Job Function	Highest Priority Soft Skills*	High Priority Soft Skills
System Network Design/Administration	Demonstrate ability to: ▪ Create supporting documents, clearly summarizing information and requirements. ▪ Communicate with variety of audiences and diverse groups. ▪ Think logically and sequentially to troubleshoot and maintain system. ▪ Recognize and prioritize problems, devise and implement plans of action. ▪ Encourage cooperation among different groups, internal and external.	Demonstrate ability to: ▪ Follow proper rules/policies/procedures. ▪ Ask open-ended and confirming questions. ▪ Be reliable and available. ▪ Evaluate project timeframes. ▪ Understand how users interact with the system. ▪ Analyze industry trends and forecast future needs.
Security & Audit Management	Demonstrate ability to: ▪ Recognize abnormal system performance. ▪ Create detailed support documentation. ▪ Identify, evaluate and resolve environmental problems. ▪ Consider risks and implications. ▪ Judge system effectiveness and efficiency. ▪ Responsibly challenge unethical practices/decisions.	Demonstrate ability to: ▪ Follow proper rules/policies/procedures. ▪ Utilize logic and math to solve problems. ▪ Communicate with diverse groups and encourage cooperation.
Data Communications	Demonstrate ability to: ▪ Communicate technical terms. ▪ Critically analyze details and needs and recommend a plan of action. ▪ Present alternatives in clear and concise language. ▪ Troubleshoot and solve problems. ▪ Analyze information and develop theories about interdependencies.	Demonstrate ability to: ▪ Resolve conflicts. ▪ Stay focused on desired outcomes. ▪ Implement and integrate new systems, continually improving processes. ▪ Participate in team tasks. ▪ Predict outcomes. ▪ Communicate and negotiate with diverse groups.
Certified Hardware LAN/WAN	Demonstrate ability to: ▪ Communicate technical terms. ▪ Critically analyze details and needs and recommend a plan of action. ▪ Present alternatives in clear and concise language. ▪ Troubleshoot and solve problems. ▪ Analyze information and develop theories about interdependencies.	Demonstrate ability to: ▪ Resolve conflicts. ▪ Work with minimal supervision. ▪ Stay focused on outcomes. ▪ Communicate and negotiate with diverse groups. ▪ Participate in team tasks. ▪ Predict outcomes.

Job Function	Highest Priority Soft Skills*	High Priority Soft Skills
Certified Desktops	Demonstrate ability to: ▪ Communicate at the appropriate audience level. ▪ Identify and solve problems, detecting underlying issues and probable causes. ▪ Resolve conflict to customer's satisfaction. ▪ Summarize /paraphrase information and requirements in a clear and concise manner. ▪ Listen attentively, observing verbal and nonverbal communication.	Demonstrate ability to: ▪ Encourage cooperation/negotiation. ▪ Work with minimal supervision. ▪ Collaborate with internal and external customers. ▪ Accept responsibility for own behavior and impact on others.
Non-certified Applications Consultants	Demonstrate ability to: ▪ Communicate at the appropriate audience level. ▪ Identify and solve problems, detecting underlying issues and probable causes. ▪ Resolve conflict to customer's satisfaction. ▪ Summarize /paraphrase information and requirements in a clear and concise manner.	Demonstrate ability to: ▪ Encourage cooperation/negotiation. ▪ Listen attentively. ▪ Accept responsibility for own behavior and impact on others. ▪ Apply reasoning skills to identify potential solutions. ▪ Make exceptional effort on customer's behalf.
Internet Web Applications/Digital Media Development	Demonstrate ability to: ▪ Predict and communicate outcomes to customers. ▪ Communicate and negotiate with customer in clear concise language. ▪ Value differences of opinion and make reasonable compromises. ▪ Visually organize information and judge product quality and appeal.	Demonstrate ability to: ▪ Apply creative thinking and innovation while problem solving. ▪ Manage project resources and timelines. ▪ Define customer needs. ▪ Communicate in public, excellent presentation skills.
Database Administration	Demonstrate ability to: ▪ Work cooperatively with others and contribute ideas, suggestions, and assistance. ▪ Understand and respond to customer concerns. ▪ Pay attention to details. ▪ Think logically and organize information. ▪ Interpret, clarify and influence communication with diverse issues and groups.	Demonstrate the ability to: ▪ Negotiate and resolve conflicts. ▪ Work with minimum supervision. ▪ Visually analyze relationship between parts and whole. ▪ Manage resources to maximize effectiveness and minimize installation time. ▪ Solve problems with innovation thinking. ▪ Understand procedures and work processes.

*Highest priority was given to the soft skills cited by five or more of the surveyed respondents.

ALASKA INFORMATION TECHNOLOGY WORKERS

Job Function	Problem Addressed	Alaska Providers Education/ Training	# Graduates '97/'98/'99	Certification	Likely Employer	Career Objective	Current Entry Salary/ 5 yr Goal	Alaska Demand
Next Generation System, Product Development, or customized application	Basic knowledge of underlying technology to create new application, system, or integrated application including code development .	Computer science and software engineer grads at UAF/UAA	UA: 16/17/11 Charter: MicroAge:	System Engineer	IBM,software development firms, Research-university CS/EE engineering department Integrators (Microage, NBS, SAIC, Digitech, CTG, etc.)	Corporate-tech track-project leader management -CIO, MIS Director if MBA/exp Research- university dept head/center director	Corporate $40-70K entry/ 80-120 K 5 -year Goal University-35-40 entry/60-100 K 5 year	Low No lead hardware software producers do R&D in AK-IBM, MS, Novell etc.
Project Management	Manage other IT projects	PMI management technology experience	Charter: MicroAge:	IT Experience & Management Ability	Both contractual and consultants	Management	$50K/entry $50-120K 5-year Goal	Moderate
Software Engineer	Customized programming and data manipulation	Software engineering with industry background/MBA	Charter: MicroAge:	System Engineer Microsoft, Novell, 3 Com, Engineer (MCSE, etc.)	Private-Entrepreneurial or corporate product dev or gov University -SE dept	Entrepreneurial firms + CIO/MIS University-Center Director	Corporate - $35-50 K entry$65-120 K 5-year Goal Univ-$35-45K entry/65-95 K 5 yr	Moderate to High Increasing with entrepreneurial activity
Computer Engineer	Hardware emphasis to system design	usually CS/EE major, UA, APU, Charter	UA: 2/3/1 Charter: MicroAge: AVTEC:14/14/14	Cisco & Novell Network Professional	Consulting-CTG, etc.	Corporate-VP Engineering	$40-70K entry/ $80-120 K 5 yr	Low-Moderate
System/Network Design/Administrator , MIS	Design overall system for hard/soft installation and operations	generally university grads in CS/EE/math/etc Certified –by NBS, Microage,Compusa	UA:32/48/35 Charter: MicroAge: AVTEC:14/14/14	CNE/MCSE Network Administrator Microsoft, Novell, Cisco	systems consultants like CTG,NBS who have IT processing contracts with oil companies, others	high position in consulting firm less likely corporate CIO	$50-70 K entry/ $100-150 K 5 year	High
Database Specialist	Administer & Operate database primarily for internal users	MicroAge		MS CDBA Oracle Most workers not certified	Industry + vendors	Detail oriented & motivated by designing solid systems	$40-60K entry w/exp. $100K 5 yr	Moderate
Security & Audit	Oversee security and audit	Some certification	Charter:	ISEAC	Vendors, internal audit		$35K	Moderate

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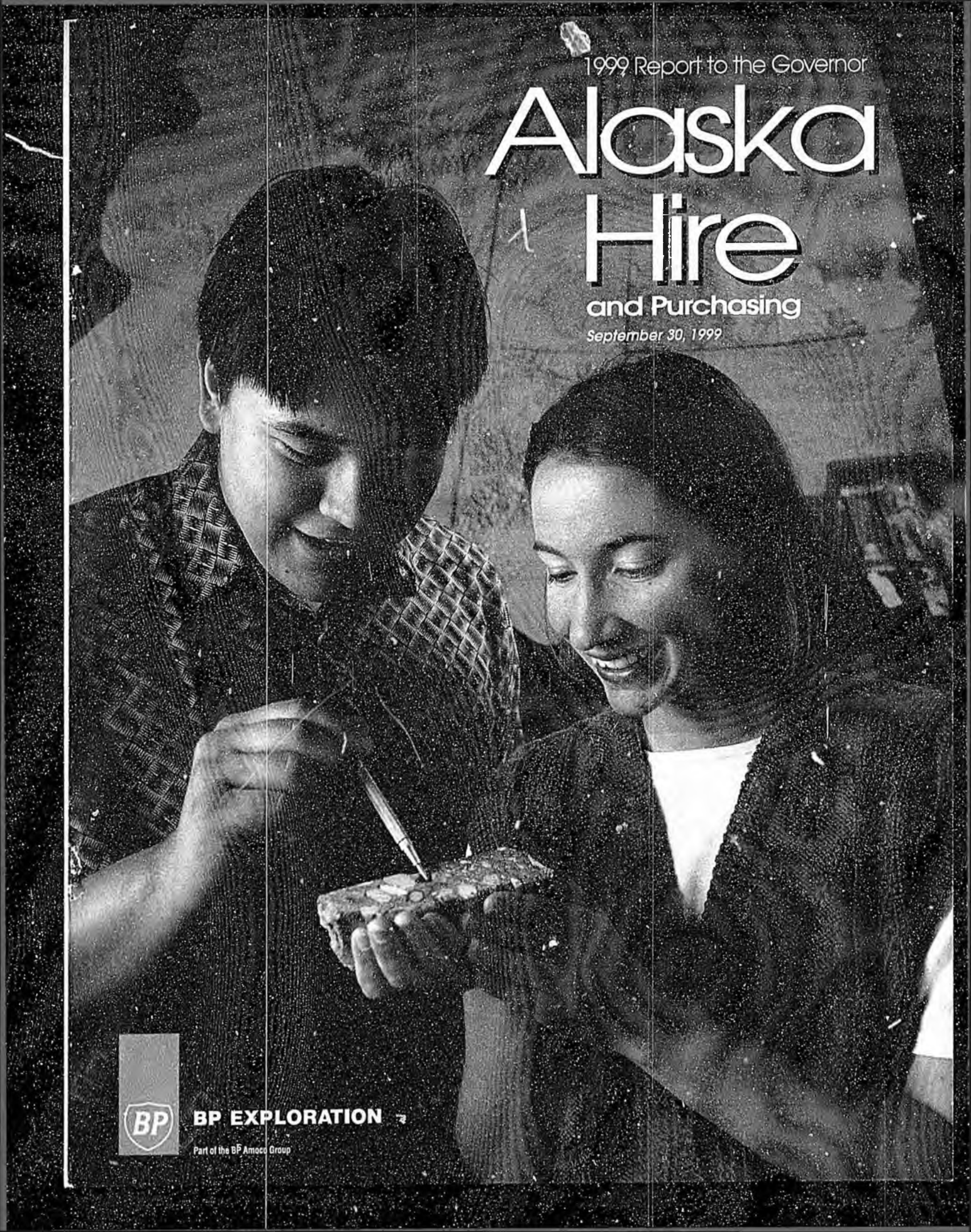
Job Function	Problem Addressed	Alaska Providers Education/ Training	# Graduates '97/'98/'99	Certification	Likely Employer	Career Objective	Current Entry Salary/ 5 yr Goal	Alaska Demand
Management	ISEAC, CISA		MicroAge:	CISA			$50-$70K 5-year Goal	
Data/Tele Communications Technicians	Set up, maintain, install, and operate data communications in public telephone ex A7m, frame relay, sonet, fiber optics, voice over IP	U.S. Military; in-house training, IBEW apprenticeship program	Charter: MicroAge: AVTEC (planned start fall2000)		All phone companies (ATU, GCI, AT&T, etc.), Alaska Fiber Star Interconnect companies (commerce)	Telephone company info managers at private firms, objective is technology mastery	$30-35K/entry $75-90K/5 years	High
Certified Hardware LAN/WANS	*Maintain & Upgrade LAN/WAN Hardware*	Trained by vendors, local packager like Microage, or Charter College on UA regional campuses	Charter: AVTEC:14/14/14 MicroAge:	Cisco, Novell, 3 Com Certified Professional Microsoft Professional	IT providers to perform to maintain systems: Microage, CTG, NBS etc. or free lance	Move up to higher certification	$30-$35K $80-$90K/5-year Goal	High
Certified Desktops	Maintain and upgrade systems	Trained by vendors, local packager like Microage, or Charter College on UA regional campuses	UA: 38/40/25 Charter: MicroAge: AVTEC:14/14/14	Professional Certified Microsoft	IT providers to perform to maintain systems: Microage, CTG, NBS etc. or free lance	Move up to nigar certification	$30-35 K entry/ $70-90 K 5 year	Very High
Non-certified Applications Consultants	Set up customized apps, optimum use of installed base, operate & maintain systems	Not certified. Many self-taught, hackers and ex-teachers, military, lib arts. Com College	UA: Charter: MicroAge:	No	usually self-employed or consulting firms or ISPs	Driven by variety of challenges and frontier practical know how	$25-40 K entry/ $50-70 K 5 years	High
Internet & Web Specialist	Design & build web pages Internet based, 3-tier applications, open platform, and other interactive capability	Mostly self-taught		Some Novell CIP Mostly self-taught	ISP's Web firms Vendors Self-employed	Continual challenges, Cutting edge publishing	$40-50K entry w/exp. $100 K 5 year	Moderate but growing

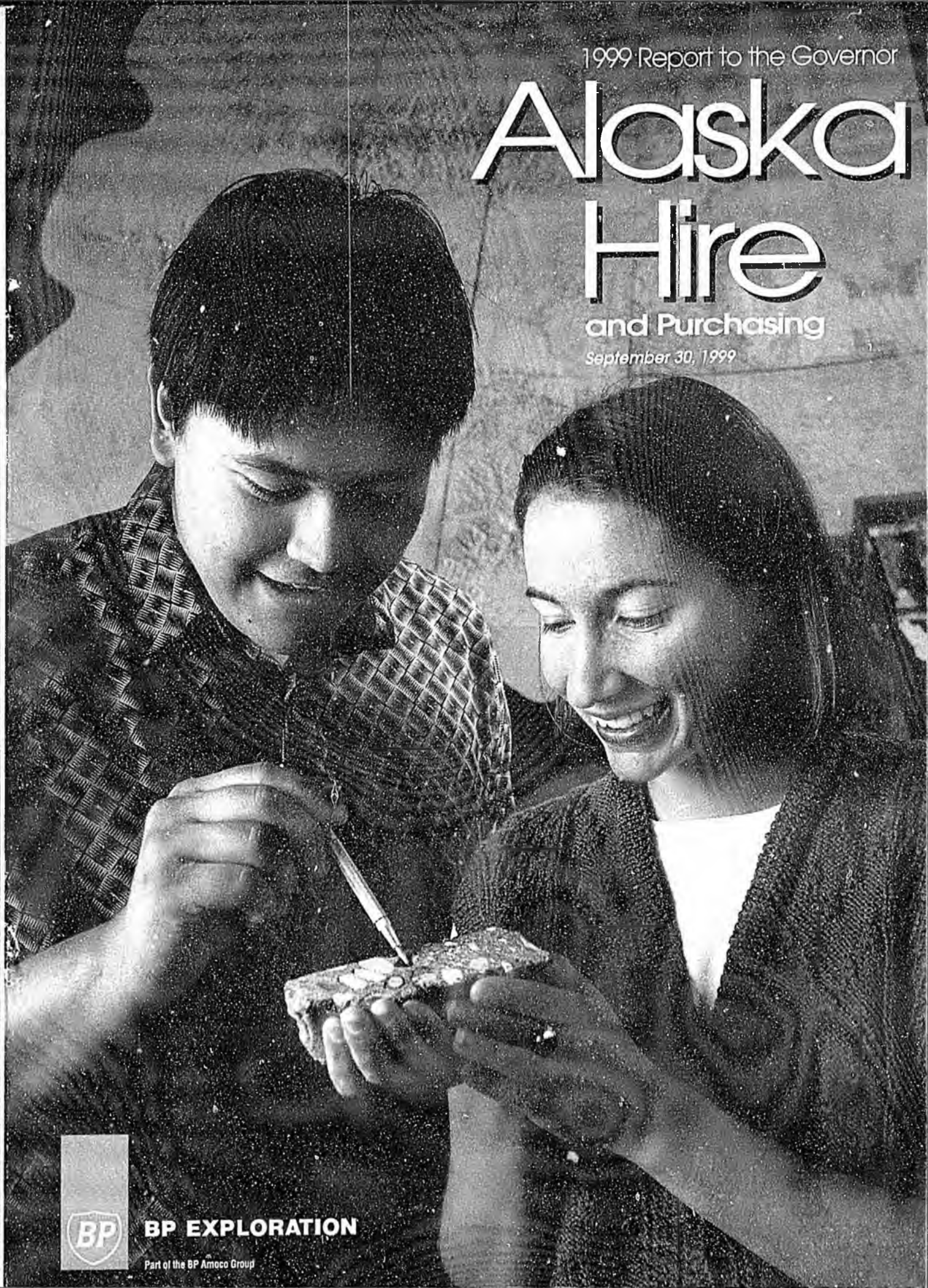
* note: AVTEC graduate count is a duplicate count. Graduates qualify for more than one job class.

Alaska Process Industry
Careers Consortium

Results to date:

- ✓ **Over 100 industry participants defined and validated skill standards for Process Operators**
- ✓ **New two year associates degree in Process Technology developed**
- ✓ **Curriculum for first two courses developed**
- ✓ **Over 80 students enrolled at the University of Alaska in Kenai, Anchorage, and Fairbanks**
- ✓ **Industry contributions, scholarships & internships**
  - Five BP scholarships to be awarded each semester beginning Spring 2000
  - Four BP internships will be awarded during summer 2000
- ✓ **Awarded USDOL Grant for $638,000 in partnership with ASHNA**
- ✓ **Partnership with five local school districts for K-12 pathways to careers**


1999 Report to the Governor
Alaska
Hire
and Purchasing
September 30, 1999
BP
BP EXPLORATION
Part of the BP Amoco Group



1999 Report to the Governor

Alaska Hire and Purchasing

September 30, 1999

BP EXPLORATION

Part of the BP Amoco Group

At a glance...

