regulation, or legislative history that defines intent.

III. Impact of State Required Coverage

The proposed bill for Arizona requires mental health and substance abuse parity for insured policies regulated by the Arizona Insurance Commissioner's authority. The bill requires parity for individual and group policies. Individual policies represent about 2.9% of the non-elderly population in Arizona. The national average is 4.5% for individual policies. The affected group policies are fully insured plans that are generally covering fewer than 200 employees.

State law cannot affect most large employers because their plans are self-insured and governed under federal ERISA laws rather than State law. Many employer benefit plans, that cover 100 or more employees, have already chosen to be exempt from State insurance laws. As more employers choose self-insurance and governance under ERISA, the effect is that the pool of employer plans impacted by State requirements (i.e. the proposed mental health and substance abuse disorder parity bill) grows smaller. National analysis indicates a range of 40-60% of non-elderly covered lives are under ERISA plans.

A state-wide requirement creates a level playing field for all insurers and allows for an appropriate spreading of risks across a large population. A State requirement is the only real option that will accomplish the objective of improved mental health and substance abuse coverage with the minimum cost increase. Optional requirements are ineffective as selection of optional coverages is minimal and anti-selection drives up the cost.

While the C&L cost analysis is appropriate for all categories of required coverage, the variation from expected costs is greatest for individual policies and small groups. However, Arizona requires banded rating (modified community rating) in the small group market. Therefore, state-wide requirement for parity creates a level playing field for all insurers and will provide adequate risksharing over a large population to minimize any cost increase applicable to the experience of any one group or individual policyholder.

Part of any legislative discussion of parity is the concern for individual coverage and the smallest of businesses in the state. Based upon EBRI, November 1996, Issue Brief, Arizona has 24% uninsured, below the average of 17.7% uninsured nationally. Arizona has 60.2% of its population covered by employment based health care (lower than national average of 65.3%).

Based on national averages, approximately forty percent (40%) of Arizona employers with 1 to 4 employees have health coverage. Sixty-one percent (61%) of Arizona employers with 5-9 workers have health coverage. Seventy-six percent (76%) have health coverage among businesses with 10-24 employees. While the cost increase may not be great for mental health and substance abuse parity, many small employers find it difficult to provide a comprehensive package of benefits when they are in a start-up phase. [It may be appropriate to consider an individual or small group (under 5 workers) exemption or some modification from the bill requirements.]

The federal approach of requiring parity only when an employer provides mental health and substance abuse coverage does not seem appropriate for state legislation (with the possible exception of partial parity). The federal act creates a "minimum standard" or floor of protection with which all insurance plans must comply.

Under the federal approach, the employer (especially a small employer) can then decide to drop coverage or not cover mental health and substance abuse at all. This would defeat the value of pooling across all group plans. Optional coverage would encourage anti-selection that could develop into unaffordable costs. Federal legislation excluded employers with 50 or fewer lives. However, the federal requirement is applicable to all remaining groups, including ERISA groups, so all groups above 50 employees are affected.

State mental health and substance abuse parity requirements may encourage some employers to become self-insured, move to ERISA plans, and become exempt from state oversight. But as in Minnesota, (see Appendix A) the legislative impact is expected to be minimal. Changing to a self-insured plan includes accepting additional risks that many employers are unwilling or unable to accept. The number of members with group health coverage is increasing. Based upon the Employee Benefit Research Institute estimates, after a long period of decline, the percentage of employees with employment-based health insurance has increased each year since 1993.

IV. Parity Options

To assist the process of legislation in Arizona, Coopers & Lybrand has produced five calculations. Analysis includes a plan representative of current Arizona mental health and substance abuse plans and four mental health and substance abuse parity options as defined below.

1. Partial Parity - C&L calculations for partial parity reflect equality for inpatient day and visit limits. An employer can still apply any deductible, coinsurance, or other plan design limitations. The cost analysis assumes the required Mental Health Parity Act of 1996 is effective (actual effective date is 1/1/98) and applicable for all size groups. That is, the mental health and substance abuse benefits are after compliance with existing federal parity of lifetime and annual limits.