Alaska Hire POLICY

BP POLICY CHANGES ENCOURAGE RESIDENCY: BP ended Alaska cost-of-living pay differentials to employees who move out-of-state in 1997, and in 1998 required new hires and transfers to live in Alaska. In 1999, non-operational jobs were relocated from the North Slope to Anchorage, which will increase Alaska residency. ***(See page 5)***

Alaska TRAINING

JOBS FORECAST: Industry estimates future needs for process control operators and maintenance technicians in Alaska, forecasting need for training 500 new workers over 10 years. ***(See page 6)***

TRAINING CONSORTIUM FORMED: Industry and educators form Alaska Process Industry Careers Consortium to define future jobs needs, skill standards and programs with education and training providers. ***(See page 7)***

OPERATOR TRAINING: University of Alaska, in cooperation with industry, initiates new two-year associate degree program in process technology, for a growing number of operator jobs. ***(See page 7)***

CONSTRUCTION TRAINING: BP and Arctic Slope Regional Corp. initiate new programs in construction skills training, including two-year welding and four-year electrical technician programs. ***(See page 8)***

ALVA IN SECOND YEAR: For the second year, BP sponsored an eight-week summer pre-college and internship program in 1999 for Alaska Native students interested in engineering careers. ***(See page 9)***

$2 MILLION INVESTED IN EDUCATION: BP contributed more than $1.3 million in 1998 to support primary, secondary and university education. Another $700,000 was spent on Alaska-hire and contractor initiatives.

Alaska BUY

MORE THAN $900 MILLION SPENT: BP spent $953 million for goods and services in 1998, 83 percent of these expenditures were spent with Alaska suppliers and contractors. ***(See page 11)***

PURCHASING RELOCATED TO ALASKA: An Alaska-based integrated supplier service was established by six Alaska supply firms, consolidating purchasing and warehousing services for BP. This results in increased Alaska jobs and more efficiency. ***(See page 11)***

Alaska BUILD

LARGE MODULE CONSTRUCTION: Investment by BP for Northstar project made possible in-state fabrication and assembly of large sea-lift module for Prudhoe Bay MIX project, and facilities for Forcenergy offshore platform. ***(See pages 12-13)***

STATISTICS: Alaska-hire percentages for BP and its major contractors were essentially unchanged between 1997 and 1998. Eighty-four percent of BP's employees lived in Alaska during 1998. Seventy-two percent of the company's workforce was eligible for Permanent Fund dividends, excluding foreign nationals ineligible for the dividend. ***(See page 14)***

Completed MIX module leaves Anchorage for the North Slope. BP's investments for its Northstar project made MIX construction in Alaska possible.

For downloadable copies of this report and other information about BP Exploration, visit **www.bpamoco.com/alaska**

A letter from our President

Richard Campbell

Dear Governor Knowles:

This is our third annual report describing BP's Alaska hire and purchasing performance. The report updates many items we've included in past years, such as our progressive Alaska hire policies, our involvement with local suppliers, training programs, and the creation of a new industry building large-scale modules in Alaska.

The report also highlights several new and expanded initiatives that demonstrate our continued commitment to:

- Maximize use of Alaska labor;
- Help grow competitive Alaska fabrication and installation infrastructure;
- Help Alaskans acquire, through training, the skills needed to work in the oil industry;
- Improve the Alaska residency record of BP Exploration (Alaska) Inc.

New this year is a construction training program that links the capabilities of three Alaska schools in an innovative work-study program for rural, Native residents. Also new is the creation of the Alaska Process Industry Careers Consortium with its goal of creating an in-state Associates degree program at the University of Alaska to train process operators.

Our commitment to Alaska hire and purchasing has deepened, even with the significant challenges and changes encountered this past year by the oil industry and the state. We have seen oil prices drop to historic lows, and intense global competition continues to drive industry consolidation. We have faced difficult challenges. The move to combine BP Amoco and ARCO will keep Alaska competitive with other oil-producing regions of the world in attracting new investment dollars.

The changes implemented this past year have not been easy. However, they position us to achieve the goal we share with the state of Alaska — to see a healthy oil industry that attracts investment, providing good business and job opportunities in Alaska for years to come.

BP has a long history in Alaska, which we plan to sustain and enhance. We will need the help of Alaska workers and Alaska-based businesses to continue this track record.

Richard Campbell

Richard Campbell
President
BP Exploration (Alaska) Inc.

ASRC shareholder Marvin Conley, in front, is a welding inspector at Natchiq Inc.'s module fabrication plant in Anchorage.

Cover:** Michael Nabers of Anchorage (left) and BP petroleum engineer Pippa Eltringham examine drilling core at the state Dept. of Natural Resources materials center. Nabers, a University of Alaska student, was part of the 1999 ALVA program sponsored by BP* ***(see page 9)*.*

BP's commitment to Alaska

by Kitty Farnham

Director of External Affairs for Alaska Hire and Training, BP Exploration (Alaska) Inc.

Kitty Farnham

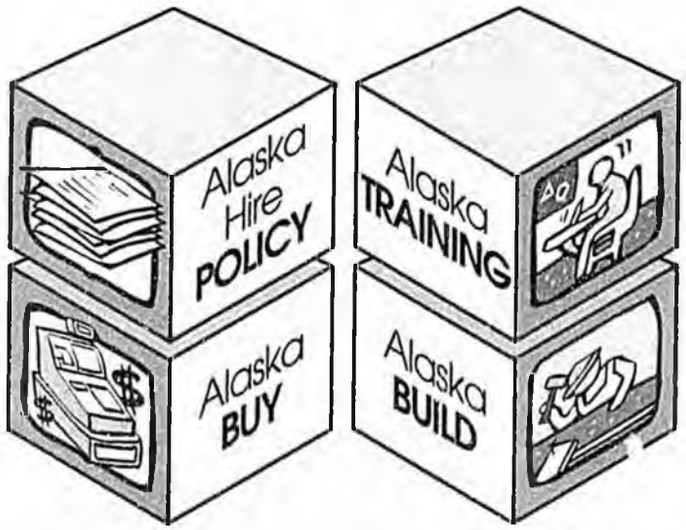
BP is excited about the future and our progress in Alaska Hire and Purchasing. Since we began reporting on these priorities in 1997, we have initiated or been part of a wide range of positive programs, policies and partnerships that collectively are making a real difference to Alaskans and Alaska businesses.

This report provides an opportunity to examine our efforts and our results. It focuses on this year's work, while also reporting on many of the long-term programs and efforts that have been part of BP's ongoing commitment to Alaskans.

The future holds much promise for Alaskans and for BP. The combination of BP Amoco and ARCO will help to provide stability and growth for Alaskans employed by the industry, both in the development of new fields and in the operation of existing ones.

BP spent over $950 million for services and supplies in 1998, and 83% of that was spent with Alaska-based companies. We are committed to continue this high level of local spending, and to increase the number of Alaskan companies who supply us with goods and services. A strong, competitive local market creates a stronger economy, which in turn helps the Alaska oil industry remain competitive globally and continue to attract investment.

Work force renewal is a growing concern for BP in Alaska. The men and women who have been on our operations team since Alaska production began are beginning to retire. As we enter the 21st century, BP is looking at its long-term business in Alaska and its need for skilled workers to keep operations environmentally sound, safe and productive. With each new employee BP hires — who by policy must live in Alaska — we are taking a positive step toward increasing residency and keeping Alaskans at the heart of the Alaska oil industry.



"Part of a good business environment is the presence of a skilled local workforce and a competitive local market. To achieve this, we must build partnerships and apply policies that encourage Alaska training and hiring, Alaska buy and Alaska build."

BP recently helped launch a consortium with other employers and educators across the state to grow the next generation of industry workers in Alaska schools and training programs. The goal is to help Alaskans learn relevant skills and find good jobs in industry, beginning with operator training, and later to encompass the broad technical skills sought by industry.

We are pleased with the progress this report presents and excited about the future, the promise of new investment, new jobs, and new Alaskans joining the workforce.

New Alaska residency policies underscore BP's commitment

BP's Alaska hire policies

Alaska cost-of-living differential:
In January 1997, BP told its employees that this cost-of-living differential would no longer be paid to employees who move out of state;

Alaska-residency requirement:
In September 1998, BP announced a new policy that new employees, or employees transferring to Alaska, would be required to live in the state;

ARCO-BP consolidation:
BP's policies will apply to the operations of the combined companies.

Following the acquisition of Atlantic Richfield Corp. by BP Amoco, the policies will also apply to the new, combined company in Alaska. Alaska residency of BP or ARCO employees will also be considered as the two companies' operations are combined.

Some operational changes BP is making will also increase residency. The company is moving some support functions off the North Slope, relocating these positions to Anchorage where employees will work a five-day work week in Anchorage instead of a shift schedule on the Slope. The change in work schedule means these employees will reside as well as work in Alaska.

BP's residency statistics have been relatively flat in past years. With good pay and benefits, there has been little attrition and, in fact, painful downsizing. This environment has not allowed for much new hiring.

Looking ahead, BP will need to renew its work force on the North Slope as employees approach retirement. The company's policies will ensure these new hires live in Alaska, thereby increasing BP's residency rates.

'BP is explicit about its Alaska hire and residency requirement in hiring, and has enacted policies to back up that commitment.'

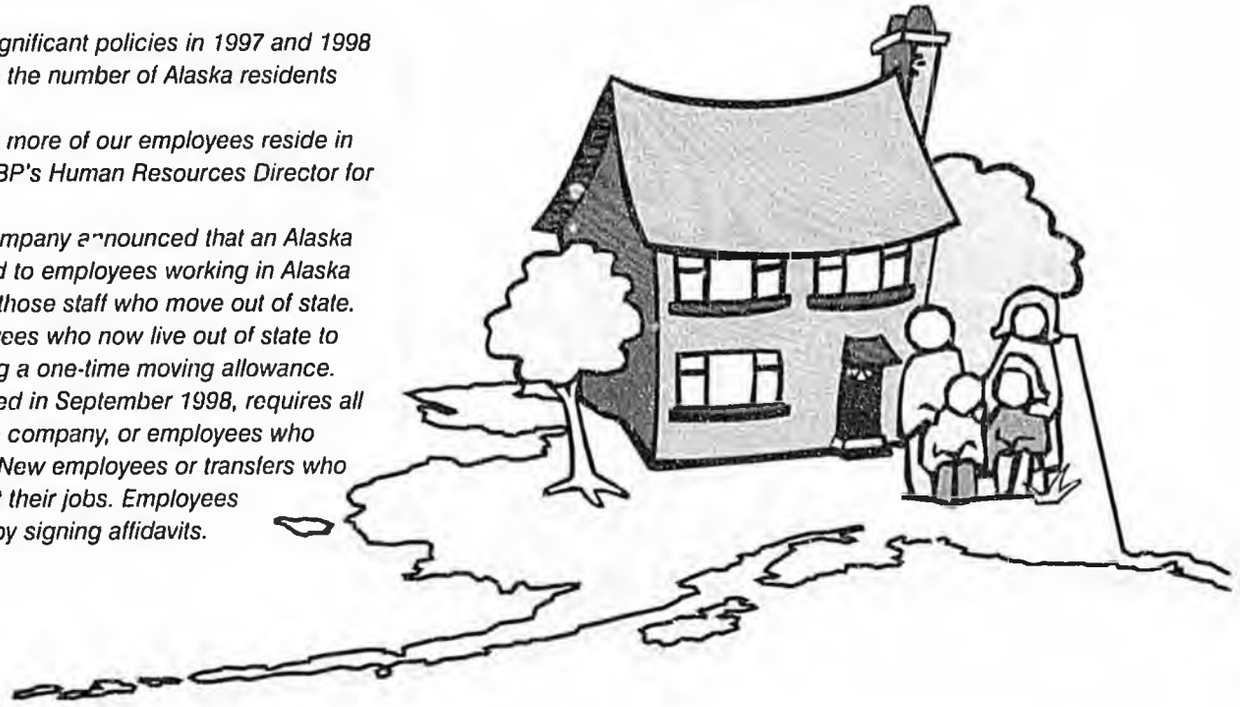
– **Richard Campbell**, President, BP Exploration (Alaska) Inc.

Commitment to Alaska-hire begins with explicit policies.

BP implemented two significant policies in 1997 and 1998 that, over time, will increase the number of Alaska residents working for the company.

"These will ensure that more of our employees reside in Alaska," said Sandy Beitel, BP's Human Resources Director for Alaska.

In January 1997, the company announced that an Alaska cost-of-living differential paid to employees working in Alaska would no longer be paid to those staff who move out of state. BP also encourages employees who now live out of state to relocate to Alaska by offering a one-time moving allowance. A second policy, implemented in September 1998, requires all new employees hired by the company, or employees who transfer in, to live in Alaska. New employees or transfers who later move out of state forfeit their jobs. Employees certify residency each year by signing affidavits.



There are future jobs in industry

Despite the industry's recent restructurings, there are job opportunities in Alaska's petroleum industry for talented people and those willing to learn.

"Our internal studies show that our North Slope workers average more than 48 years of age," said Tim Holt, BP's Business Unit Leader for the Central North Slope. "Even with the consolidation of ARCO and BP operations in Alaska, there will be opportunities for Alaskans interested in long-term, good-paying jobs in the petroleum industry."

Retirements, combined with new developments brought by investment, will create new opportunities for Alaskans to enter the petroleum industry work force. "To develop that local talent, BP is working with Alaska's training providers and recruiting new workers from local schools," said BP's Kitty Farnham.

The aging workforce is a concern of contractors and other industries as well: "We need to make an all-out effort to recruit young people into training and apprenticeship programs," said Don Pfaff, a Senior Recuiter at VECO Corp., a major Alaska contractor. "Our experienced labor force is aging, and replacing those skilled craft workers will be difficult."

Ginger Steffy, Director of the Kenai Peninsula College, a part of the University of Alaska Anchorage, says: "It's hard to convince high school graduates and their parents there's a future in petroleum when they read newspaper headlines about industry cutbacks. But the industry is telling us there is a future. Training today positions students for good jobs in the future."

A ten-year forecast of new hire needs among the oil, gas and power industry reveals that there are current and growing gaps in certain technical skill areas. In particular, initial estimates show a need for about 30 new operators each year. Local schools, however, are only training a handful in the relevant programs.

"Renewal": Training the n

Pipe fabrication for BP's Northstar project in Anchorage

Alaska's oil producers and their key contractors have new, long-term training initiatives under way to prepare a new generation of Alaska workers for permanent op[illegible]s and maintena[illegible]n the North Slope [illegible]lds.

This is important because the industry is now involved in planning for its first operations work force renewal.

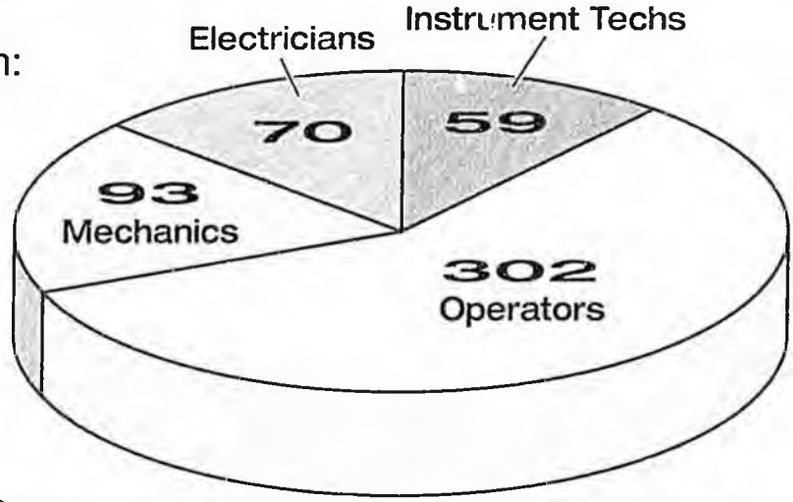
As the first generation of North Slope production workers prepare to retire, (many began their jobs in the 1970s, the years of rapid industry expansion), the producing companies and contractors are beginning to focus on the need to train skilled replacements who can be recruited within Alaska.

The most significant new renewal program is a two-year associate degree in process technology that will be offered for the first time in early 2000 by the University of Alaska.

Demand grows for Alaska workers

Includes data from:

- BP
- ARCO
- Alyeska
- Unocal
- Phillips
- Tesoro
- Williams
- Chugach Electric
- Matanuska Electric



Total = more than 500 future jobs

ext generation of Alaska's oil workforce

Alaska TRAINING

This is being developed by a consortium of industry and education partners, led by BP, ARCO Alaska Inc., Alyeska Pipeline Service Co., the university and other employers in process technology industries, such as mining and power generation. The Alaska Process Technology Careers Consortium will develop skill standards and curriculum to train process operators.

"All of our member employers look forward to hiring from the new program as a means of renewing their workforce with skilled Alaskans," said Kitty Farnham of BP.

The industry will continue to work closely with the university once the program begins. For example, faculty and students will be invited to intern or job shadow with experienced technical staff on job locations. Some industry employees will become adjunct faculty or student mentors.

These steps will keep the faculty and students up to date on the latest technology. The new program builds on work the industry has done before with the university's Kenai Peninsula College program.

'For the first time, we see a unified approach and focused industry involvement ... our hope is to be able to deliver this program statewide ... we want to see students able to do the initial work on several of the university's campuses, and then finish up in one or two hub sites, where the specialized equipment is available.'

– **Joyce Helens**, Executive Director, University of Alaska Corporate College

Sam Kanayurak, left, and Don Ahlers, in electrical technician training, part of BP's Itqanaiyagvik program.

Alaska Process Industry Careers Consortium

A new initiative offers opportunities for more in-state training

The University of Alaska and other post-secondary schools offer a range of vocational education around the state, including long-established one and two-year degree and certificate programs for the petroleum and construction industries. The Alaska Process Technology Careers Consortium is a new effort to integrate these programs and focus them on current industry skill standards and detailed manpower needs. Most important, this will create a partnership between the university and industry to ensure students will get hired.

According to Joyce Helens, Executive Director of the University of Alaska's new Corporate College, "For the first time we see a unified approach and focused industry involvement."

"We'll know what needs to be delivered to train to industry standards," Helens said. "Our graduates will just about be guaranteed jobs because of that close involvement by employers. It's a wonderful partnership."

The Alaska consortium is looking at an industrial training model developed by the Gulf Coast Process Technology Alliance, an effort led by BP Amoco and other companies in Texas and Louisiana. This will allow Alaska to develop its programs faster. "We'll build on their nationally-recognized success and avoid their mistakes," Helens said.

"Our hope is to be able to deliver this program statewide," she said. "Some components, requiring equipment, can't be moved around, but other parts can be offered anywhere there are students and educators willing to adopt the standards."

Looking ahead, the consortium will help integrate and standardize industry training beyond operations and potentially include construction, maintenance and regulatory training.

Alaska
TRAINING

Training for construction jobs in the petroleum industry

A program to train North Slope residents in petroleum industry construction skills is well under way. A first class of 12 finished three months of classroom and laboratory work last spring at Ilisagvik College in Barrow, brushing up on math and basic technical skills. This summer they had on-the-job training with contractors at Prudhoe Bay, Anchorage and Fairbanks. This fall the trainees have the opportunity to begin more advanced training in welding, pipefitting, electrical and instrumentation crafts.

The participants come from several Alaska communities, including villages on the North Slope and Interior Alaska.

Ilisagvik College welding instructor Jerry Trainor, with Joshua Okpik, a trainee in the Itqanaiyagvik welding training program.

Trainees are attending Alaska Vocational Technical Center (AVTEC) or the University of Alaska Anchorage. Welding students will obtain their welding certification and then go to work for contractors in early 2000 constructing BP's Northstar modules.

Electrical trainees will attend AVTEC in Seward through June 2000. After that they will resume on-the-job training with contractors, also working on Northstar, and will continue their apprenticeship training for an additional two years.

Itqanaiyaġvik

Job Training and Employment Opportunities

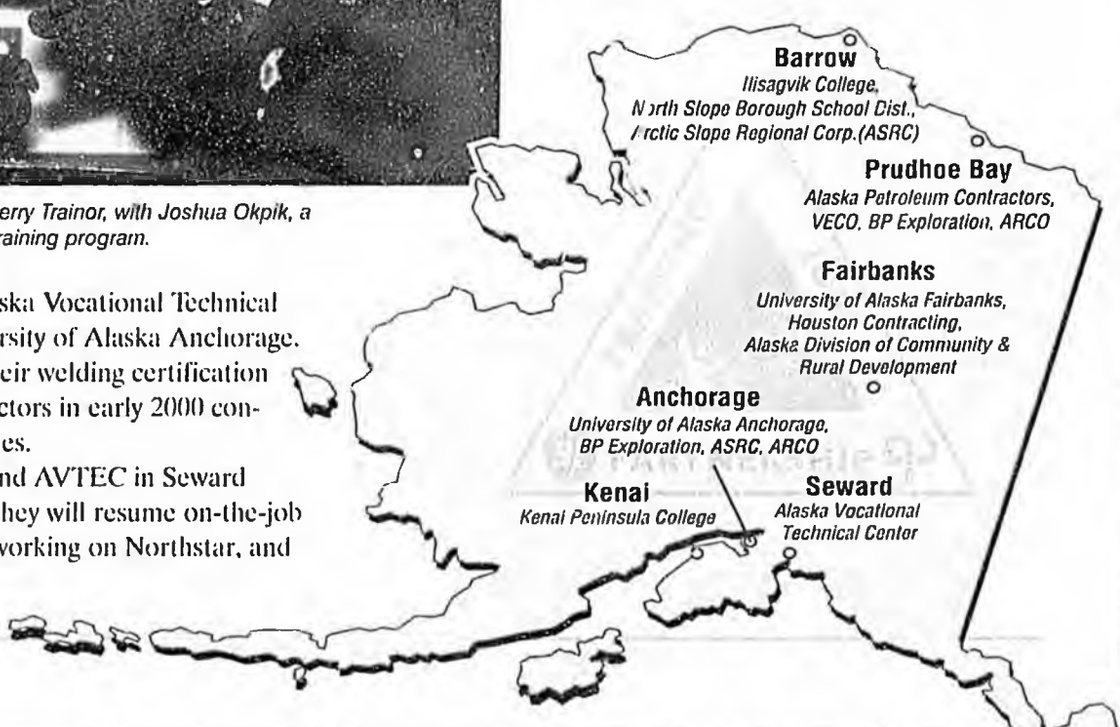
The construction skills training effort is part of a broader program — Itqanaiyagvik (Inupiat for "a place to get ready") — that was initiated over a year ago by BP and Arctic Slope Regional Corporation.

The program includes an integrated set of training initiatives to suit several entry points and career goals. Since its inception, more than 60 youths and adults have taken part in the training.

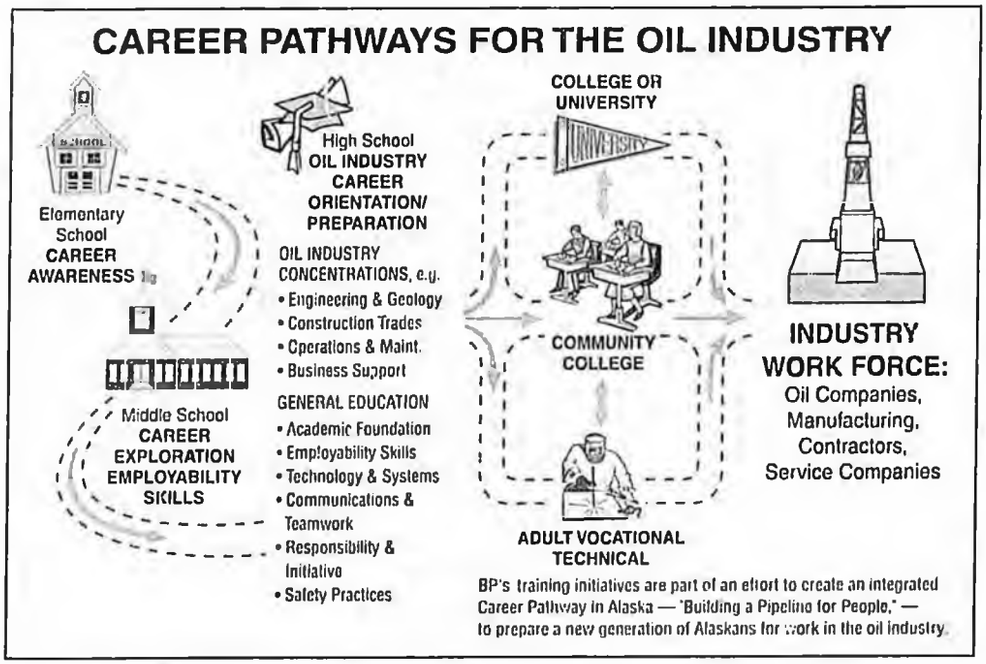
In addition to the long-term construction skills training, Itqanaiyagvik includes a North Slope job shadow component to encourage high school students from North Slope communities to become interested in petroleum jobs, as well as an adult job shadowing program that helps North Slope residents with basic skills obtain entry-level jobs in the oil fields.

The program also includes ALVA, a pre-university program for students entering engineering and technical degree programs. Itqanaiyagvik will soon incorporate operations training in the process technology degree program that will be delivered by the University of Alaska and their partners.

Itqanaiyagvik Partners



Laying the foundation for a highly skilled Alaska work force



The foundation for skilled jobs and technical professions is laid in elementary, middle and high school. There are many examples of programs that create opportunities to learn industry skills. For several years BP has worked with the Anchorage School District, the North Slope Borough School District and Alaska's School-to-Work program in sponsoring high school mentoring and job shadowing programs.

BP's approach is to offer something for students at several points in their education. The goal is for them to see the industry as a good place to work.

These programs are key steps on a career path to the oil and gas industry.

In Anchorage, BP has sponsored the largest and longest-lasting mentoring program of any business in the school district. Each year, as many as 20 talented high school students interested in engineering or professional careers are matched with mentors, professionals at BP. They take on projects aimed at furthering their understanding of technical fields and gain first hand exposure to Alaska's oil industry.

On the North Slope, BP is the primary sponsor of an annual high school job shadowing program, in which students from several villages spend four days at Prudhoe Bay experiencing and learning about technical jobs in the oil fields. Last year 50 North Slope students applied to enter the program, of which 20 were selected by a school district and industry panel after interviews and reviews of student-written essays.

BP joins Alyeska Pipeline Service Co., other industry partners, and the Alaska Federation of Natives on a new proposal to work with school districts around the state on ways to reinforce science and technology learning in the classroom through curriculums that are relevant to industry.

One example is to introduce "SciTeKS" (Science Technology, Knowledge and Skills) into high schools across the state. This is a modular curriculum developed by the American Chemical Society and industry partners that builds understanding of basic science and math concepts. It uses real examples taken from industries like petroleum, refining, minerals, health care, or waste-water processing.

The coursework models the work that process and laboratory technicians do on the job.

CONTINUED ON PAGE 10

ALVA: Training new engineers

BP has sponsored a second group of Native Alaska ALVA students in an eight-week pre-college internship and study program. ALVA prepares minority high school graduates for successful engineering or other technical degree programs at the University of Alaska Anchorage.

The summer program combines intensive mathematics instruction with work experience at BP, UAA and Arctic Slope Regional Corp., a partner in the program, select ALVA students. They are housed in university dormitories during the summer program.

BP worked with UAA two years ago to develop an Alaska ALVA program. It is based on similar, successful programs at several major universities. Students at UAA will be in the Alaska Native Student Engineering Program, directed by Dr. Herb Schroeder.

1999 ALVA STUDENTS: *From left (center foreground) Michael Nabors, Carrie Fox, Melissa Vallee, Robert Gransbury (Rebecca Frenzl not pictured). At rear (left), BP's Pippa Eltringham and (center) UAA's Jen Lauterbach. Right (foreground): Mark Forsythe, of Wood Group Gas Turbines.*

Alaska TRAINING

Laying the foundation...

FROM PAGE 9

"Choices," an interactive curriculum, will be taught by volunteers from business organizations in middle schools. Two one-hour presentations will help students realize how self-discipline, academic and personal choices made today affect their future. Young people will also learn time and money management techniques. The program was developed by the Choices Education Foundation and has been given to 5 million students since 1985. BP and Providence Health Systems are sponsoring Choices for use throughout Alaska.

The Alaska Business Education Compact, an organization of business and education leaders, will provide coordination for these programs statewide to connect volunteers from business with schools. Anchorage School District's Business Partnership group is providing similar support and connections for Anchorage schools and businesses.

Another program being offered is "Wheels of Learning," a five-year technical curriculum developed nationally by the National Center for Construction Education and Research. Wheels of Learning has standardized curricula in five key skills: electrical, welding, millwright, instrumentation and pipefitting.

Valdez High School, in partnership with Alyeska Pipeline Service Co., brought the program to Alaska, to teach the millwright specialty. The program spans the last two years of high school in Valdez, followed by three years at Prince William Sound Community College. Students who perform well are hired by Alyeska for summer jobs at the Valdez Marine Terminal. Alyeska has had as many as 14 students working during summer.

Anchorage's East High School science teacher Bill Ennis (above) was BP's first Teacher of the Year, part of its Teachers of Excellence program. BP puts substantial resources into supporting education.

BP to expand its Alaska

BP's activities in Alaska generate over $950 million in spending with contractors and suppliers, 83 percent of which is spent in-state. From Anchorage to Fairbanks and Barrow, BP's spending on new and existing operations creates business opportunities and jobs in a wide range of business sectors.

Spending is done by BP directly, and also by its many service contractors and suppliers in support of BP work. This spending trickles down through wages and purchasing in other businesses, creating a significant multiplier effect.

The pending combination with Atlantic Richfield Corp. will generate even more business opportunities for Alaska companies.

After the merger, PP plans to increase the number of Alaska companies in its Preferred Supplier Network. Competition and a strong local market are critical to the industry's long-term success in Alaska.

BP is committed to building bigger and better bridges with the contractor / supplier community. Mike Cortez, procurement manager for BP, has made it clear in public forums that the door is open.

"I encourage any business wanting to learn more about our procurement processes, or wanting to educate us on their capabilities, to simply give us a call. Our team is always interested in hearing from suppliers who can deliver a better mouse trap," Cortez said.

In addition to the invitation to call, BP's procurement group is offering a series of workshops to answer questions and build stronger relationships with the supplier and contractor community.

BP recognizes that local contractors and suppliers are experts at doing business in Alaska. "They know our operations and they know our needs better than anyone," Cortez said. "They also understand the need to keep the Alaska oil industry competitive, so that we can maximize North Slope production."

Alaska BUY

Mike Vivlamore

FRONTIER PLUMBING AND SUPPLY, *a long-established Fairbanks firm, is one of BP's Alaska Network suppliers of industrial commodity goods. The company sells plumbing, heating and refrigeration equipment and supplies to BP for its North Slope oil field operations, and also coordinates BP's purchases of lumber and wood from another Fairbanks company, Northland Wood.*

Other Fairbanks firms sell supplies and do work for the North Slope oil field operators, too. Alaska Tent and Tarp supplies liners for pits; Flowline Inc. does pipe insulation.

Mike Vivlamore, Frontier's founder and owner, said he's happy to see the petroleum industry buying more from companies in Interior Alaska.

For more than three years Alaska-based firms have supplied over 80 percent of BP's requirements for services and goods for its oil field operations. Even as the company tightened its belt in the first half of 1999, in response to low oil prices, Alaska companies kept their share of sales.

In 1998, BP spent $953 million in contracts for services, parts, supplies and transportation, of which $791 million, or 83 percent, was spent in the state, according to James Cox, Manager of Contracts for BP Exploration (Alaska) Inc.

In the first half of 1999, as industry spending declined, BP spent $298 million on its field operations. Of this, $245.1 million, or 82 percent, was spent in Alaska.

"Alaska firms were able to hold their share during a downturn. That shows they can be competitive with out-of-state suppliers," Cox said.

Some purchases, like specialized large turbines or drilling pipe and bulk chemicals are made directly from out-of-state manufacturers. But BP buys most of its general commodities — supplies and small mechanical parts — from a group of 30 Alaska network suppliers.

These companies, in Anchorage and Fairbanks, have demonstrated they can be competitive with Lower 48 competitors, Cox said. BP directs its commodity purchases to these firms.

BP relocates purchasing to Alaska

Six Alaska supply firms have formed a new joint-venture company to coordinate purchasing for BP. The new company has relocated BP's purchasing from Price, Utah, to Anchorage.

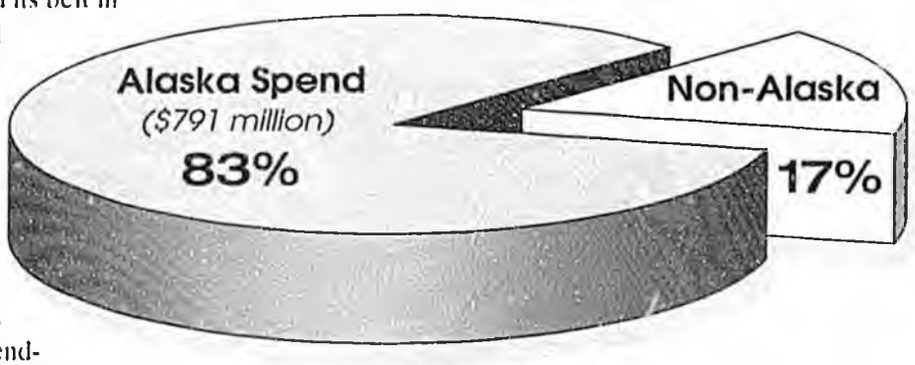
Before, BP contracted its purchasing for general commodities through Fairmont Supply Co., a national firm. The new Alaska-based company, Alaska Supply Chain Integrators (ASCI), assumed Fairmont's role in March 1999.

Partners in the company include Alaska Pump and Supply, Dowland Bach, Engineered Equipment Co., and Puget Sound Pipe and Supply, all of Anchorage; Frontier Plumbing and Supply of Fairbanks, and Fairmont Supply.

ASCI coordinates purchases but does not select the company to buy from. These decisions are made by BP, according to ASCI's General Manager, Cathy Williams.

BP spent $791 million in Alaska

1998 operating expenditures



'Alaska suppliers are holding their own during this downturn in activity. The percentage of BP's local purchases is about the same – over 80 percent – despite the decrease in activity.'

– James Cox, Manager of Contracts
BP Exploration (Alaska) Inc.

Industry, contractors create a new large mo

It was a gamble for North Slope oil producers and their contractors, but it paid off. A new high-wage industry — fabrication and construction of large sea-lift oil process modules -- has been created in Alaska. These large modules used to be built in the Lower 48.

"BP paved the way for this with a commitment in 1997 to build large processing modules for its new Northstar field in Alaska," said Bill Allen, Chairman of VECO Corporation, a major contractor.

Northstar was delayed by lawsuits, but investment by BP Exploration (Alaska) Inc. in an Anchorage module assembly site allowed the Prudhoe Bay field owners, mainly ARCO Alaska Inc., BP and Exxon Corp. USA, to award a contract to VECO in 1998 to build the Prudhoe Bay Miscible Injectant Expansion (MIX) project in Anchorage, Allen said.

The module was completed and shipped to the North Slope on July 19.

Unions in Fairbanks upgrade members' pipeline skills

Fairbanks-area unions are working with Houston Contracting Co. on training sessions to upgrade their members' skills in pipeline construction. Jim Plaquet (below), of the Operating Engineers Local 302 in Fairbanks, says the training has helped Alaska workers become very efficient.