2. Parity by SMI Diagnosis - The C&L model assumes costs of serious mental illnesses (SMI) diagnoses are covered at full parity with medical care. The model assumes insurance carriers, HMOs, and managed behavioral health companies can appropriately manage, verify, and monitor mental health and substance abuse diagnoses. Pricing reflects potential for "diagnosis creep" and the natural uncertainty of changing clinical conditions.

Arizona is not proposing SMI parity coverage. SMI is not common, but it is frequently a part of any mental health and substance abuse parity debate. Costs 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 health (see Appendix B). This is because the best data available on SMI analysis is developed under that definition.

3. Full Parity - Full parity provides equality of mental health and substance abuse (all diagnoses) and medical care coverages within an insured plan with separate but equal costsharing for deductible, maximum out of pocket, and annual or lifetime maximums. For example, a plan can have a medical deductible of \$250 and a separate but equal \$250 deductible for medical and chemical dependency expenses.

4. Comprehensive Parity - Comprehensive parity is used in this report to represent mental health and substance abuse covered under insured policies on the same basis as medical care. This is the primary proposal in Arizona for mental health and substance abuse parity. All eligible health care expenditures are used to accumulate towards a common plan deductible, maximum out of pocket limit, and annual or lifetime limits. Comprehensive parity includes equal inpatient and outpatient coverages that remove any arbitrary day or visit limits on mental health and substance abuse disorders when no such limits are used for medical care. (see Appendix A for actual experience in Minnesota and North Carolina)

V. Delivery Systems Modeling Assumptions

The four delivery systems assumed are:

Delivery System 1. Indemnity plans with utilization review found on typical medical plans. There is no special mental health and substance abuse focus and the review (preadmission certification and continued stay review) generally only applies to inpatient care.

Delivery System 2. Indemnity plans with specialized behavioral health utilization review. The utilization review applies to inpatient care, but may also apply to intensive or lengthy outpatient treatments.

Delivery System 3. Preferred Provider (PPO) and Point of Service (POS) plans that have specialized mental health and substance abuse networks. These are not carve-out programs, but act with similar attention to negotiated rates, utilization controls, and limited provider access. There is no gatekeeper mechanism. Plan design and costsharing are primarily used to channel members to network providers.

Delivery System 4. HMO/Gatekeeper plans and carve-out managed behavioral health care programs. Access to mental health and substance abuse providers is through a primary care gatekeeper or other similar intensive utilization controls. Provider reimbursements highly negotiated. HMO POS plans are also included.

Plan design modeling assumptions are established with commonly found benefit limits within each delivery system. A typical current design and four mental health and substance abuse parity designs are outlined (see next section) for each delivery system. Each option assumes compliance with the recently passed federal legislation, the Mental Health Parity Act of 1996 (MHPA) which provides for equality of annual and lifetime limits. Groups of 50 or fewer lives are not impacted by this federal legislation.

Cost estimates in this report are increased by the full impact of MHPA even though the law is already applicable to the larger cases. Estimated costs for insured plans under each of the delivery systems is minimal. C&L estimated the additional costs under each delivery system in a report "An Actuarial Analysis of S.2031, the 'Mental Health Parity Act of 1996' " as .25%, .13%, .05%, and .015%, respectively (an average of 0.12%). We assumed an average current plan annual maximum of \$25,000 for mental health and substance abuse costs.

VI. Plan Design Modeling Assumptions

Mental Health And Substance Abuse coverages under employer health plans have evolved with numerous design variables for inpatient care, outpatient care, and other alternative services. Excluded from recent federal legislation, small employer group mental health and substance abuse benefits can be very restrictive. However, nearly all employer plans provide some level of mental health and substance abuse coverage. Approximately 1-2% of employers do not provide for inpatient mental health and substance abuse coverage, and 2-3% of employers do not provide outpatient mental health benefits.

Plans vary significantly in providing coverage for alternative services, such as partial hospitalization, day care, intensive outpatient care, etc. Sometimes these benefits are only provided under a custom-designed program of care for a specific patient. The variables of day limits, visit limits, annual maximums, lifetime maximum, managed care programs, alternate coverages, etc., add to the complexity of modeling the impact of the Arizona bill.