The MIX module, the largest built in Alaska, moves away from the dock in Anch

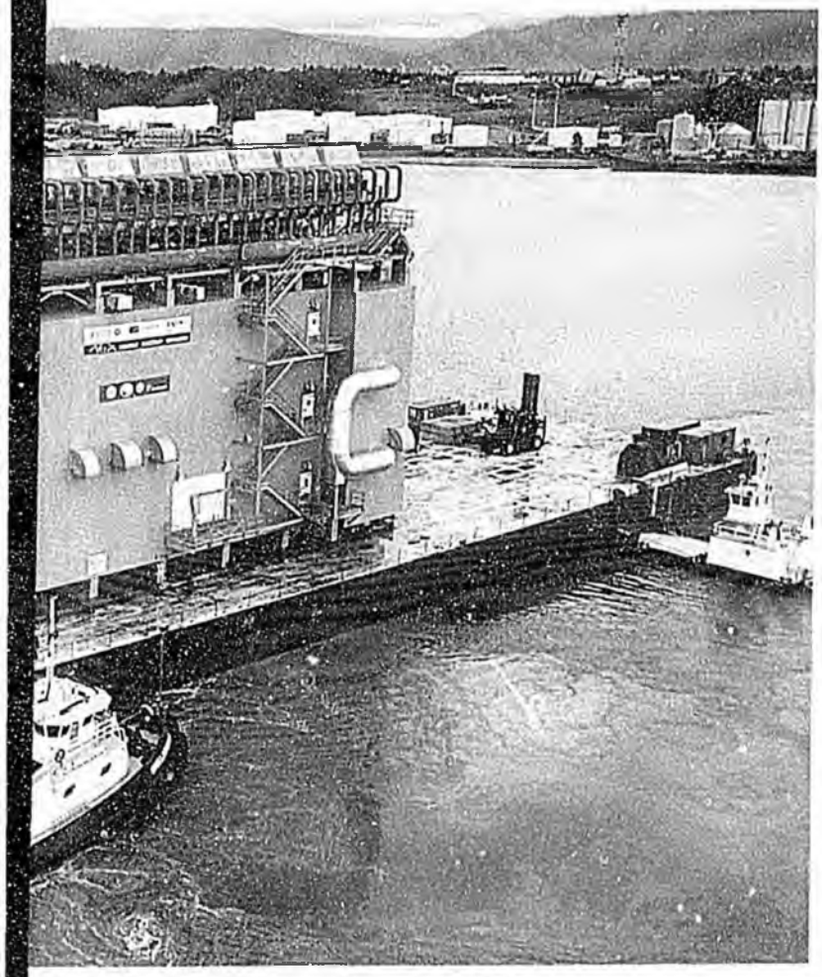
With the Northstar project past its recent legal and regulatory challenges, VECO and Natchiq Inc., an Arctic Slope Regional Corporation subsidiary, are beginning work on the Northstar modules. Natchiq is fabricating internal steel and components for the modules in its south Anchorage plant, while VECO will assemble the modules at the Anderson Dock near the Port of Anchorage.

Although Northstar was delayed, its start-up coincides nicely with the completion by Natchiq of modules for ARCO's Alpine field. Those were shipped to the North Slope in early July, said Gary Buchanan, Manager of the company's Anchorage plant. Northstar's modules, which will include the largest yet built in Alaska, will be shipped in July 2000 and 2001.

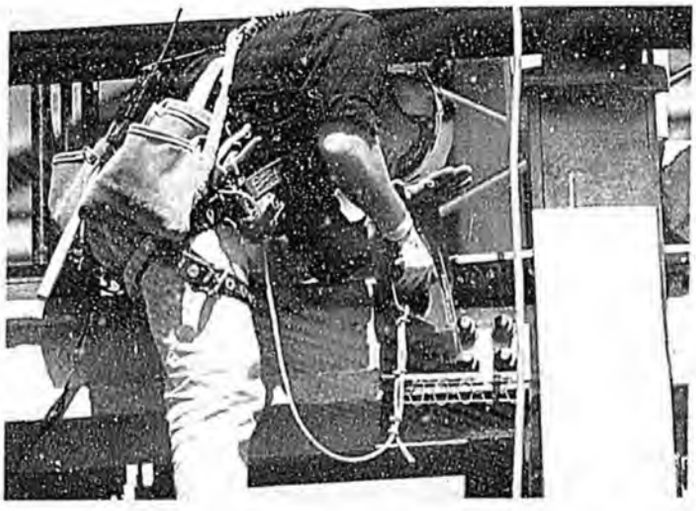
BP and other North Slope producers have awarded contracts to local firms to build smaller truckable module units for more than 10 years. The MIX, Alpine and Northstar modules are the first large modules, which must be moved by barge to the North Slope.

dule construction industry

Alaska BUILD



ge July 19, en route to the North Slope.



VECO Construction worker on MIX module project.

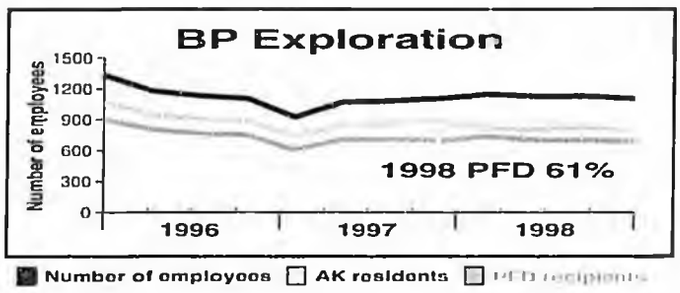
Having helped create this new industry, BP intends to continue awarding fabrication contracts to local firms that can deliver quality work on time at competitive cost.

Fabrication under way at Natchiq's plant in Anchorage.

'The timing of BP's Northstar module work has been lucky for us. We were able to finish work on Alpine module fabrication in late May, do a smaller job on a drilling module, and then jump right on Northstar fabrication.'

– **Gary Buchanan**, Manager Alaska Petroleum Contractors fabrication plant, Anchorage.

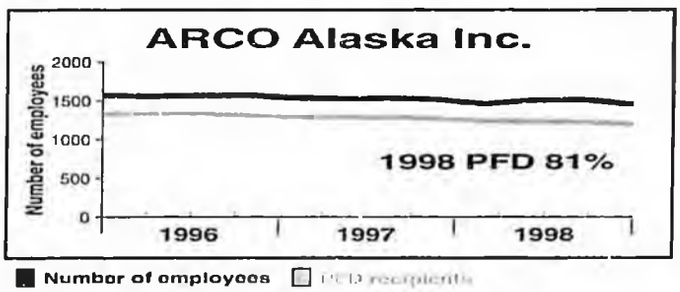
Statistics

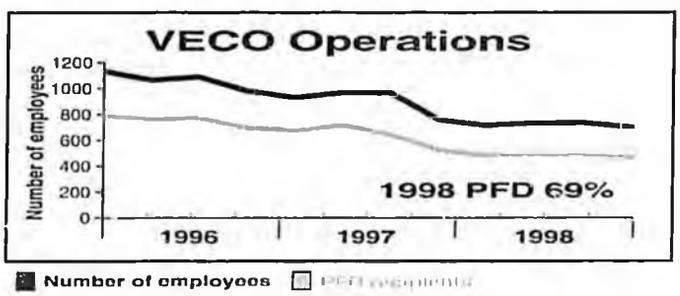


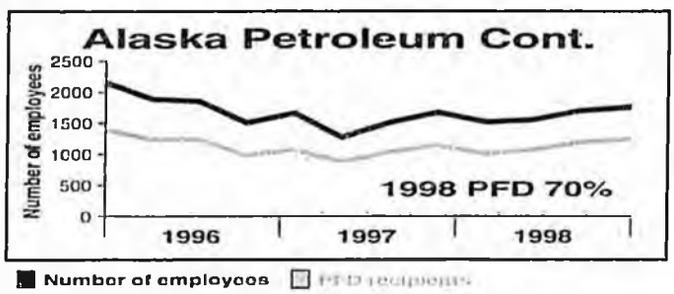
BP residency statistics

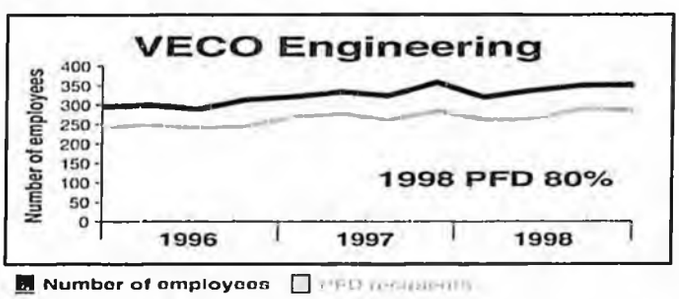
Residency*	84 %
PFD eligibility	61 %
PFD eligibility adjusted for foreign nationals working abroad	72 %

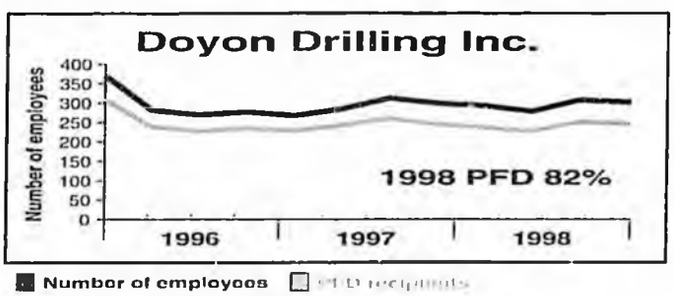
** Residency validated annually by employee affidavit*

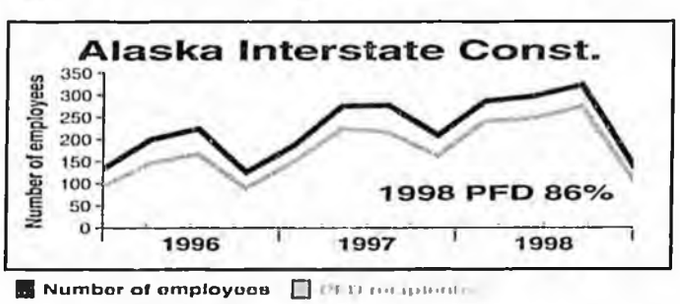


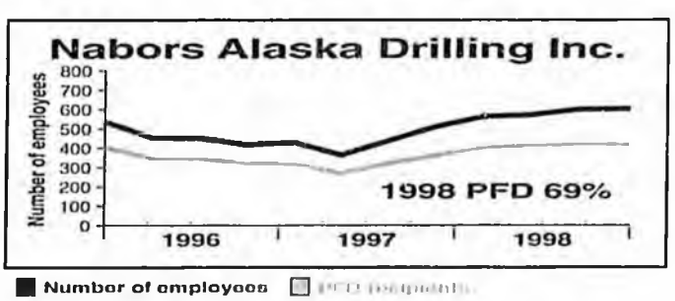












There's a bright new future ahead

Over the past five years, BP and ARCO have invested a combined total of $4.1 billion in Alaska.

$4.1 billion

1995 -1999

There's a bright future ahead for oil and gas development in Alaska after the acquisition of Atlantic Richfield Co. by BP Amoco.

"The combination of these two pioneer Alaska companies will give this state the personnel, technology and financial capacity to ensure that Alaska continues to be a major oil and gas producer for decades to come," said Richard Campbell, President of BP Exploration (Alaska) Inc.

This will lead to more investment and more oil development. New field development projects will employ Alaskans in construction, engineering and support work. Once in operation, new oil fields will provide long-term employment for Alaskans in field operation and maintenance.

BP's Alaska-hire, Alaska-build and Alaska-buy policies will apply to the new, combined company in Alaska.

As a generation of North Slope workers prepares for retirement, BP, ARCO and the companies' main North Slope contractors are working to train replacements.

With construction of the MIX and Alpine sea-lift modules in 1999, Alaska contractors have proven they can build large modules in Alaska at a price competitive with the Lower 48.

Cost cuts = gains in productivity = more investment = more jobs

The equation is simple, and it works. Streamlining costs allows gains in productivity, which allows an enterprise to become more competitive and to grow its business.

This is good for business and the economy as a whole.

This scenario has been played out countless times, including manufacturing in the depressed U.S. Midwest in the 1970s. Many economists were ready to write off the Midwest, and its transition was tough. But in the 1990s, Midwest manufacturers became productive and highly competitive. Now the region has one of the tightest labor markets for skilled white- and blue-collar workers in the nation.

Closer to home, the petroleum industry's belt-tightening in the early-to-mid 1990s had, by 1996, made the North Slope oil fields more competitive.

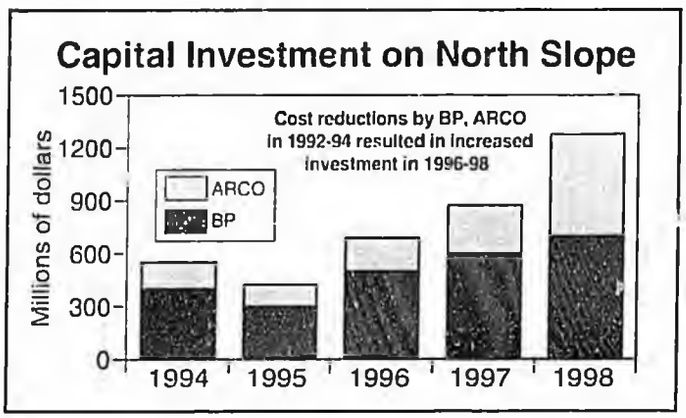
Production costs were cut about 25 percent in the early 1990s. The result was almost a doubling in investment by BP Exploration and ARCO Alaska from 1997 through 1999, compared with 1994 through 1996 ($3 billion compared with $1.6 billion.) There was more drilling, and hundreds of millions of barrels of new oil reserves were discovered or developed.

Employment in the oil industry started increasing after several years of reductions. Between 1996 and 1998, there was an 8 percent gain in industry jobs in Alaska. In 1998, there were 8,877 people employed by oil producing companies and oil service firms compared with 8,209 in 1996.

A new beginning for Alaska

Some of these employment gains were lost when record low oil prices in late 1998 and early 1999 caused a dramatic retrenchment in the Alaska oil industry.

The joining of BP and ARCO will help reduce costs once more. "The result will be more capital spending, greater ultimate oil recovery and more stable state oil revenues," said Kevin O. Meyers, President of ARCO Alaska Inc.



Alaskans at work in a new industry, large oil field module construction.

BP Exploration

Part of the BP Amoco Group

Alaska Hire and Purchasing

P.O. Box 196612
Anchorage, AK 99519-6612
www.bpamoco.com/alaska

KITTY FARNHAM, Director of External Affairs for Alaska Hire and Training

MENTAL PARITY TASK FORCE REPORT

2/22/99

Mental Health Parity for Alaska

Assuring equal health coverage for people experiencing mental illnesses

Right now, 90 percent of health insurance policies nationwide provide less coverage for mental illnesses than for physical illnesses. Many policies provide no mental health coverage at all. Several states have addressed this inequality of insurance coverage and many more – including Alaska – are considering action.

Studies and the experience of states that have addressed this issue demonstrate that the costs of requiring equal coverage for mental illnesses are minimal. In Alaska, for instance, providing equal insurance coverage for mental illnesses would cost employers an average of $2.62 per employee, per month. Put another way, it would amount to giving each employee a 3.5 cent per hour raise.

Why consider mental health parity?

- An estimated 44,500 Alaskans experience some form of mental illness.
- Mental illness is treatable – and often costs less to treat than common physical illnesses.
- Many people with mental illnesses want to work but can't because their medication and mental health services would not be covered in private-sector jobs. In such cases, people with mental illnesses are forced to rely on Medicaid and public assistance instead of productive employment.
- Mental health parity is cost effective. Money spent treating mental illnesses leads to higher productivity, lower absenteeism – and helps prevent more serious and costly conditions.

What is happening elsewhere?

- In 1996, Congress passed the Mental Health Parity Act. Under the legislation, certain insurance policies are required to offer the same level of annual and lifetime benefits for mental and physical illness coverage. While it was a good start, the new law has several limitations. For example, it only applies to firms with 50 or more employees, it keeps mental health coverage as optional, and it does not cover substance abuse treatment.
- Partly because the federal law did not go far enough, at least 15 states have passed their own mental health parity legislation and more than 30 others are considering action. States have adopted a wide array of solutions – some assuring limited mental health parity, others taking a more comprehensive approach.

What is happening in Alaska?

Last year, the Alaska Legislature established the Mental Health Parity Task Force to study the "differential treatment in health insurance coverage for a person with a mental disorder and a person with a physical disorder." The task force recently issued its final report, which outlines the situation in Alaska. Based on its report, the task force is recommending legislation that would:

- Assure that people needing treatment for mental illnesses and substance abuse disorders have insurance benefits equal to those of people with physical illnesses.
- Exempt employers with fewer than 20 employees.
- Make mental health coverage mandatory – rather than voluntary – for employers who offer health insurance to their employees.

Mental Health Parity Task Force

FINAL REPORT

February 1999

Representative Gary Davis, Co-Chairman
Senator John Torgerson, Co-Chairman

Executive Summary

In 1998, the Twentieth Alaska State Legislature passed Senate Concurrent Resolution 14 that established the Alaska Task Force on Parity for Mental Health. The purpose of the Task Force was to examine issues related to parity in health insurance coverage between mental health and physical health and to make recommendations to the Twenty-first Alaska State Legislature. Parity, as referred to in this report, describes the degree of equity in health care insurance between mental health coverage and medical or surgical coverage. The Task Force began meeting in August 1998 and completed its investigation in December 1998, publishing a draft report for public comment. Following public comment and Task Force deliberations, the findings and recommendations included in this report were adopted.

The U. S. Congress passed the Mental Health Parity Act of 1996 that became effective on January 1, 1998. This legislation was limited in scope and, as of April 30, 1998, 15 states had passed their own mental health parity legislation. The elements of the federal legislation that provided motivation for legislation by the various states were:

- The legislation applied only to firms with more than 50 employees;
- It provided for parity only with regard to annual and lifetime dollar limits on health care policies;
- It allowed other cost-shift mechanisms such as day/visit limits as well as disparate deductibles, co-payments, and co-insurance;
- It applied only to employers that offered mental health coverage – there was no mandate to provide such coverage;
- It did not include substance abuse; and
- It allowed employers to opt out of the mandate if they could demonstrate cost increases exceeding one percent.

The various states, in designing and implementing parity for mental health and, in some cases, substance abuse, adopted different approaches and levels of parity depending on situations existing in each state. Some states adopted very inclusive parity mandates that covered all cost-shifting mechanisms while others have taken narrower approaches more like the federal legislation. Four states, Arizona, Maine, Maryland, and North Carolina, specify minimum levels of mental health coverage.

There is no existing Alaska statute addressing mental health parity nor is mental health coverage required in health care insurance policies. Alaska Statute 21.42.365, which applies to private businesses that are not self-insured and have 20 or more employees, requires that substance abuse treatment coverage be included in health care policies. It also sets a level of parity between substance abuse coverage and medical/surgical coverage that addresses deductibles, co-payments, and co-insurance. It sets minimum benefit levels at $9,600 over two consecutive benefit years, with a $19,200 lifetime limit. These limits are adjusted for inflation every three years.

The concept of parity, both in mental health and substance abuse, is not a simple "yes or no" question. There are various elements and levels of parity ranging from narrow, highly restrictive approaches to the broader, more inclusive approaches. In examining the issue of parity, two basic dimensions must be addressed. The first dimension is that of applicability. In defining the scope of applicability, any parity mandate must address the following:

- **The conditions that will be subject to parity (also referred to as *diagnostic criteria*).** Some states have limited applicability only to conditions defined as "serious mental illness" while others include all conditions listed in the Diagnostic and Statistical Manual (DSM IV). DSM IV also identifies a number of conditions that are more related to situational problems such as personal and work place relationship problems. These types of conditions are identified within DSM IV by the assignment of "V" codes. Determinations with regard to diagnostic criteria must also address whether or not conditions identified by these "V" codes will be covered. Most health insurance policies do not currently cover services for these conditions.
- **The size of businesses subject to the mandate.** Federal legislation applies only to businesses with more than 50 employees. Alaska substance abuse mandates apply to firms with 20 or more employees. States may not impose insurance mandates on firms that are subject to the Employee Retirement Income Security Act (ERISA), the federal legislation designed to protect the retirement systems of companies that are self-insured. State insurance regulations do not apply to the employee insurance programs of governmental entities.
- **The inclusion or exclusion of substance abuse in parity mandates.**
- **Mandatory mental health coverage.** Some mandates apply to mental health coverage, if it is offered as part of the health insurance plan. Other states have chosen to require mental health coverage in all impacted health care plans.

The other dimension that must be addressed is the level of parity between mental health/substance abuse and medical/surgical benefits. There are certain *elements* of parity that define the level. These elements are:

- parity for annual and lifetime dollar limits;
- parity for days/visits limits;
- parity for maximum out-of-pocket expenses;
- parity for required deductible payments; and
- parity for co-insurance and co-payments.

For ease of analysis, the elements that define the level of parity can be grouped into discrete models. Ron Bachman, a national actuarial consultant with PricewaterhouseCoopers, developed one specific set of models. His system contains the following levels or models of parity:

MHPA Extended. MHPA refers to the federal Mental Health Parity Act of 1996. One particular model of parity is for states merely to adopt the standards of MHPA with possible increases in applicability. This requires parity for annual and lifetime dollar limits between mental health and medical/surgical benefits.

Limited Parity Model. This model extends the provisions of the MHPA model by including parity for outpatient visits and inpatient days limits.

Catastrophic Parity Model. This model includes the features of Limited Parity listed above and adds parity for maximum out-of-pocket (OOP) expense limits.

Significant Parity Model. This model includes all of the elements listed in the MHPA, Limited, and Catastrophic models and extends parity to the co-insurance and co-payment features of an insurance plan design.

Financial Parity Model. This model represents the point at which all plan reimbursement features for existing plan-eligible expenses are made on the same basis as non-mental health eligible expenses. In addition to the features of the previously listed models, this brings parity to the issue of deductibles.

One of the key factors in determining what, if any, model of parity would be appropriate for Alaska is the estimated cost of additional claims. Mr. Bachman developed cost estimates for three different models using Alaska specific data and information. The three models for which estimates were developed were the MHPA Extended Model, the Catastrophic Model, and the Financial Model. He developed estimates both with and without substance abuse included. Costs are stated in terms of percentage of increase in overall health care claims as well as in estimated "per member per month" (PMPM) premium increases. A key variable in determining costs is the type of delivery systems and penetration of managed care in the state. An assumption used in developing costs that has been confirmed as other states have implemented parity is that parity will encourage increased presence of treatment delivery systems employing managed care practices. These practices include the use of network providers, pre-authorization for certain types of treatment, in-process case review, and the use of "gatekeepers" who control access to treatment. Faced with any increases in costs due to parity, insurance carriers and employers can institute these principles or practices to help control the cost of treatment and to prevent waste and inefficiency in the system. Mr. Bachman provided cost increase estimates for two situations. The first set are estimates of the cost increases not taking any increase in managed care practices into account. The second set of estimates takes into account the anticipated increase in the use of managed care practices. In the following tables, estimates are provided in the form ***<Cost Estimate Without Managed Care Practices>/<Cost Estimate With Managed Care Practices>:***

Percentage Increase in Claims Costs with and without Managed Care Practices

	MPHA	Catastrophic Model	Financial Model
Mental Health Only	0.10%/0.04%	2.0%/0.8%	3.2%/1.3%
Mental Health/Substance Abuse	0.20%/0.08%	3.0%/1.2%	4.3%/1.7%

PMPM* Increase with and without Managed Care Practices

	MPHA	Catastrophic Model	Financial Model
Mental Health Only	$0.15/$0.06	$3.10/$1.24	$4.87/$1.95
Mental Health/Substance Abuse	$0.36/$.14	$4.51/$1.80	$6.55/$2.62

* "Per member per month" monthly premium increase

To illustrate the impact of parity in practical terms, the cost to employers for the Financial Model of parity, before any allowance is made for the introduction of managed care practices, is $6.55 per member per month in increased insurance premiums. This is analogous to an hourly pay raise of $0.087 per employee. If employers and insurance carriers implement some of the managed care principles noted above, then the $2.62 per member per month premium increase would translate into costs as little as a $0.035 per hour pay increase (both hourly increases assume a 173 hour work month and 2.3 lives covered for each employee).

Another key variable in determining costs is the number of lives covered under policies subject to any mandate. The Task Force conducted the evaluation exempting businesses with less than 20 employees. Using Department of Labor statistics, the Task Force estimated that policies of approximately 115,000 lives would be impacted. The Task Force also examined what, if any, disparity would be created between State of Alaska employees' coverage and private company coverage in the event parity was implemented (since a mandate cannot be placed on State employees' coverage). We noted that all existing state employee policies have comprehensive parity so that any parity mandate being considered by this Task Force would not create any adverse disparity for state employees.

The Task Force, after considering the research, costs, experiences of other states, and public input, recommends that legislation be developed that implements mental health parity with the following level and applicability:

Recommended Level: ***Financial Parity***

Applicability:
(1) Businesses with 20 or more employees;
(2) Self-insured (ERISA), state/local/federal government exempt;
(3) Includes substance abuse;
(4) Applies to all disorders listed in the DSM IV except "V" codes; and
(5) Mental health/substance abuse coverage required where health plans are offered by firms subject to the mandate.

One of the main objectives of implementing any level of mental health parity is to improve early access to appropriate and effective mental health treatment. Achieving this objective also brings economic benefits to families, employers and society as a whole. Many studies, both government and private, have repeatedly demonstrated the cost-effectiveness of providing such early and appropriate treatment. Studies examined as a part of the research for this project demonstrated as much as a nine dollar net return in terms of increased productivity as well as decreased employee absenteeism and turnover for every dollar spent treating mood disorders.[1] Another study, conducted at Yale University, revealed that decreasing the amount of mental health care provided in a large organization resulted in reduced work performance, increased absenteeism and an increase in general health care costs. These increased costs more than offset the amount saved by reducing services.[2] A report in the Journal of the American Medical Association in 1995 reported the results of a study that compared outcomes and cost-effectiveness of specialty mental health care by psychiatrists with less costly provision of mental health services by primary care physicians. The results were consistent with other studies that indicate the savings from reducing specialty care are lost in reduced productivity, employee turnover, and an increase in general health care costs.[3] Studies consistently show that early and appropriate mental health care makes good economic sense for business. Parity for mental health coverage is a key tool in improving access to such care.

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[1] Zhang, M., Rost, K.M., Fortney, J.C., and Smith, G.R., "Economic Returns on Treatment for Depression," Paper presented a the Eighth Biennial Research Conference on Economics of Mental Health, Bethesda, MD, 1996

[2] U. S. Department of Health and Human Services, National Institute of Mental Health, Parity in Financing Mental Health Services: Managed Care Effects on Costs, Access, and Quality, p 36, Washington, D.C., 1998

[3] Sturm, R., & Wells, K.B., "How can care for depression become more cost-effective?" Journal of the American Medical Association, 273 (1), pp 51 – 58, 1995

COMMITTEE:
House Labor & Commerce Standing Committee

DATE: February 22, 1999

Subject of meeting:

MENTAL HEALTH PARITY TASK FORCE REPORT

SIGN-IN

PLEASE PRINT!

NAME	ADDRESS (MAILING / ZIP)	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY ?
Susanne Nelson	3030 Pleasant Dr Anch. AK 99502	243-6913	NASW	No
MARIE LAVIGNE	4220 Resurrection Drive Anchorage, Alaska 99504	338-5122	NASW	No
JOHN FERENCE	SOS	4652560	DOT	NO

TCN#:

COMMITTEE TAPE LOG

COMMITTEE: LABOR & COMMERCE (H) DATE: FEBRUARY 22, 1999 TIME: 3:28pm

SUBJECT: MENTAL HEALTH PARITY TASK FORCE REPORT

MEMBERS: ROKEBERG (~~NR~~) HALCRO (AH) SANDERS (JS) NURKOWSKI (LN) HARRIS (JH) BRICE (TB) CISSNA (SC) Rep. Davis GD

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
NR	0001 (1-A) 99-	~~MEETING CALLED TO ORDER @~~
		(Note time & tape number task force
		hearing begins)
NR	0000	We continue meeting / interview at 3:28pm
GD	0027	begins overview of Task Force,
		reference Report. Recommend Comp & MH
		insurance over 20 employees not already
		covered.
Waltemeyer WM	0601	Begins interview, advocate MH coverage.
		Goes over handout
NR	1338	Fed Statutes?
State Admin SH	1355	Begins interview, technical info.
AH	1780	Several questions
SH	1844	refer to Task force member.
NR	1862	asks WM to return
WM	1873	Responds to question.
AH	1896	task force benefits
WM	1905	Correct
AH	1914	pg. 6 source
WH	1925	Center. on MS.
AH	1940	clarify
WH	1951	closer better MH.
AH	1960	MD Coverage?
WH	1966	don't know.
AH	1998	substance, college
WH	2021	predominate. don't have exact.

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
AH	2023	Hedwig
WH	2035	don't know)
AH	2045	clarify data.
SH	2081	any mistake, will review / correct
AH	2098	20 or more eliminate risk pool.
WH	2124	yes concerns)
AH	2136	Pg 24
SH	2151	yes assumptions.
NR	2162	pt.
TB	2168	address membership
NR	2189	interject —
TB	2199	Can we finish rest of presentation
WH	2201	presentation not concluded
NR	2222	Fed Assis police
SH	2240	Fed law applies to areas.
NR	2256	self insured
SH	2265	correct
NR	2268	... leave at that, sorry I thought was done.
SH	2286	begin presentation again.
NR	2410	chart mandate
SH	2416	does not have chart
NR	2417	State employees
SH	2451	NO
NR	2460	areas mandate
SH	2466	—
Jm	2477	Fed Def.
SH	2476	Def. new differently
NR	2485	Continue
SH	2487	Continue overview

PAGE: _____

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
SH	0001/6	continues tech. overview
SH	0046	walk thru 5 models & parts
NR	0101	2
SH	0104	elder, continues overview
NR	0128	co pay
SH	0130	explains
NR	0140	100%
SH	0141	yes, continues
NR	0184	most expensive model.
SH	0202	yes. --
NR	0212	could not afford
SH	0218	yes, deductible.
NR	0240	Panel
SH	0241	Next area, cost
JH	0269	VP Life & group health ins. (Hewitsen)
SH	0295	gives lead in to JH presentation.
JH	0334	Begins presentation
NR	0449	example HMO
JH	0461	POS none, no HMOs, continues presentation
NR	0502	contract, large group...
JH	0521	have PPO's — goes on
NR	0532	some elements non-Cal
JH	0546	Waiting
NR	0548	—
JH	0555	—
NR	0556	—
JH	0561	—
NR	0565	Confused
SH	0579	Cost slide-info, goes thru assumptions
		goes back to Data Attributes

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
SH	0612	Confident w/report.
NR	0639	looking for #'s last 4 yrs. drugs up his bill.
SH	0748	Very difficult to construct model
NR	0763	NO coverage
SH	0781	High Dup coverage
NR	0802	Co-payment
SH	0812	picked break pt. at 20.
NR	0860	—
SH	0861	—
NR	0866	interjects no one anyone understands
SH	0889	Yes
NR	0890	Risk pool.
SH	0908	Reliable piece Blue Cross. 38%
NR	0942	understand?
SH	0950	assumptions went in with,
NR	1047	accuracy, Parity w/in other State.
SH	1089	accuracy, Confidence w/in him
NR	1167	Ins. Industries?
SH	1175	NJ, Connecticut
NR	1214	questions
TB	1224	pass.
Lm	1226	considerable cost, state
SH	1259	not because already w/in place. Coverage if mH SA Abuse.
Lm	1293	Desperate
SH	1299	Yes
Lm	1301	pt. swell by efforts towards illness.
SH	1349	policy call take place
Lm	1358	JMP?

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
WH	1359	equality, not Cadillacs.
LH	1407	Input Chambers
WH	1416	Rep D, Chamber W/ meet level
NR	1460	join us. WH
TH	1472	explain, price.
AH	1504	level playing field understands this desire.
TH	5410	cannot ask these questions.
AH	1563	economic cost, pt as employer cannot.
TH	1614	If by. Can put in place.
SC	1642	Further, cost by related, mental conditions.
WH	1726	Couple of studies, Varies widely.
SH	1764	explained.
		Pause to change tape 4:55pm
NR	0001 JB	Re convened at 4:58pm.
LM	0001	Begin to speak, talks about report
WH	0106	Defers to GD or TB
TB	0124	Begin to explain his pt.
GD	0258	Begin to explain his pt.
LM	0336	Thank you
TH	0337	usually against this, but is for this plan.
AH	0431	Data is quantifiable, balanced gathered all data available. Competition of task force.
WH	0525	
GD	0618	sentiments came out during task force. Will hear from people when leg is introduced

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
NR	0652	basic materials?
GD	0665	Mr Chairman....
NR	0676	Continues w/ question.
SH	0701	Act meeting pushed range.
		passed 3
NR	0757	—
SH	0758	- w/and w/o substance abuse
NR	0771	Small bz.
JH	0787	2
TB	0790	answers question did set range.
NR	0864	no basis to who was on comm. be has basis
GD	0893	No more questions, good debate.
NR	0909	closing questions? Timing actual
		#15
GD	0926	prelim.
SH	0930	1st wk Jan. (range)
NR	0948	important pt. can com. himself.
		numbers. 32, 33rd
NR	1090	close. thank you. adjourned at 5:14pm

Mental Health Parity Task Force

FINAL REPORT

February 1999

Representative Gary Davis, Co-Chairman
Senator John Torgerson, Co-Chairman

Executive Summary

In 1998, the Twentieth Alaska State Legislature passed Senate Concurrent Resolution 14 that established the Alaska Task Force on Parity for Mental Health. The purpose of the Task Force was to examine issues related to parity in health insurance coverage between mental health and physical health and to make recommendations to the Twenty-first Alaska State Legislature. Parity, as referred to in this report, describes the degree of equity in health care insurance between mental health coverage and medical or surgical coverage. The Task Force began meeting in August 1998 and completed its investigation in December 1998, publishing a draft report for public comment. Following public comment and Task Force deliberations, the findings and recommendations included in this report were adopted.

The U. S. Congress passed the Mental Health Parity Act of 1996 that became effective on January 1, 1998. This legislation was limited in scope and, as of April 30, 1998, 15 states had passed their own mental health parity legislation. The elements of the federal legislation that provided motivation for legislation by the various states were:

- The legislation applied only to firms with more than 50 employees;
- It provided for parity only with regard to annual and lifetime dollar limits on health care policies;
- It allowed other cost-shift mechanisms such as day/visit limits as well as disparate deductibles, co-payments, and co-insurance;
- It applied only to employers that offered mental health coverage – there was no mandate to provide such coverage;
- It did not include substance abuse; and
- It allowed employers to opt out of the mandate if they could demonstrate cost increases exceeding one percent.

The various states, in designing and implementing parity for mental health and, in some cases, substance abuse, adopted different approaches and levels of parity depending on situations existing in each state. Some states adopted very inclusive parity mandates that covered all cost-shifting mechanisms while others have taken narrower approaches more like the federal legislation. Four states, Arizona, Maine, Maryland, and North Carolina, specify minimum levels of mental health coverage.

There is no existing Alaska statute addressing mental health parity nor is mental health coverage required in health care insurance policies. Alaska Statute 21.42.365, which applies to private businesses that are not self-insured and have 20 or more employees, requires that substance abuse treatment coverage be included in health care policies. It also sets a level of parity between substance abuse coverage and medical/surgical coverage that addresses deductibles, co-payments, and co-insurance. It sets minimum benefit levels at $9,600 over two consecutive benefit years, with a $19,200 lifetime limit. These limits are adjusted for inflation every three years.