There is little information on the percentage of plans covered under different benefit combinations. However, it is possible to estimate the cost impact of mental health and substance abuse parity legislation through reasonable assumptions and proper modeling. Coopers & Lybrand has developed a matrix of plan options to estimate the potential range and impact of legislation on the employer market. Four delivery systems of varying intensity of managed mental health and substance abuse disorder care are used in the modeling. Mental Health And Substance Abuse costs and associated cost increases are stated as a percentage of a typical underlying plan of medical/surgical benefits. In this way, a percentage impact on employer health care plans is determined.

All cost information is based on health care cost projections to January 1, 1998. For modeling purposes it is assumed that all medical plans provide \$1,000,000 lifetime medical and mental health and substance abuse limits. Current plan design assumptions use a \$25,000 annual limit for mental health and substance abuse. This is the current design assumption for all plans even though the MHPA requires the same limits as for medical/surgical for cases above 50 lives.

To provide a conservative (high) estimate of the impact of state mental health and substance abuse parity laws, C&L assumed an average \$25,000 limit for all insured plans as the present benefit design. Under this assumption, the full impact of the federal law is included for group plans. According to the 1991 Bureau of Labor Statistics Employee Benefits Survey, approximately 15% of private plans already include inpatient mental health "as any other illness." Those plans in Arizona would generally be unaffected by the proposed bill.

Representative plan designs by "Delivery System" and type of parity:

Plan Design: Delivery System 1

		<u>Current</u>	<u>Partial</u>	<u>SMI Parity</u>	<u>Full</u>	<u>Comprehensive</u>
Inpatient	Days/Yr	30	Unlim	30/Unlim	Unlim	Unlim
	Coinsurance	80%	80%	80%	80/100%	80/100%
Outpatient:	Visits/Yr	20	Unlim	20/Unlim	Unlim	Unlim
	Coinsurance	50%	50%	50/80%	80/100%	80/100%
Max Out of Pocket		None	None	None/\$1250	\$1,250	Comp \$1250
Lifetime Maximums:		\$25K	\$1 M	\$1M	\$1 M	\$1 M
Provider Network:		None	None	None	None	None
Utilization Review:		Basic	Basic	Basic	Basic	Basic

Plan Design: Delivery System 2

		<u>Current</u>	<u>Partial</u>	<u>SMI Parity</u>	<u>Full</u>	<u>Comprehensive</u>
Inpatient	Days/Yr	30	Unlim	30/Unlim	Unlim	Unlim
	Coinsurance	80%	80%	80%	80/100%	80/100%
Outpatient:	Visits/Yr	20	Unlim	20/Unlim	Unlim	Unlim
	Coinsurance	50%	50%	50/80%	80/100%	80/100%
Max Out of Pocket		None	None	None/\$1250	\$1,250	Comp \$1250
Lifetime Maximums:		\$25K	\$1 M	\$1M	\$1 M	\$1 M
Provider Network:		None	None	None	None	None
Utilization Review:		Special	Special	Special	Special	Special

Plan Design: Delivery System 3 (Network)

<u>In Network Benefits</u>		<u>Current</u>	<u>Partial</u>	<u>SMI Parity</u>	<u>Full</u>	<u>Comprehensive</u>
Inpatient	Days/Yr	30	Unlim	30/Unlim	Unlim	Unlim
	Coinsurance	80%	80%	80/90/100%	90/100%	90/100%
Outpatient:	Visits/Yr	20	Unlim	20/Unlim	Unlim	Unlim
	Coinsurance	50%	50%	80/90/100%	90/100%	90/100%
Max Out of Pocket		None	None	None/\$1250	\$1,250	Comp \$1250
Lifetime Maximums:		\$25K	\$1 M	\$1M	\$1 M	\$1 M
Provider Network:(80%)		Yes	Yes	Yes	Yes	Yes
Utilization Review:		Special	Special	Special	Special	Special

Plan Design: Delivery System 3 (Out of Network)

<u>Out of Network Benefits</u>		<u>Current</u>	<u>Partial</u>	<u>SMI Parity</u>	<u>Full</u>	<u>Comprehensive</u>
Inpatient	Days/Yr	30	Unlim	30/Unlim	Unlim	Unlim
	Coinsurance	50%	50%	50/70%	70%	70%
Outpatient:	Visits/Yr	20	Unlim	20/Unlim	Unlim	Unlim
	Coinsurance	50%	50%	50/70%	70%	70%
Max Out of Pocket		None	None	None	None	None
Lifetime Maximums:		\$25K	\$1 M	\$1M	\$1 M	\$1 M
Provider Network (20%)		No	No	No	No	No
Utilization Review:		Special	Special	Special	Special	Special