The concept of parity, both in mental health and substance abuse, is not a simple "yes or no" question. There are various elements and levels of parity ranging from narrow, highly restrictive approaches to the broader, more inclusive approaches. In examining the issue of parity, two basic dimensions must be addressed. The first dimension is that of applicability. In defining the scope of applicability, any parity mandate must address the following:

- **The conditions that will be subject to parity (also referred to as *diagnostic criteria*).** Some states have limited applicability only to conditions defined as "serious mental illness" while others include all conditions listed in the Diagnostic and Statistical Manual (DSM IV). DSM IV also identifies a number of conditions that are more related to situational problems such as personal and work place relationship problems. These types of conditions are identified within DSM IV by the assignment of "V" codes. Determinations with regard to diagnostic criteria must also address whether or not conditions identified by these "V" codes will be covered. Most health insurance policies do not currently cover services for these conditions.
- **The size of businesses subject to the mandate.** Federal legislation applies only to businesses with more than 50 employees. Alaska substance abuse mandates apply to firms with 20 or more employees. States may not impose insurance mandates on firms that are subject to the Employee Retirement Income Security Act (ERISA), the federal legislation designed to protect the retirement systems of companies that are self-insured. State insurance regulations do not apply to the employee insurance programs of governmental entities.
- **The inclusion or exclusion of substance abuse in parity mandates.**
- **Mandatory mental health coverage.** Some mandates apply to mental health coverage, if it is offered as part of the health insurance plan. Other states have chosen to require mental health coverage in all impacted health care plans.

The other dimension that must be addressed is the level of parity between mental health/substance abuse and medical/surgical benefits. There are certain *elements* of parity that define the level. These elements are:

- parity for annual and lifetime dollar limits;
- parity for days/visits limits;
- parity for maximum out-of-pocket expenses;
- parity for required deductible payments; and
- parity for co-insurance and co-payments.

For ease of analysis, the elements that define the level of parity can be grouped into discrete models. Ron Bachman, a national actuarial consultant with PricewaterhouseCoopers, developed one specific set of models. His system contains the following levels or models of parity:

MHPA Extended. MHPA refers to the federal Mental Health Parity Act of 1996. One particular model of parity is for states merely to adopt the standards of MHPA with possible increases in applicability. This requires parity for annual and lifetime dollar limits between mental health and medical/surgical benefits.

Limited Parity Model. This model extends the provisions of the MHPA model by including parity for outpatient visits and inpatient days limits.

Catastrophic Parity Model. This model includes the features of Limited Parity listed above and adds parity for maximum out-of-pocket (OOP) expense limits.

Significant Parity Model. This model includes all of the elements listed in the MHPA, Limited, and Catastrophic models and extends parity to the co-insurance and co-payment features of an insurance plan design.

Financial Parity Model. This model represents the point at which all plan reimbursement features for existing plan-eligible expenses are made on the same basis as non-mental health eligible expenses. In addition to the features of the previously listed models, this brings parity to the issue of deductibles.

One of the key factors in determining what, if any, model of parity would be appropriate for Alaska is the estimated cost of additional claims. Mr. Bachman developed cost estimates for three different models using Alaska specific data and information. The three models for which estimates were developed were the MHPA Extended Model, the Catastrophic Model, and the Financial Model. He developed estimates both with and without substance abuse included. Costs are stated in terms of percentage of increase in overall health care claims as well as in estimated "per member per month" (PMPM) premium increases. A key variable in determining costs is the type of delivery systems and penetration of managed care in the state. An assumption used in developing costs that has been confirmed as other states have implemented parity is that parity will encourage increased presence of treatment delivery systems employing managed care practices. These practices include the use of network providers, pre-authorization for certain types of treatment, in-process case review, and the use of "gatekeepers" who control access to treatment. Faced with any increases in costs due to parity, insurance carriers and employers can institute these principles or practices to help control the cost of treatment and to prevent waste and inefficiency in the system. Mr. Bachman provided cost increase estimates for two situations. The first set are estimates of the cost increases not taking any increase in managed care practices into account. The second set of estimates takes into account the anticipated increase in the use of managed care practices. In the following tables, estimates are provided in the form ***<Cost Estimate Without Managed Care Practices>/<Cost Estimate With Managed Care Practices>:***

Percentage Increase in Claims Costs with and without Managed Care Practices

	MPHA	Catastrophic Model	Financial Model
Mental Health Only	0.10%/0.04%	2.0%/0.8%	3.2%/1.3%
Mental Health/Substance Abuse	0.20%/0.08%	3.0%/1.2%	4.3%/1.7%

PMPM* Increase with and without Managed Care Practices

	MPHA	Catastrophic Model	Financial Model
Mental Health Only	$0.15/$0.06	$3.10/$1.24	$4.87/$1.95
Mental Health/Substance Abuse	$0.36/$.14	$4.51/$1.80	$6.55/$2.62

* "Per member per month" monthly premium increase

To illustrate the impact of parity in practical terms, the cost to employers for the Financial Model of parity, before any allowance is made for the introduction of managed care practices, is $6.55 per member per month in increased insurance premiums. This is analogous to an hourly pay raise of $0.087 per employee. If employers and insurance carriers implement some of the managed care principles noted above, then the $2.62 per member per month premium increase would translate into costs as little as a $0.035 per hour pay increase (both hourly increases assume a 173 hour work month and 2.3 lives covered for each employee).

Another key variable in determining costs is the number of lives covered under policies subject to any mandate. The Task Force conducted the evaluation exempting businesses with less than 20 employees. Using Department of Labor statistics, the Task Force estimated that policies of approximately 115,000 lives would be impacted. The Task Force also examined what, if any, disparity would be created between State of Alaska employees' coverage and private company coverage in the event parity was implemented (since a mandate cannot be placed on State employees' coverage). We noted that all existing state employee policies have comprehensive parity so that any parity mandate being considered by this Task Force would not create any adverse disparity for state employees.

The Task Force, after considering the research, costs, experiences of other states, and public input, recommends that legislation be developed that implements mental health parity with the following level and applicability:

Recommended Level: *Financial Parity*

Applicability:
(1) Businesses with 20 or more employees;
(2) Self-insured (ERISA), state/local/federal government exempt;
(3) Includes substance abuse;
(4) Applies to all disorders listed in the DSM IV except "V" codes; and
(5) Mental health/substance abuse coverage required where health plans are offered by firms subject to the mandate.

One of the main objectives of implementing any level of mental health parity is to improve early access to appropriate and effective mental health treatment. Achieving this objective also brings economic benefits to families, employers and society as a whole. Many studies, both government and private, have repeatedly demonstrated the cost-effectiveness of providing such early and appropriate treatment. Studies examined as a part of the research for this project demonstrated as much as a nine dollar net return in terms of increased productivity as well as decreased employee absenteeism and turnover for every dollar spent treating mood disorders.[1] Another study, conducted at Yale University, revealed that decreasing the amount of mental health care provided in a large organization resulted in reduced work performance, increased absenteeism and an increase in general health care costs. These increased costs more than offset the amount saved by reducing services.[2] A report in the Journal of the American Medical Association in 1995 reported the results of a study that compared outcomes and cost-effectiveness of specialty mental health care by psychiatrists with less costly provision of mental health services by primary care physicians. The results were consistent with other studies that indicate the savings from reducing specialty care are lost in reduced productivity, employee turnover, and an increase in general health care costs.[3] Studies consistently show that early and appropriate mental health care makes good economic sense for business. Parity for mental health coverage is a key tool in improving access to such care.

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[1] Zhang, M., Rost, K.M., Fortney, J.C., and Smith, G.R., "Economic Returns on Treatment for Depression," Paper presented a the Eighth Biennial Research Conference on Economics of Mental Health, Bethesda, MD, 1996

[2] U. S. Department of Health and Human Services, National Institute of Mental Health, Parity in Financing Mental Health Services: Managed Care Effects on Costs, Access, and Quality, p 36, Washington, D.C., 1998

[3] Sturm, R., & Wells, K.B., "How can care for depression become more cost-effective?" Journal of the American Medical Association, 273 (1), pp 51 – 58, 1995

Table of Contents

Introduction

Background. The U. S. Congress passed the Mental Health Parity Act of 1996 that became effective on January 1, 1998. As of April 30, 1998, 15 states had passed mental health parity legislation in one form or another while another 25 states had introduced legislation[4]. In 1998, the Twentieth Alaska State Legislature passed Senate Concurrent Resolution 14 (SCR 14) establishing the Alaska Task Force on Parity for Mental Health. The purpose of the Task Force was to examine the issues related to parity in health insurance coverage between mental health and physical health.

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

- On a national level, mental illness costs are estimated to be more than $150 billion annually for treatment, costs of social service and disability payments, lost productivity, and premature mortality. Schizophrenia alone accounts for $30 billion of those costs.
- While costs are staggering, there is clear evidence that early and appropriate treatment can significantly reduce the costs. For example, lithium therapy for manic depressive illness is estimated to have saved the U. S. economy more than $145 billion since 1970. Clozapine treatment for schizophrenia saves an average of $23,000 per patient annually, largely by reducing the need for hospitalization.
- An analysis conducted for the U. S. Senate Appropriations Committee projected that appropriate and timely treatment for severe mental disorders would produce a 10 percent reduction in the use and cost of medical services by people with these illnesses, yielding a savings greater than the cost of providing the treatment.
- A new type of medication combined with appropriate therapy has been shown to reduce symptoms in 80 percent of individuals suffering from obsessive compulsive disorder[5].

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

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

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[4] U.S. Department of Health and Human Services, National Institute of Mental Health, Parity in Financing Mental Health Services: Managed Care Effects on Costs, Access, and Quality, p 57, Washington, D.C., 1998.

[5] U.S. Department of Health and Human Services, National Institute of Mental Health, Mental Illness in America: The National Institute of Mental Health Agenda, pp 1-2, Washington, D.C., 1998.

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

Methodology. In accomplishing its objectives, the Task Force and support staff used the following methods:

Public Input. The Task Force held public meetings on:

August 19, 1998 – Alaska Psychiatric Institute, Anchorage, Alaska
September 1, 1998 – Alaska Psychiatric Institute, Anchorage, Alaska
October 1, 1998 – Teleconference
October 26, 1998 – Leg.slative Information Office, Anchorage, Alaska
December 7, 1998 – Alaska Psychiatric Institute, Anchorage, Alaska
December 30, 1998 – Teleconference
January 13, 1999 – Legislative Information Office, Anchorage, Alaska

At the October 26 meeting, a specific two-hour time period was set aside for in-person public comment and an additional two-hour slot for telephone testimony. At this meeting, a total of 21 people testified and another 10 attended but did not testify. On January 13, 1999, a meeting of the Task Force was held specifically to receive public comment on the Draft Report that was published on December 31, 1998. At that meeting, a total of seven members from the public attended with one giving testimony.

In addition to testimony provided at Task Force meetings, the contractor contacted key stakeholder groups to appraise them of the process and offer the opportunity for comment. Among those groups were the National Federal of Independent Businesses, Alaska Chamber of Commerce, and the Health Insurance Association of America. Representatives from provider and consumer groups participated actively in the meetings. These parties were provided with copies of the draft report when it was published.

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

Publicity. To inform the public of the proceedings, all meetings of the Task Force were publicized in the Anchorage Daily News. In addition, a project description, schedule, and meeting notices as well as the Task Force membership directory were published on the contractor Internet web site. Advocacy groups from consumers, providers, and the insurance industry also helped to publicize the process. Copies of the draft report were distributed to mental health providers, advocacy organizations, grantees, representatives of the insurance industry, the National Federation of Independent Businesses, the Alaska Chamber of Commerce, various lobbyists, and consumers (as requested). The draft was also posted as an Adobe

Acrobat® document on the C & S Management Internet web site. When requested, copies of agenda, minutes, and research were provided to interested organizations or individuals.

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

Project Support. Administrative and logistics support for the project was provided by Ms. Julie Tauriainen from Representative Davis' office, the Alaska Mental Health Board, and the contractor, C & S Management Associates.

Existing Legislation: Federal/Other States

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

- The law requires equality between mental health and physical health for insurance coverage purposes with regard to aggregate lifetime and annual limits. It allows differential treatment with regard to limits on days/visits.
- The law covers mental illness; it does not cover substance abuse.
- The law exempts small businesses with 50 employees or less.
- The law applies to both fully insured state-regulated health plans and self-insured plans that are exempt under ERISA.
- The law applies only to employers who offer mental health coverage; it does not mandate employers to offer such coverage.
- State laws that require equal or greater parity are not prohibited or preempted by this law.
- The law allows an increased cost exemption; employers who can demonstrate a one percent or more rise in costs due to parity implementation are allowed to exempt themselves from the law.
- The law does not place restrictions on businesses' ability to manage care.

One of the issues with this law that provides incentive for additional legislation is that the only real element of parity addressed is the annual and lifetime limits differential. The elimination of this differential is offset by the fact that employers can set restrictions on the number of hospital days or outpatient visits annually, which has the same effect as differential annual dollar limits. Another issue with the law is that there is no mandate for impacted employers to include mental health coverage in their health insurance policies. This allows companies to drop mental health coverage rather than implementing parity. While the law does allow businesses that experience a one percent increase in costs because of parity to exempt themselves, it is unclear how much impact this will have since the law only went into effect on January 1, 1998.

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

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

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

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

Features recently enacted legislation in Arizona, Missouri, and South Carolina, are not reflected in the Table 1. Some specific experiences of other states as they implemented mental health parity are included below.

Arizona

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

or out-of-pocket expenses. For Arizona, the equating of financial requirements required combined limits rather than "separate but equal."

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

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

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

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

Column Descriptions.

Type of Delivery System: This describes the types of systems used for providing services ranging from the fee-for service type of system to the HMO and Gatekeeper models.

Distribution: This is the percentage of each type of the four types of delivery systems as they exist in Arizona.

Partial: This column shows the estimate of cost of claims increases for Partial Parity – the model that merely extends the features of the MHPA to include parity for inpatient days and outpatient visits.

SMI: This column shows the estimate of cost of claims increases for Full Parity (next column) only when the diagnosis identifies a serious mental illness.

Full Parity: This column shows the estimated cost of claims increases for Full Parity. Full Parity requires equity between mental health and medical benefits with separate but equal cost-sharing provisions.

Comprehensive Parity: This column shows the estimated cost of claims increases for Comprehensive Parity. Comprehensive parity requires equity between mental health and medical benefits with composite cost-sharing provisions.

A more complete discussion of the various models of parity is provided on page 16.

The increases noted above are estimated increases in the cost of claims. While increases in costs of claims should drive an increase in the amount of policy premiums, the exact relationship between costs of claims and premium increases is not clear. The composite gross figure is the expected increase before any additional cost containment actions by employers and/or insurers. The composite net is the expected increase taking anticipated cost containment measures into

account. Because this is new legislation (1998) there is no quantitative data on actual experience.[6]

Maryland

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

- equal inpatient day coverage; at least 60 days of partial hospitalization;
- no visit limits for outpatient visits; co-insurance amounts increase with the number of visits;
- benefits may be delivered in a managed care setting;
- parity of maximum out-of-pocket expenses; and
- parity for deductibles and co-insurance.

The legislation went into effect on July 1, 1995. During the year after transition, several rigorous studies were conducted using data from major managed care companies in the state. The first set of data examined represented the experience of 650,000 employees and dependents using a combination of delivery systems. In terms of utilization, the study noted that the number of mental health inpatient admissions increased slightly during the first year but the cost was more than offset by significantly lower lengths of stay. Overall, mental health outpatient utilization decreased. In terms of cost increases, the premium costs increased slightly during the transition but then returned to pre-parity levels. A different managed care company confirmed that their cost increases were less than one percent during the first seven months following the transition to parity.[7] We were not able to locate reliable data for the years following the first year after transition to parity.

Rhode Island

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

Cost increases experienced in Rhode Island following the implementation of mental health parity legislation were less than one percent. A notable result of implementing limited mental health parity in Rhode Island was a marked shift toward greater managed care. As expected, premiums

[6] Ronald E. Bachman, F.S.A., M.A.A.A., An Actuarial Analysis of Comprehensive Mental Health Benefits and Other Options for Improved Coverages in the State of Arizona, p 17, Atlanta, Georgia, 1998.

[7] U.S. Department of Health and Human Services, National Institute of Mental Health, Parity in Coverage of Mental Health Services in an Era of Managed Care: An Interim Report to Congress by the National Advisory Mental Health Council, p 19, Washington, D.C., 1997

for the traditional fee-for-service plans increased and, as a result, subscriptions in the lower cost managed care plans increased five-fold.[8]

Other States – General

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

- presence and strength of advocacy groups on each side of the issue;
- state demographics;
- characteristics of the health care delivery systems; and
- economic issues.

Alaska Legislation – Substance Abuse.

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

- This legislation mandated that substance abuse coverage be included in health insurance policies written in Alaska.
- The benefits must be at least $9,600 over two consecutive benefit years.
- The lifetime benefits must be at least $19,200.
- The benefits specified above must be adjusted for inflation every three years.
- The legislation provided for parity for substance abuse insurance in terms of co-payments and deductibles.
- The legislation provided for parity in terms of claim payment methodology, second opinion or pre-notification policies, or other coverage issues.
- The statute applies to employers with 20 or more employees only.

[8] ibid. p 20

Mental Health Parity Options

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

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

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

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

Mandatory vs. Optional

Some states have required that all health insurance policies written contain coverage for mental health while it is optional in other states. While there is no data indicating that companies are dropping mental health coverage as parity is implemented, if that coverage is not required firms, could drop employees' mental health coverage if the costs become onerous. Making mental health coverage mandatory prevents companies from dropping coverage, an action that decreases the size of the risk pool.

Substance Abuse

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

Diagnostic Criteria

Although technically not an element of parity, the diagnostic criteria used to determine which disorders are covered by parity mandates is a tool that is used to shape the impact of parity on consumers, providers, insurance carriers, and employers. The most restrictive criteria in use today is that of ***serious mental illness*** (see definition in glossary section). In this case, only care for disorders classified as serious mental illnesses would be covered under a parity mandate. Some states have taken more descriptive approaches by specifically identifying each disorder covered. Another approach is to use all disorders identified in the Diagnostic and Statistical Manual (DSM IV) as the criteria for application of parity. The DSM IV, however, includes some disorders that are more related to situations than mental illness such as relationship or workplace problems. These types of disorders are usually not covered by health insurance policies and are identified in the DSM IV by the assignment of "V" codes. A common approach to diagnostic criteria used in many states is to use all disorders listed in the DSM IV except for disorders represented by "V" Codes.