Plan Design: Delivery System 4 (Network)

<u>In Network Benefits</u>		<u>Current</u>	<u>Partial</u>	<u>SMI Parity</u>	<u>Full</u>	<u>Comprehensive</u>
Inpatient	Days/Yr	30	Unlim	30/Unlim	Unlim	Unlim
	Copayment	\$100/day	\$100/day	\$100/100%	100%	100%
Outpatient:	Visits/Yr	20	Unlim	20/Unlim	Unlim	Unlim
	Copayment	\$10/visit	\$10/visit	\$10/visit	\$10/visit	\$10/visit
Max Out of Pocket		None	None	None/\$1250	\$1,250	Comp \$1250
Lifetime Maximums:		\$25K	\$1 M	\$1M	\$1 M	\$1 M
Provider Network:(90%)		Yes	Yes	Yes	Yes	Yes
Utilization Review:		Special	Special	Special	Special	Special

Plan Design: Delivery System 4 (Out of Network)

<u>Out of Network Benefits</u>		<u>Current</u>	<u>Partial</u>	<u>SMI Parity</u>	<u>Full</u>	<u>Comprehensive</u>
Inpatient	Days/Yr	30	Unlim	30/Unlim	Unlim	Unlim
	Coinsurance	50%	50%	50/70%	70%	70%
Outpatient:	Visits/Yr	20	Unlim	20/Unlim	Unlim	Unlim
	Coinsurance	50%	50%	50/70%	70%	70%
Max Out of Pocket		None	None	None	None	None
Lifetime Maximums:		\$25K	\$1 M	\$1M	\$1 M	\$1 M
Provider Network (10%)		No	No	No	No	No
Utilization Review:		Special	Special	Special	Special	Special

VII. Managed Care Modeling Assumptions

Data provided by the Hoechst Marion Roussel Managed Care Digest and the InterStudy Competitive Edge: HMO Industry Report 7/1/96 shows commercial HMO enrollment in Arizona below national averages at 40% of the state population for a total of 1,771,600 lives. National average HMO penetration in 1996 was 29.2% of the U.S. population. Arizona HMO managed care enrollment increased 25.9% in 1996, placing Arizona well above the national HMO growth rate of 14.4%.

As in other states, HMO penetration varies by location. Larger more populated cities and regions tend to have higher HMO penetration and other forms of managed care. In 1996, using Metropolitan Statistical Areas the percentage of Americans with commercial health insurance enrolled in plans by type are:

	<u>Fee-for-Service</u>	<u>POS/PPO</u>	<u>HMO</u>
Phoenix-Mesa	7.9%	37.2%	54.9%
Tucson	7.0	16.4	76.6
Las Vegas(NV/AZ)	12.2	46.7	41.1

The InterStudy Competitive Edge:Regional Market Analysis as of 1/1/97 shows the following HMO enrollments in key Arizona MSAs:

	<u>Population</u>	<u>HMO Enrollment</u>	<u>Penetration</u>
Flagstaff	119,000	15,291	12.8%
Phoenix-Mesa	2,606,000	864,799	33.2%
Tucson	768,800	323,739	42.1%
Yuma	131,100	9,752	7.4%

HMOs operating in Arizona include: HealthPartners Health Plans, HMO Arizona, Intergroup of Arizona, Premier Healthcare of Arizona, PacifiCare, CIGNA, and United HealthCare.

Arizona enrollment in PPO/POSs is estimated at 30% of the population. It is believed that managed behavioral health care has greater penetration than medical coverage. While statistics on managed behavioral carve out programs are not readily available, United/Aetna (HAI), U.S Healthcare/CIGNA (MCC), Value Health, Merit Behavioral Health, and others have been marketing carve-out programs in Arizona to large and medium sized plans in advance of employers' movement to managed medical plans.

To account for the lower managed care penetration of smaller insured groups, C&L estimates the managed behavioral care contracts are 30% HMO and/or carve out plans and 25% PPO/POS. Managed indemnity is estimated at 25% with the balance of 20% with Fee-for-service and minimal utilization review. We have not factored in the continued growth in managed care (expanding HMO, PPO, managed indemnity, and carve out behavioral health programs). These assumptions were verified as reasonable and conservative with the HMO and PPO industry reporting and associations.

VIII. Cost Estimates from Modeling

Delivery System 1

Typical Medical Plan Claim Cost: \$138.60

Percentage of Plans with Delivery System 1: 20%

Type of MH&SA Coverage	<u>MH&SA Claim Costs Per Member Per Month</u>				
	<u>Current</u>	<u>Partial</u>	<u>SMI</u>	<u>Full</u>	<u>Comp.</u>
Inpatient:	\$4.44	\$5.90	\$ 7.17	\$ 7.85	\$ 8.34
Outpatient:	<u>\$.89</u>	<u>\$1.20</u>	<u>\$ 2.07</u>	<u>\$ 2.36</u>	<u>\$ 2.99</u>
Total MH PMPM Claims Costs	\$5.33	\$7.10	\$ 9.23	\$10.21	\$11.33
Additional PMPM:Claims Cost		\$1.77	\$3.90	\$4.88	\$6.00
MH&SA as a Percent of the Medical Plan:	3.8%	5.1%	6.7%	7.4%	8.2%
MH&SA Incr. as % of Medical Plan:	0.0%	1.3%	2.8%	3.5%	4.3%

Cost Increase for Proposed Arizona MH&SA Parity

as a Percentage of Base Medical Plan.....4.3%

Delivery System 2

Typical Medical Plan Claim Cost: \$138.60
 Percentage of Plans with Delivery System 2: 25%

Type of MH&SA Coverage	<u>MH&SA Claim Costs Per Member Per Month</u>				
	<u>Current</u>	<u>Partial</u>	<u>SMI</u>	<u>Full</u>	<u>Comp.</u>
Inpatient:	\$3.32	\$4.20	\$5.29	\$5.78	\$ 6.22
Outpatient:	<u>\$0.90</u>	<u>\$1.53</u>	<u>\$2.07</u>	<u>\$2.36</u>	<u>\$ 3.03</u>
Total MH&SA PMPM Claims Costs	\$4.22	\$5.73	\$7.36	\$8.14	\$ 9.25
Additional PMPM:Claims Cost		\$1.51	\$3.14	\$3.92	\$5.03
MH&SA as a Percent of the Medical Plan:	3.0%	4.1%	5.3%	5.8%	6.6%
MH&SA Incr. as % of Medical Plan:	0.0%	1.1%	2.3%	2.8%	3.6%

**Cost Increase for Proposed Arizona MH&SA Parity
 as a Percentage of Base Medical Plan.....3.6%**

Delivery System 3

Typical Medical Plan Claim Cost: \$119.70
 Percentage of Plans with Delivery System 3: 25%

Type of MH&SA Coverage	<u>MH&SA Claim Costs Per Member Per Month</u>				
	<u>Current</u>	<u>Partial</u>	<u>SMI</u>	<u>Full</u>	<u>Comp.</u>
<u>80% In-Network</u>					
Inpatient:	\$2.24	\$2.77	\$3.35	\$3.63	\$3.56
Outpatient:	<u>\$0.87</u>	<u>\$1.20</u>	<u>\$2.33</u>	<u>\$2.70</u>	<u>\$3.04</u>
Total MH&SA PMPM Claims Costs	\$3.11	\$3.97	\$5.69	\$6.33	\$6.60
<u>20% Out-of-Network</u>					
Inpatient:	\$1.81	\$2.21	\$3.25	\$3.61	\$4.68
Outpatient:	<u>\$0.90</u>	<u>\$1.23</u>	<u>\$1.72</u>	<u>\$1.92</u>	<u>\$2.24</u>
Total MH&SA PMPM Claims Costs	\$2.71	\$3.44	\$4.97	\$5.53	\$6.92
Composite PMPM Claims Costs	\$3.03	\$3.86	\$5.54	\$6.17	\$6.66
Additional PMPM:Claims Cost		\$0.83	\$2.51	\$3.14	\$3.63
MH&SA as a Percent of the Medical Plan:	2.5%	3.2%	4.6%	5.1%	5.5%
MH&SA Incr. as % of Medical Plan:	0.0%	0.7%	2.1%	2.6%	3.0%