Other Features

There are other tools available to insurance carriers and employers that are technically not elements of parity but impact parity by limiting the applicability. One such tool is limiting the services that may be covered under parity provisions. Mental health services typically exempted under such provisions include marriage counseling, psychoanalysis or psychotherapy credited toward earning a degree, and services and supplies that are not

considered medically necessary. Small business exemptions are also used in legislation to impact the costs of parity. Finally, there have been some instances in which provisions of mental health parity have applied only to certain types of providers such as psychologists, psychiatrists, etc.

Existing Parity Models.[9] The following models, developed by Mr. Ron Bachman, each contain certain elements of parity that are described above.

Mental Health Parity Act Model. The federal Mental Health Parity Act (MHPA) prevents differing lifetime or annual dollar limitations between mental health and non-mental health insurance coverage. The MHPA does not require or mandate that mental health coverage be provided under any plan. If mental health coverage is provided, however, the plan cannot impose annual or lifetime dollar limitations on mental health coverage that are not imposed on coverage for non-mental health conditions. This model, when enacted at the state level, applies these limitations to whatever population that the individual state selects. The estimated cost, at the national level, for implementation of this model is 0.13 percent of total plan costs.

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

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

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

[9] Ronald E. Bachman, F.S.A., M.A.A.A., Mental Health: Parity Issues and Costs, pp IV-1 – IV-4, Atlanta, Georgia, 1998.

mandated. The estimated costs of implementation at the national level if coverage is mandated are 1.6 percent, assuming that all other elements of the coverage remain the same.

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

In the previous models, Mr. Bachman also notes that the increases will likely be mitigated significantly by available cost controls within each model and the increased use of managed care practices. This is a realistic expectation according to the U. S. Department of Health and Human Services.[10]

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

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

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

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

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

Impact of Delivery Systems on Costs of Parity. When describing models of mental health parity and the associated implementation costs, it is necessary to include a discussion of health care delivery systems since they have a significant impact on costs. Cost estimates are provided in terms of increased cost of claims; not increased cost of premiums and were obtained from PricewaterhouseCoopers' principal Ron Bachman in his publication Mental Health: Parity Issues and Costs, and from the SAMHSA publication The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits. The mental health treatment delivery system in Alaska is dominated by fee-for-service and managed indemnity delivery systems.

[10] U. S. Department of Health and Human Services, National Institute of Mental Health, Parity in Financing Mental Health Services: Managed Care Effect on Cost, Access, and Quality, p 45, Washington, D.C., 1998.

Fee-for-Service (FFS). FFS delivery systems are the most expensive because there is relatively little systematic emphasis on cost control. Providers of services are paid on a per-service basis for any services they deliver. Enrollees can typically use any provider they choose with the provider being paid for the services either based on charges or on some determination of customary fees. Mr. Bachman estimates costs for implementation of mental health parity are the highest for this delivery model with those costs ranging from 0.9 percent to 1.3 percent for partial parity (see discussion above), and from 2.7 percent to 4.9 percent for comprehensive parity. SAMHSA, using several different models, suggests that FFS systems faced with implementation of mental health parity will evolve and witness a much greater penetration of managed care, which will serve to dampen costs. They cite several experiences where, following implementation of parity and subsequent penetration of managed care, mental health costs actually declined.[11]

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

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

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

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

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

Estimates of Cost: Actuarial Studies

General. Mr. Ron Bachman of PricewaterhouseCoopers provided the following discussion and cost estimates in a letter to the Task Force dated January 8, 1999. The cost estimates are based on that firm's proprietary algorithms. The calculations outline the impact of potential mental health and substance abuse legislation in Alaska. Actual legislative language, if developed, may alter the results up or down. Cost estimates shown are (1) for mental health only and (2) for mental health and substance abuse combined. The cost projections are higher than national averages due to three key factors specific to Alaska. One, the current coverage levels of mental health and substance abuse are low. This is true in spite of the substance abuse mandate that requires more up-front reimbursements through equalized deductible and co-insurance rates. The $9,600 over two consecutive years; $19,200 lifetime limit is less than generally available elsewhere. Second, the current level of managed care in Alaska is very low. Most of the 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.

Delivery Systems. 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 (pre-admission certification and continued stay review) generally applies only 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 cost sharing 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.

Parity Options. The following is a summary of the three parity options priced within the four delivery systems:

Mental Health Parity Act (MHPA). This is limited parity for mental health and substance abuse for annual/lifetime dollar limits. It is consistent with the federal legislation except that it is applicable to groups with 20 or more employees, includes substance abuse coverage, and mental health and substance abuse coverage is mandated.

Catastrophic Parity. This requires parity for any lifetime/annual/episode limits, day and visit limits, and maximum out-of-pocket provisions. It does not require parity for deductibles, co-payments, or co-insurance (except after any maximum out-of-pocket limit).

Comprehensive Parity. This requires financial parity with mental health and substance abuse benefits reimbursed under health insurance plans on the same basis as medical/surgical benefits.

Cost Estimates. The following are cost estimates for mental health and combined mental health and substance abuse parity. The cost increases are based on the cost of claims. Composite market analyses represent the aggregate of the costs over the various distribution systems before any impact of increased managed care. The net composite information takes into account efforts by employers and carriers to contain costs through a variety of mechanisms including increased cost share, lower overall benefits, or managed care.

Table 2 - Mental Health Only				
		Percentage Increase of Claims Filed in Base Medical Plan for Change to Type of Parity		
Type of Delivery System	**Distribution**	**MHPA**	**Catastrophic**	**Comprehensive**
1. Fee for Service	20%	0.1%	2.6%	3.7%
2. Managed Indemnity	55%	0.1%	2.0%	3.1%
3. PPO & POS	20%	0.1%	1.6%	3.4%
4. HMO & Gatekeeper	5%	0.1%	1.8%	2.3%
Composite Market Information				
Composite Market Analysis		0.1%	2.0%	3.2%
Composite PMPM*		$0.15	$3.10	$4.87
Net Composite Market Information				
Net Market Impact		0.04%	0.8%	1.3%
Net PMPM Impact*		$0.06	$1.24	$1.95

*PMPM – "Per member per month"

Table 3, which follows, provides these analyses for a plan that includes both mental health and substance abuse. Certain assumptions were made as to the impact on parity relative to the existing substance abuse 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 co-insurance coverage would be decreased to 50%, generally. In spite of these tradeoff limitations, we estimated the cost of the substance abuse coverage to increase slightly.

Under the catastrophic option, the equalized deductible and co-insurance 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%. The deductible and co-insurance value of the existing substance abuse legislation, however, is particularly important to those using outpatient and very short-term inpatient (detox) care.

Table 3 - Mental Health and Substance Abuse				
		Percentage Increase of Claims Filed in Base Medical Plan for Change to Type of Parity		
Type of Delivery System	**Distribution**	**MHPA**	**Catastrophic**	**Comprehensive**
1. Fee for Service	20%	0.3%	4.1%	5.4%
2. Managed Indemnity	55%	0.2%	3.0%	4.1%
3. PPO & POS	20%	0.2%	2.1%	4.1%
4. HMO & Gatekeeper	5%	0.3%	2.2%	2.7%
Composite Market Information				
Composite Market Analysis		0.2%	3.0%	4.3%
Composite PMPM*		$0.36	$4.51	$6.55
Net Composite Market Information				
Net Market Impact		0.08%	1.2%	1.7%
Net PMPM Impact*		$0.14	$1.80	$2.62

*PMPM – "Per member per month"

The PricewaterhouseCoopers 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. We 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;
- intensively negotiating lower provider costs;
- cutting plan administrative costs;
- increasing plan cost sharing by members;
- increasing premium contributions by members;
- reducing other benefits; and, in the extreme;
- dropping plan coverages and reducing wages (or reducing wage increases).

The Potential Impact of Mental Health Parity Legislation

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

Applicability

ERISA. Under the terms of ERISA, non-government employers who offer self-insured health plans will be exempt from any mental health parity legislation. In Alaska, this accounts for a significant portion of the lives covered under health insurance plans. All large private companies who are self-insured would be exempt.

Governmental Entities. Health insurance for state employees as well as federal and local government employees would be exempt.

Policies Written Outside Alaska. Some companies operating in Alaska have their headquarters and offices in other states. Employees' health plans for these types of operations are sometimes written outside Alaska and, therefore, they would also be exempt.

Small Businesses. A major concern in implementing any changes in health insurance mandates in Alaska is the impact on small businesses. Alaska Statute 45.21.56 defines a small business for certain purposes as those having from 2 to 100 employees. For purposes of this report and the included recommendations, this definition does not apply. The following analyses were conducted assuming an exemption for businesses with less than 20 employees.

A Note on Methodology. There are a number of factors and assumptions that introduce the possibility of error. These factors include uncertainty about the percentage of small businesses providing coverage for their employees, uncertainty regarding the extent to which dependents of small business employees are covered, and timing differences for the data. Some data represents conditions existing at the time of the report while other information is based on 1997 data. Another source of uncertainty is that the number of lives covered is based on a small sample of the insurance companies operating in the state. The different sources of error impact the results in different directions so it is difficult to speculate on whether the estimates are high or low. The following analyses represent our best estimate of the number of impacted employees and lives covered. We recognize that these numbers might vary as much as ten percent in either direction. In many of the following computations, we will employ rounding to the nearest one thousand in recognition that many of the figures are estimates.

Number/Size of Employers. According to the Alaska Department of Labor, there were 11,997 small businesses with less than 20 employees in 1997. This represents 86% of the businesses in Alaska. There were 1,916 firms that employed between 20 and 50 employees. The numbers begin to fall off dramatically for firms with more than 50 employees.

Number of Employees	Number of Firms
1 – 19	11,997
20 – 49	1,224
50 – 99	395
101 – 249	241
251 – 499	88
Over 500	75

Data Source: Alaska Department of Labor

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

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

Employer/Employee Information

Estimated 1997 Alaska Private Sector Small Business* Employees:

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

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

Data Source: Alaska Department of Labor

Estimate of Small Business Employees Covered by Health Insurance

While we can estimate the number of employees working for firms with less than 20 employees, we must still know what percentage of these are covered by health care insurance. Based on reports from five states, the incidence of health insurance for specific size companies are estimated as follows:

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

Data Source: Coopers & Lybrand Actuarial Analyses

These figures represent the percentages of employers within each size category that offer health care insurance. For purposes of this analysis, we assume that the proportion of employers offering insurance is approximately the same as the proportion of small business employees covered by health insurance. For our analyses we used the following proportions: 1 through 4 employees – 40%; 5 through 9 employees – 60%; 10 through 19 employees – 75%. In using these percentages, we also assume that the percentages of covered small business employees in Alaska are comparable to the percentage covered in other states.

Applying these ratios to the numbers of employees in each size category we find:

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

Total Small Business Employees Covered by Health Insurance: 48,267 or approximately **48,000**

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

Non-ERISA Lives Covered in Alaska

To determine the number of non-ERISA lives covered in Alaska, we contacted individual insurance companies and requested estimates from them. The four firms listed below represent four of the top five companies in terms of market share. Market share, as used in this report, refers to the share of the dollar amount of premiums written. By using the percentage market share in conjunction with the estimates of lives covered, we can arrive at an approximation of the total number of lives covered in the state.

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

The above figures were obtained from two different sources. The market share information was obtained from the State of Alaska Division of Insurance while the number of lives covered was obtained from individual carriers based on their records or estimates. There are a number of

mechanisms that present sources of error. First, there is not a perfect correlation between market share (based on the amount of premiums) and the number of lives covered. Second, there are obvious timing differences. The market share information covers 1997 while the lives covered represents current data. For this reason, extrapolating a total number of covered lives based on the individual companies' data will each yield different results. We used four of the top five carriers in the aggregate in an attempt to minimize the error.

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

Lives Covered – Method 1

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

Total Lives Covered = (18,463/16.9%) + 60,000
Total Lives Covered = 109,248 + 60,000

Total Lives Covered = 169,248 or 169,000

Lives Covered – Method 2

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

Total Lives Covered = Blue Cross Lives / Blue Cross Market Share
Total Lives Covered = 60,000 / 38%

Total Lives Covered = 157,894 or 158,000

Averaging the two, we end up with an estimate of total non-ERISA lives covered in Alaska of approximately **163,000**.

Data Source: Key Informant Interviews 11/98

Adjustment for Small Business Employees

We next needed to reduce this figure to account for businesses with less than 20 employees. As stated before, there is uncertainty with regard to the actual percentage of small business employees who are insured as well as the extent to which dependents are covered under small business health insurance policies. Using the data derived in the analysis of small businesses, we note that approximately 48,000 small business employees are likely to be covered by health insurance. Adjusting for this in the total number of lives covered we find:

Total Lives Covered:	163,000
Less Small Business Employees:	- 48,000
Total Impacted Lives Covered	**115,000**

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

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

Concerns of Major Stakeholder Groups

General. The following is a summary of the concerns of major stakeholder groups based on key informant interviews, written comment, and testimony given before the Task Force.

Consumers. Key informant interviews and testimony provided to the Task Force repeatedly advanced the concern that individuals and families are frequently brought to the brink of financial ruin because of inadequate mental health and substance abuse benefits. They cited benefit levels that were widely disparate with the medical and surgical benefits in their plans. Once they exhaust their coverage, they revert to public treatment systems. This often means changing providers and ending treatment relationships that have, to that point, been productive and helpful. Among those consumers who closely monitor their benefit utilization, some indicated that they have sometimes chosen not to receive treatment when needed in order to conserve benefits. This has unnecessarily led to emergencies and more intensive treatment than would have otherwise been needed. Mental illness and substance abuse disorders are treatable. With early and appropriate treatment, people who experience these illnesses can continue to function as productive members of society. Many find, however, that when their insurance coverage is exhausted, they are forced to quit their jobs in order to qualify for Medicaid or other publicly funded care.

Treatment Providers. The key concern expressed by providers of mental health and substance abuse treatment was that, faced with the exhausted insurance benefits and high costs, patients and families of patients frequently elect to forego needed treatment. Long-term, however, electing not to receive care can lead to crises and the requirement for care at a much more intensive level such as hospitalization. They also cite concerns that patients who exhaust their benefits frequently revert to the public treatment system ending productive relationships and placing additional pressure on an already overburdened system. As with consumers, treatment providers told the Task Force that mental illness and substance abuse disorders are treatable. Providing parity between mental health/substance abuse coverage and medical/surgical coverage in health insurance will help to assure that people receive early and appropriate treatment.

Insurance Industry. The insurance industry expressed a general opposition to parity mandates for several reasons. First, a parity mandate carries a cost that, from the insurance industry point of view, will ultimately be passed on to the purchaser of the plans. One of the response options for employers would be to discontinue health care benefits rather than absorb the premium increases. This leads to fewer people insured. A second concern is that employers are forced to purchase coverage that they may not otherwise need or choose. Spending money on an unwanted or unneeded option reduces their ability to purchase other needed or wanted options.

Employers. The Task Force provided a draft copy of the report to several organizations representing employers including the National Federation of Independent Businesses (NFIB) and the Alaska State Chamber of Commerce. The feedback received was very similar to that from the insurance industry. Specifically, they stated that mental health parity in Alaska would unduly target small business owners who can least afford to pay the cost increase. They further indicated that, although the costs associated with this particular issue might seem small, they become a part of overall cost increases that, in difficult economic times, puts undue burden on small business owners. They argue, as did the insurance industry, that placing these types of

mandates on small business owners could result in an overall decrease in health care coverage for small business employees since many owners might choose to discontinue coverage rather than to absorb the cost of the mandates. In cases where employers choose to continue coverage, they could pass the additional costs along to employees in the form of salary reductions or reductions in other benefits; a tradeoff that employees might not want.

The Task Force will continue to work with stakeholder groups to gather and consider further input.

Task Force Recommendations

General. The Task Force, having studied the various issues and elements of mental health parity, initially developed a set of three different models for consideration. In developing the recommendations, the Task Force carefully considered key policy issues that needed to be addressed regardless of which, if any, of the parity models were to be recommended:

Organizational Applicability.

Type of Policy. One of the first questions addressed was that regarding the organizations that would be impacted by any parity recommendations. State legislatures do not have the authority to regulate insurance plans covered by ERISA, the federal legislation that deals with self-insured firms. Likewise exempted from state regulatory control are the plans for state, local, and federal government employees. Another group that is exempt are those employees working for firms with headquarters outside Alaska where the health policies are written outside the state.

Size of Organization. The federal mental health parity legislation exempted firms with 50 employees or less. Adopting that criteria would create a risk pool so small that any parity legislation would be impractical. In examining past legislative action, the Task Force noted those firms with less than 20 employees were exempted from similar substance abuse mandates in 1988. After gathering data from the Alaska Department of Labor that described the employer and employee population, the Task Force chose to exempt firms with less than 20 employees.

Diagnostic Criteria. Different states have approached the issue of diagnostic criteria differently with some choosing highly restrictive models while others elected to be more inclusive. There were several key considerations to be addressed in this area:

Diagnosis Creep. Much of the literature addressing parity issues cautioned against overly restrictive diagnostic criteria because of what they called ***diagnosis creep***. This is a phenomenon whereby some treatment providers can display a tendency to over-diagnose clients in an effort to insure that benefits are available. This not only serves to negate any cost savings that might have been realized by the restrictive policy, but also saddles individuals with inappropriate diagnoses that follow them in future years.

Manageability. A few states have elected to specifically identify those diagnoses that would be covered under parity. This approach saddles the legislature with the responsibility of "re-inventing the wheel." Insurance carriers and treatment providers both currently use a pre-determined set of diagnostic criteria that are listed in the Diagnostic and Statistical Manual IV (DSM IV). Most carriers cover all disorders except those assigned "V" Codes. This system of defining criteria is well understood by both groups and using a different definition merely adds confusion to the process.

In considering the issue of diagnostic criteria, the Task Force decided to recommend the use of the existing system recognizing all disorders listed in the DSM IV with the exception of those assigned "V" codes.