**Cost Increase for Proposed Arizona MH&SA Parity
 as a Percentage of Base Medical Plan.....3.0%**

Delivery System 4

Typical Medical Plan Claim Cost: \$100.80

Percentage of Plans with Delivery System 4: 30%

Type of MH&SA Coverage	<u>MH&SA Claim Costs Per Member Per Month</u>				
	<u>Current</u>	<u>Partial</u>	<u>SMI</u>	<u>Full</u>	<u>Comp.</u>
<u>90% In-Network</u>					
Inpatient:	\$1.19	\$1.40	\$1.88	\$2.05	\$2.34
Outpatient:	<u>\$1.30</u>	<u>\$1.79</u>	<u>\$1.69</u>	<u>\$1.79</u>	<u>\$2.12</u>
Total MH&SA PMPM Claims Costs	\$2.49	\$3.19	\$3.57	\$3.84	\$4.46
<u>10% Out-of-Network</u>					
Inpatient:	\$1.81	\$2.21	\$3.25	\$3.61	\$4.68
Outpatient:	<u>\$0.90</u>	<u>\$1.23</u>	<u>\$1.72</u>	<u>\$1.92</u>	<u>\$2.24</u>
Total MH&SA PMPM Claims Costs	\$2.71	\$3.44	\$4.97	\$5.53	\$6.92
Composite PMPM Claims Costs	\$2.51	\$3.22	\$3.71	\$4.01	\$4.71
Additional PMPM: Claims Cost		\$0.70	\$1.20	\$1.50	\$2.19
MH&SA as a Percent of the Medical Plan:	2.5%	3.2%	3.7%	4.0%	4.7%
MH&SA Incr. as % of Medical Plan:	0.0%	0.7%	1.2%	1.5%	2.2%

Cost Increase for Proposed Arizona MH&SA Parity

as a Percentage of the Medical Plan.....2.2%

The following table summarizes the actuarial modeling results. The composite impact on the health insurance market ranges from 0.9% for Partial Parity to 3.2% for Comprehensive Parity. The cost increase for Fee-for-Service plans range from 1.3% to 4.3%. The lowest cost impact occurs under HMO & Gatekeeper programs where the cost impact of the parity options range from 0.7% to 2.2%.

Table 1
Mental Health & Substance Abuse Combined

<u>Type of Delivery System</u>	<u>#</u>	<u>Distribution</u>	<u>Percentage Increase in Base Medical Plan for Change to Type of Parity</u>			
			<u>Partial</u>	<u>SMI</u>	<u>Full</u>	<u>Comprehensive</u>
Fee-for-Service	1	20%	1.3%	2.8%	3.5%	4.3%
Managed Indemnity	2	25%	1.1	2.3	2.8	3.6
PPO & POS	3	25%	0.7	2.1	2.6	3.0
HMO & Gatekeeper	4	30%	0.7	1.2	1.5	2.2
Composite Market Analysis			0.9%	2.0%	2.5%	3.2%
Composite PMPM			\$1.12	\$2.46	\$3.08	\$3.90
Net Market Impact			0.4%	0.8%	1.0%	1.3%
Net PMPM Impact			\$0.45	\$0.98	\$1.23	\$1.56

Similar values were run for mental health parity only. All assumptions were held constant as to plan design for medical benefits, managed care impacts, and percentage distribution of the various delivery systems. Values for mental health only are shown below.

The Arizona proposal strongly endorses and requires parity for mental health and substance abuse. The attached analysis calculates parity for the proposed bill (Table 1) and mental health only (Table 2). The purpose of this analysis is to frame the cost discussions with facts related to cost of various options that might come under debate.

Table 2
Mental Health Only

<u>Type of Delivery System</u>	<u>#</u>	<u>Distribution</u>	<u>Percentage Increase in Base Medical Plan for Change to Type of Parity</u>			
			<u>Partial</u>	<u>SMI</u>	<u>Full</u>	<u>Comprehensive</u>
Fee-for-Service	1	20%	0.9%	2.0%	2.5%	3.1%
Managed Indemnity	2	25%	0.7	1.7	2.1	2.7
PPO & POS	3	25%	0.6	1.7	2.2	2.5
HMO & Gatekeeper	4	30%	0.5	0.8	1.0	1.1
Composite Market Analysis			0.6%	1.5%	1.9%	2.3%
Composite PMPM			\$0.84	\$1.95	\$2.44	\$2.95
Net Market Impact			0.24%	0.6%	0.8%	0.9%
Net PMPM Impact			\$0.34	\$0.78	\$0.98	\$1.18

The C&L modeling assumes a reasonable, but conservatively low managed care penetration for Arizona. The assumptions were established conservatively to account for the impact of fewer small groups currently using managed care. C&L did not find data available to determine the split of managed care for behavioral health plans in Arizona solely for insured plans.

IX. Comparison to Congressional Budget Office Calculations

In a letter to Senator Nancy Kassebaum (R-KS) dated April 23, 1996, the Congressional Budget Office (CBO) estimated the cost impact of the mental health and substance abuse parity proposal by Senators Domenici (R-NM) and Wellstone (D-MN) at 4.0%. The Domenici-Wellstone proposal is similar to the Comprehensive Parity option presented in this paper which includes parity of coverage for mental health and substance abuse. The CBO cost estimate including mental health and substance abuse and substance abuse is 5.3% for Fee for Service plans and 4.0% for the market composite that includes managed care plans. As written in the CBO letter, "Because employers would be better able to control costs for mental health and substance abuse disorder services, CBO assumed that the average premium increase initially would be 4 percent."

The C&L model result is 4.3% for the Delivery System 1 Comprehensive Parity calculation (Table 1, fee-for-service). This is directly comparable to the CBO value of 5.3%. The composite market analysis C&L model result of 3.2% (see Table 1) relates directly to the 4.0% cost estimate of the CBO. C&L has performed similar analysis in numerous states. In most states, the CBO values are slightly higher than the C&L values. In Arizona the C&L results are about 80% of the National values determined by CBO. The difference in values seem to be caused mainly by the fact there is more managed care in Arizona than in the nation as a whole. In addition, the relative costs of mental health and substance abuse costs to medical/surgical costs in Arizona are low relative to national relationships.

This analysis indicates a fair comparison of the governmental economic analysis and C&L actuarial analysis of the cost of mental health and substance abuse parity legislation. In general, the Congressional Budget Office national cost estimates are similar to the C&L models for Arizona (especially when accounting for the difference in managed care penetration). The estimated costs show a consistency and comparability between the C&L model results and the Congressional Budget Office estimates for mental health and substance abuse parity costs.

X. Impact on Employer Premium Contributions

Employers respond to any potential increase in benefit costs in variety of ways including, competitively marketing the plan to obtain lower premiums, intensely negotiating lower provider costs, cutting plan administrative costs, increasing plan costsharing by members, increasing premium contributions by members, reducing other benefits, and in the extreme, dropping plan coverages and reducing wages (or wage increases). The CBO typically estimates that these employer responses to required coverages will result in cost offsets of about 60% of the gross cost estimates. Using the standard CBO economic modeling approach, employer contributions for health insurance would rise about 40% of the estimate or 1.3 percent.

XI. Conclusions

Based upon the Coopers & Lybrand mental health and substance abuse modeling, the proposed Arizona mental health and substance abuse parity legislation has an aggregate cost impact of 3.2 percent increase over the current market costs of health care (\$3.90 per member per month). Employers are likely to respond in varying ways to offset any cost by increasing deductibles, copays, and reducing other benefits. The net employer cost is determined by using the CBO ratio of 40% of the total cost. This reflects the net impact on employer costs after benefit design and other offsets. This approach yields a net employer cost impact of about 1.3% or \$1.56 per member per month. This analysis is consistent with the Congressional Budget Office estimates of mental health and substance abuse parity studied in 1996 during the national debate over the Domenici-Wellstone Amendment.

The impact of the proposed Arizona legislation varies based upon the type of delivery system and utilization controls built into an insured plan. For example, the impact is lowest for managed care programs with strong utilization controls. These plans already have internal cost controls and significant case management oversight. Preferred Provider Organizations (PPOs) and Point of Service plans (POS) are impacted on average 3.0%, HMO and other gatekeeper models show cost increases of 2.2 percent.