Inclusion or Exclusion of Substance Abuse. Although substance abuse disorders are included in the DSM IV, the federal government and all other states have chosen to specifically indicate whether or not substance abuse was covered under parity legislation. The federal legislation specifically excludes substance abuse, as does the legislation for seven states. Five states have included substance abuse in their legislation. In those states that included substance abuse, this element accounted for a relatively small part of the projected costs. Alaska, however, has two offsetting considerations to examine. First, Alaska already has some level of parity for substance abuse insurance so inclusion in a mental health parity mandate would be less expensive than starting from nothing. Second, Alaska has a much higher utilization rate for substance abuse services than the national average. As a result, the projected cost of including substance abuse in the most comprehensive of parity models is approximately 1.1%.

Aside from projected costs, there is also the consideration that there is a high incidence of substance abuse among the mentally ill and, unless both disorders are treated, positive outcomes for either are unlikely. For these reasons, the Task Force elected to include substance abuse in the recommended parity mandate.

Mandatory versus Optional Mental Health Coverage. The final consideration before actually selecting a recommended parity model is that of mandatory versus voluntary mental health coverage. Federal legislation applies only to those policies that include mental health coverage; it does not provide any mandate for health insurance policies to include mental health coverage. Likewise, there is no current mandate in Alaska for health insurance policies to include mental health coverage. The central issue in consideration of mandatory coverage is the phenomenon of what Mr. Bachman calls "anti-selection." Anti-selection is the tendency of companies to drop mental health coverage for employees to avoid the increased costs of parity. This serves to decrease the size of the risk pool making parity even more expensive. This is particularly critical in Alaska with our already small risk pool. According to Mr. Bachman, anti-selection becomes a factor when any level of parity greater than the catastrophic model is chosen. Considering this, the Task Force decided to recommend that coverage be mandated for impacted policies.

Level of Parity: The Models Considered. The Task Force initially considered three different models or levels of parity and obtained actuarial data for all three.

Model 1: Federal Legislation Extended. The first model considered was the extension of the terms of MHPA of 1996 (federal legislation) to Alaska firms with 20 or more employees. This would involve equating annual and lifetime dollar limits between mental and physical health. As noted above, it would also mandate that mental health coverage be provided in health care plans provided by firms subject to the mandate. Although the federal legislation did not include substance abuse, the Task Force elected to include it for purposes of analysis. The main reason for rejecting this model is the same reason that states have elected to enact their own legislation despite the presence of the federal law. The essence of the federal legislation is the elimination of disparity in annual and lifetime dollar limits between mental health and medical/surgical benefits. It allows, however, disparity in the limits on annual visits or inpatient days between mental health and medical/surgical benefits. This, in effect, allows carriers to re-define the limits using visits and day limits instead of dollar limits while providing no protection for consumers.

Model 2: Catastrophic Model. The next model would add, in addition to the elements of MHTA noted above, parity with regard to days and visit limits and maximum out-of-pocket expenses. As the title indicates, this model is designed correct the inequities of the federal legislation with regard to days and visits limits and to help families avoid financial ruin that can accompany massive out-of-pocket expenses. While correcting this problem, it does, however, leave another gap. It does not address disparity of deductibles, co-payments, and co-insurance between mental health and medical/surgical benefits. This is important because these elements represent the first set of barriers to receiving treatment. Medical/surgical deductibles, co-payments, co-insurance are set at levels that encourage appropriate utilization of benefits. Setting these cost-sharing elements at the same level for mental health benefits would serve the same purpose. For this reason, the Task Force also rejected this model.

Recommended Model: Financial Parity. This model would add, in addition to the elements of the two models noted above, parity with regard to co-insurance, co-payments, and deductibles. In short, it merely requires that the benefit levels for mental health coverage be equal with those for medical and surgical benefits.

Benefits of Mental Health Parity. According to a report commissioned by the National Institute of Mental Health published in 1997, the intended benefits of parity legislation are:

1. To overcome discrimination against people with mental illness based on artificial and scientifically untenable distinctions between mental and physical disorders;
2. To make parity mandatory for every health plan so that no plan suffers the "adverse selection" of being preferred by people with severe and costly illnesses;
3. To lessen out-of-pocket expenses for people with severe mental illness and their families;
4. To reduce disability through appropriate access to effective treatment; and
5. To increase the productivity and social and economic contributions of people with treated mental illnesses – contributions that can yield a national net economic return amounting to billions of dollars yearly.[12]

The first four intended benefits listed above are obvious and are targeted primarily to consumers. Benefit number five, however, suggests that additional overall economic benefits may result from implementation of mental health parity. There are a number of different studies, some government-sponsored and others sponsored by private organizations, which seem to support this premise. In examining this concept, we will start with the assumption that parity mandates will lead to better access to appropriate mental health care by consumers. This is basically what parity is intended to accomplish.

In a study conducted by UNUM Life Insurance Company of America published in 1998, D. Salkever noted that employers with health plans having high deductibles for mental health expenses experienced substantially higher rates of psychiatric disability claims and decreased likelihood of employees returning to work than firms with lower deductible plans. The savings

[12] U. S. Department of Health and Human Services, National Institute of Mental Health, Parity in Coverage of Mental Health Services in an Era of Managed Care: An Interim Report to Congress by the National Advisory Mental Health Council, p 13, Washington, D.C., 1997

realized by lower premiums for high deductible plans were more than offset by losses due to disability claims and employee turnover.[13]

In an unpublished study at Yale University (Rosenheck et al), researchers examined the impact of limiting specialty mental health care in a large national corporation over a three-year period. They found that, when the company decreased mental health services by 44%, there were three unintended results:

(1) Reduced work performance (down by 5.1%);
(2) Increased absenteeism (sick leave up by 21.9%); and
(3) Increased general health expenses (up by 36.6%).

The savings generated by reducing mental health care was, again, more than offset by decreased productivity and increased spending for general health care.[14] The employer was able to reduce costs in the short run by purchasing cheaper insurance that limited mental health care, however, increases in other costs negated that savings.

In a 1995 study reported in the Journal of the American Medical Association, investigators compared treatment patterns, effectiveness, and costs of treatment for depression by primary care physicians and mental health clinicians. In treatment of depression, they found that psychiatrists produced better functional outcomes than did primary care physicians, at greater cost, but overall with greater cost-effectiveness. They concluded that providing reduced care or more non-specialized care may incur less direct costs for treatment, but given the generally worse outcomes, tended to be less cost-effective in the long run.[15]

Two studies in 1995 and 1996 examined the economic consequences of not treating mood disorders. Rupp (1995) concluded that there is a net return of one dollar for each dollar spent on treating the most severely mentally ill. He also found that the current market conditions offer no incentives for private firms to provide adequate mental health coverage because they risk adverse selection by attracting those workers or their family members who have more serious mental problems.[16] Zhang (1996) found that each dollar spent on treating mood disorders yields between three and nine dollars net return.[17] The differences in the net returns noted in the two studies may be explained by the fact that Rupp used national level epidemiological, clinical, and economic data while Zhang used a small community sample from a primarily rural southern state.

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[13] Salkever, D., "Psychiatric Disability in the Workplace," Insight (5) 1, UNUM Disability Lab, UNUM Life Insurance Company of America, 1998

[14] U. S. Department of Health and Human Services, National Institute of Mental Health, Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access, and Quality, p 36, Washington, D.C. 1998

[15] Sturm, R., & Wells, K.B., "How can care for depression become more cost-effective?" Journal of the American Medical Association, 273 (1), pp 51 – 58, 1995

[16] Rupp, A., "The Economic Consequences of not Treating Depression," The British Journal of Psychiatry, 166 (suppl. 27), pp 29 – 33, 1995

[17] Zhang, M., Rost, K.M., Fortney, J.C., and Smith, G. R., "Economic Returns on Treatment for Depression," Paper presented at the Eighth Biennial Research Conference on the Economics of Mental Health, Bethesda, Md. 1996

Study after study has confirmed the positive economic benefits from appropriate and timely access to mental health and substance abuse treatment. The implementation of parity between mental health benefits and medical/surgical benefits is intended to increase access to such care.

Glossary of Terms

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

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

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

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

Chemical Dependency. Physiological or physical dependence on a psychoactive substance.[18]

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

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

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

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

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

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

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[18] Alaska Advisory Board on Alcoholism and Drug Abuse, Results Within Our Reach: Alaska State Plan for Alcohol and Drug Abuse Services 1999 – 2003, Juneau, Alaska 1998.

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

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

Financial Requirements. The term "financial requirements" refers to co-payments, deductibles, out-of-pocket contributions, fees, annual limits, and lifetime aggregate limits imposed on covered individuals.[19]

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

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

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

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

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

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

Mental Illness. The term "mental illness" includes mental disorders defined in the Diagnostic and Statistical Manual IV (DSM IV) or subsequent editions published by the American Psychiatric Association, except those codes defining substance abuse disorders (291.0 to 292.9 and 303.0 to 305.9) and the "V" codes.[20]

Mental Health Benefits. Benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.[21]

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[19] Ronald E. Bachman, F.S.A., M.A.A.A., Mental Health: Parity Issues and Costs, p I-1, Atlanta, Georgia, 1998.
[20] ibid., p II-1
[21] ibid., p II-1

Parity. The term "parity" as used in this study refers to the various levels of equality in coverage between mental health and physical health. The range of levels can span from complete lack of equality to comprehensive parity in which all elements of mental health and physical health coverage are provided equally. (Definition developed by Task Force)

POS. Point-of-service. Point-of-service plans are managed care plans that cover both in-network and out-of-network services. To encourage use of network providers, patient out-of-pocket costs are higher when non-network providers are used. POS plans generally manage in-network services more tightly than PPOs because POS plans use gatekeepers.

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

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

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

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

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

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

Substance Abuse. Use of alcohol, other drugs, or inhalants in a way that is illegal or deviates from medically accepted use.[22]

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

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[22] Alaska Advisory Board on Alcoholism and Drug Abuse, Results Within Our Reach: Alaska State Plan for Alcohol and Drug Abuse Services 1999 – 2003, Juneau, Alaska 1998.

Appendices

Appendix A: Task Force Membership

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

Appendix B: Resources and Suggested Readings

Documents and Reports

1. Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Consumer Bill of Rights and Responsibilities, 1997

2. American Managed Behavioral Healthcare Association, Performance Measures for Managed Behavioral Healthcare Programs, 1995

3. Bachman, Ronald E., FSA, MAAA, Mental Health: Parity Issues and Costs, 1998

4. Bush, S., "Important Milestones on the Path to Comprehensive Parity," Mental Health Issues Today, 1998

5. Caldwell, B., "Mental Health Advocates Turn to ADA, Courts to Address Shortfall in Parity Law," Employee Benefit Plan Review, 1998

6. Christianson, J.B., Wholey, D., & Peterson, M.S., "Strategies for Managing Service Delivery in HMOs: An Application to Mental Health Care," Medical Care Research and Review, Vol. 54, No. 2, 1997

7. Congressional Budget Office, CBO's Estimate of the Impact on Employers of the Mental Health Parity Amendment in H.R. 3103, 1996

8. Frank, R.G. & McGuire, T.G., "Mandating Employer Coverage for Mental Health Care," Health Affairs, 1990

9. Frank, R.G., McGuire, T.G., Bae, J.P., & Rupp, A., "Solutions for Adverse Selection in Behavioral Health Care," Health Care Financing Review, 1997

10. Gately, J., "Enforcing the Mental Health Parity Act of 1996," National Mental Health Association: State Advocacy Update, 1998

11. Goldman, W., McCulloch, J., & Sturm, R., "Cost and Utilization of Mental Health Services Before and After Managed Care," Health Affairs, 1998

12. Hay/Huggins Company, Inc., "Hay/Huggins Benefits Report," 1996

13. Health Policy Tracking Service, Behavioral Health: Parity, 1997

14. Heiser, N., Smolkin, S., Maxfield, M., "Parity Study Background Report #1: State Parity Laws," Draft report submitted to the Substance Abuse and Mental Health Services Administration, 1998

15. Hill, S., Sing, M., Smolkin, S., "Parity Study Background Report #2: Case Studies," Draft Report submitted to the Substance Abuse and Mental Health Services Administration, 1998

16. Institute of Medicine, Managing Managed Care: Quality Improvement in Behavioral Health, Vols 1 and 2, 1996

17. Jensen, G.A., Morrisey, M.A., Gaffley, S., & Liston, D., "The New Dominance of Managed Care: Insurance Trends in the 1990s," Health Affairs, 1997

18. Mercer, W.M., Case Studies: A Guide to Implementing Parity for Mental Illness, 1997

19. National Advisory Board on Mental Health Council, "Health Care Reform for Americans with Severe Mental Illness: Report of the National Advisory Mental Health Council," American Journal of Psychiatry, 150:10, 1993

20. O'Grady, M., "CRS Report for Congress: Mental Health Parity: Issues and Options in Developing Benefits and Premiums," Congressional Research Service, 1996

21. Rodgers, J., Analysis of the Mental Health Parity Provisions in S.1028, 1996

22. Salkever, D., "Psychiatric Disability in the Workplace," Insight, 1998

23. Scott, J.E., Greenberg, D., & Pizarro, J., "A Survey of State Insurance Markets Covering Alcohol and other Drug Treatment," The Journal of Mental Health Administration, Vol 19, No. 1, 1992

24. Sing, M. & Hill, S., "Parity Study Background Report #3: Actuarial Assumptions," Draft report submitted to the Substance Abuse and Mental Health Services Administration, 1998

25. Sing, M. & Hill, S., "Parity Study Background Report #4: Cost Estimates," Draft report submitted to the Substance Abuse and Mental Health Services Administration, 1998

26. Sturm, R., McCulloch, J., & Goldman, W., Sturm, R., McCulloch, J., & Goldman, W., Mental Health and Substance Abuse Parity: A Case Study of Ohio's State Employee Program, Working, 1998

27. Sturm, R. & Wells, K.B., "How can Care for Depression become more Cost-Effective?" Journal of the American Medical Association, 1995

28. U. S. Department of Health and Human Services, National Institute of Mental Health, Parity in Coverage of Mental Health Services in an Era of Managed Care: An Interim Report to Congress by the National Advisory Mental Health Council, 1997

29. U. S. Department of Health and Human Services, National Institute of Mental Health, Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access, and Quality, 1998

30. U. S. Department of Health and Human Services, National Institute of Mental Health, Mental Illness in America: The National Institute of Mental Health Agenda, 1998

31. U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, The Costs and Effects of Parity for Mental Health and Substance Abuse Benefits, 1998

32. White, R., "Employers fine-tune Plans to Comply with Parity Law," Business Insurance, 1998

33. Zuvekas, Samuel, et al., "Mental Health Parity: How Large are the Gaps in Coverage?" Achives of General Psychiatry, 1997

Internet Web Sites

The following listing of informational Internet web sites is not meant to be exhaustive but rather to give the reader a number of well-designed, informative sites that also contain further links to valuable sites.

1. www.athealth.com	Mental Health Resources, @Health
2. www.mentalhealth.com	Internet Mental Health
3. www.mentalhealth.org	U. S. Department of Health and Human Services, Center for Mental health Services: Knowledge Exchange Network
4. www.nami.org	National Alliance for the Mentally Ill
5. www.mhsource.com	Mental Health Infosource
6. www.nih.gov	National Institutes of Health (link to specific institutes such as NIMH, NIDA, etc.)
7. www.nmha.org	National Mental Health Association
8. www.psych.org	American Psychiatric Association
9. www.samhsa.gov	U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration
10. www.touchngo.com/akmhcweb	Alaska Mental Health Consumer Web

Appendix C: Senate Concurrent Resolution 14

HCS FOR CS FOR SENATE CONCURRENT RESOLUTION NO. 14(RLS) am H

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE HOUSE RULES COMMITTEE

Amended: 4/24/98
Offered: 4/8/98

Sponsor(s): SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

A RESOLUTION

Establishing the Alaska Task Force on Parity for Mental Health.

BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

WHEREAS persons in Alaska with mental health disorders and their families face disparity in the adequacy, scope, and coverage of private health insurance that they need; and

WHEREAS it is estimated that mental health disorders cost the Alaska economy $187,272,000 in 1996 in lost productivity, absenteeism, disability, and early death; and

WHEREAS other states that have adopted insurance parity laws for mental disorders have demonstrated that costs of parity have been far less than projected and that savings to the public through decreased costs of Medicaid, Medicare, and other programs have far outweighed the additional costs; and

WHEREAS the Alaska Mental Health Board estimates there are over 44,000 children, youth, and adults in the state who experience serious mental illnesses and emotional disorders; and

WHEREAS the Congress passed the Mental Health Parity Act of 1996 that does address parity for lifetime benefits and annual reimbursement limits for mental health services, but does not address differentiation between mental and physical illnesses with respect to co-payments, deductibles, and benefit design; and

WHEREAS 15 other states have established laws addressing mental health parity in insurance practices, and 25 other states introduced bills on the subject in 1997;

BE IT RESOLVED by the Alaska State Legislature that the Alaska Task Force on Parity for Mental Health is established for the purpose of studying, after defining the terms "mental disorders," "mental illness," "serious mental illness," "mental injury," and "mental health consumers" for purpose of its work,

(1) differential treatment in health insurance coverage between a person with a mental disorder and a person with a physical disorder;

(2) costs of mental health coverage in relation to other health care insurance, with special emphasis on parity, and the extent of such coverage, including deductibles and co-payments, disorders and conditions to be covered, and other pertinent issues;

(3) ways to define and quantify unmet mental health needs in the state and recommending meaningful ways to measure the efficacy of treatment of mental health needs by analyzing possible outcome data collection measures;

(4) the positive and negative effects on mental health consumers if parity for mental health coverage is mandated in Alaska;

(5) the feasibility of implementing any recommendations of the task force through legislation; and

(6) the effect of the September 30, 2001, sunset date for the Mental Health Parity Act of 1996 on matters set out in (1) - (5) of this clause; and be it

FURTHER RESOLVED that the task force shall be composed of 11 members, as follows:

(1) two members of the Senate appointed by the President of the Senate; one member shall be a member of the majority, and one member shall be a member of the minority;

(2) two members of the House of Representatives appointed by the Speaker of the House of Representatives; one member shall be a member of the majority, and one member shall be a member of the minority;

(3) the commissioner of health and social services, or a designee;

(4) one member representing the Alaska Mental Health Board appointed by the Alaska Mental Health Board;