State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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September 16, 2005

Senator Dale Schultz
Senate Majority Leader
Room 211 South, State Capitol
P.O. Box 7882
Madison, WI 53707-7882

Representative John Gard
Speaker of the Assembly
Room 211 West, State Capitol
P.O. Box 8952
Madison, WI 53708

RE: Social and financial impact report – Senate Bill 128/Assembly Bill 252

Dear Senator Schultz and Representative Gard:

SB 128/AB 252 increases the minimum dollar amounts that must be covered for inpatient, outpatient, and transitional treatment related to mental health and AODA treatment in group health insurance plans and certain individual health benefit plans. As required in, s. 601.423, Wis. Stats., I am submitting a social and financial report on the proposed health insurance mandate.

Current Wisconsin Law

Wisconsin's current mental health mandated benefits law applies only to group health insurance policies. The services covered under current law are; inpatient services, outpatient services and transitional services.

There are certain minimum coverage amounts for each of the three previously mentioned services.

A group policy that provides coverage for inpatient hospital services must annually cover:

- At least expenses for the first 30 days as an inpatient in a hospital; or
- At least $7,000 minus a co-payment of up to 10% or actuarially equivalent benefits measured in services rendered.
- At least $3,000 minus a co-payment of up to 10% for transitional treatment or actuarially equivalent benefits measured in services rendered.

A group policy that provides coverage for outpatient services must annually cover:

- At least $2,000 of services minus a co-payment for up to 10% or equivalent benefits measured in services rendered.
- At least $3,000 minus a co-payment of up to 10% for transitional treatment or equivalent benefits measured in services rendered.

** However, total coverage for inpatient, outpatient, and transitional treatment services need not exceed $7,000 or equivalent benefits per year.

Additionally, 2003 Act 178 specifically excludes costs incurred for prescription drugs or diagnostic testing from the minimum required coverage.

Proposed Coverage Changes

SB 128/AB 252 increases the minimum coverage amounts for inpatient, outpatient, and transitional treatment as well as the overall minimum coverage amount for a group health insurance policy.

More specifically, SB 128/AB 252 would:

a. Increase the minimum for inpatient treatment of nervous and mental disorders and alcohol and other drug abuse (NM/AODA) from $7,000 annually to $18,300 minus applicable cost sharing or $16,500 with no cost sharing.
b. Increase the minimum for outpatient treatment of NM/AODA from $3,100 annually to $3,100 minus applicable cost sharing or $2,800 with no cost sharing.
c. Increase the minimum for transitional treatment of NM/AODA from $4,700 annually to $4,600 minus applicable cost sharing or $4,200 with no cost sharing.
d. Increase the minimum for all treatment of NM/AODA from $7,000 annually to $18,300.
e. Require the Department of Health and Family Services to annually report to the governor and the legislature on revising the limits based on the change in the federal consumer price index for medical costs. The Legislature is not required to change the required coverage based on this report.

Impact of Mandates

Wisconsin has long benefited from a healthy and competitive insurance market. The state currently has one of the lowest uninsured rates (48 of 51) in the country, according to the U.S. Census Bureau[1]. Increasing the amount of mandated coverage for NM/AODA would raise premium costs which could make insurance coverage more expensive for businesses. A bi-product of increased costs could be the shifting of premium increases to employees in the form of greater cost sharing arrangements.

It is difficult to project the actual impact of any mandate because of the factors involved. The structure of a benefit will affect, either positively or negatively, the level of consumer demand or utilization of service. For example, a limited benefit may lead consumers to decide not to seek treatment that is not vitally necessary. On the other hand, a broader set of benefits could lead to additional utilization for a specific treatments not previously covered. Taking these two limited factors into account, OCI's survey and analysis projects the following impacts of this mandate.

- **The mandate could add approximately $10.9 to $36.6 million per year to premium costs for group health insurance consumers, mostly small and medium sized businesses and potentially employees through cost shifting mechanisms including but not limited to new co-pays, deductibles and coinsurance amounts. This would represent a .15 to .50 %increase of the total premium collected in Wisconsin of $7.3 billion.**

- **Individuals who remain covered under group policies will have an increased access to care for certain treatments as specified.**

[1]DeNavas-Walt, Carmen; Bernadette D. Proctor; and Robert J. Mills, U.S. Census Bureau, Current Population Reports, P60-226, *Income, Poverty, and Health Insurance Coverage in the United States: 2003*, U.S. Government Printing Office, Washington, DC, 2004.

Social Impact Factors

Fully insured group health insurance products cover approximately 1.4 million state residents[2]. This is a dramatic decrease over the past decade in the number of Wisconsin residents who are insured under a group health insurance policy, representing less than 30% of Wisconsin's population. This mandate will expand coverage for those individuals. It is unclear whether there would be any indirect impact with unregulated self-funded plans as such plans are not required to submit for review benefit packages offered to employees with OCI.

People with individual health insurance policies are not covered by Wisconsin's NM/AODA mandate. By extension, this means that they would not be covered by SB 128/AB 252. In 2004 there were approximately 134,769 people in Wisconsin with individual health insurance policies.[3]

Individuals who are members of groups whose benefit plans are self-funded are exempt from state regulation by the Employee Retirement and Income Security Act of 1974 (ERISA) and will not be affected by SB 128/AB 252. Because self-funded plans do not have to offer state-mandated benefits, this option offers self-funded plans the opportunity to limit benefits provided to employees and save on premium costs. Some self-funded plans may, however, choose to provide comparable NM/AODA coverage.

Self-funding of health benefits has historically been used mostly by larger employers, however; over the last decade, the number of medium employers shifting from fully insured to self-funded products has increased. It is unclear to what extent either large or medium size employers are experiencing success in reducing premium costs associated directly to the avoidance of providing employees state mandated coverage.

Figure 1 below demonstrates this occurrence. While commercial insurance coverage has declined in Wisconsin since 2000, enrollment in self-funded health plans has grown by nearly 40 percent. Movement from commercially insured plans into public insurance programs has also increased 24% since 2000; however, it is less certain that health insurance mandates were the main factor in this shift. Wisconsin's ailing economy in 2000 and 2001 and the high cost of health care in general may have had more of an impact than mandates specifically.

According to testimony before the 2002 Study Committee on Mental Health Parity, as many as 1.3 million Wisconsin residents are diagnosed with either a mental disorder or a substance abuse problem which is roughly 22% of the population of Wisconsin. The number of these residents with group health insurance coverage that would be covered under SB 128/AB 252 is unknown at this time.[4]

There is no risk of employers dropping MH/AODA coverage under SB 128/AB 252 and since the mandate itself is not new, there would be no effect on the number of people who would be eligible nor would there be any effect on availability of coverage without the mandate. However, with the increase in health care costs being experienced by employers in Wisconsin during the previous years and the movement toward more consumer directed types of health care benefits being offered by employers, more of these increases will be shifted to the employees, possibly making the coverage unaffordable (even though it is available) for the employee.

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[2] Office of the Commissioner of Insurance (June 2005). *Health Insurance Coverage in Wisconsin* (PI-094 R 06/2005) p. 14. Madison, WI.

[3] Id.

[4] Lang, K. and Zimmerman, D. (October 24, 2002). *Department of Health and Family Services Presentation to the Legislative Council Study Committee on Mental Health Parity*. Madison, WI

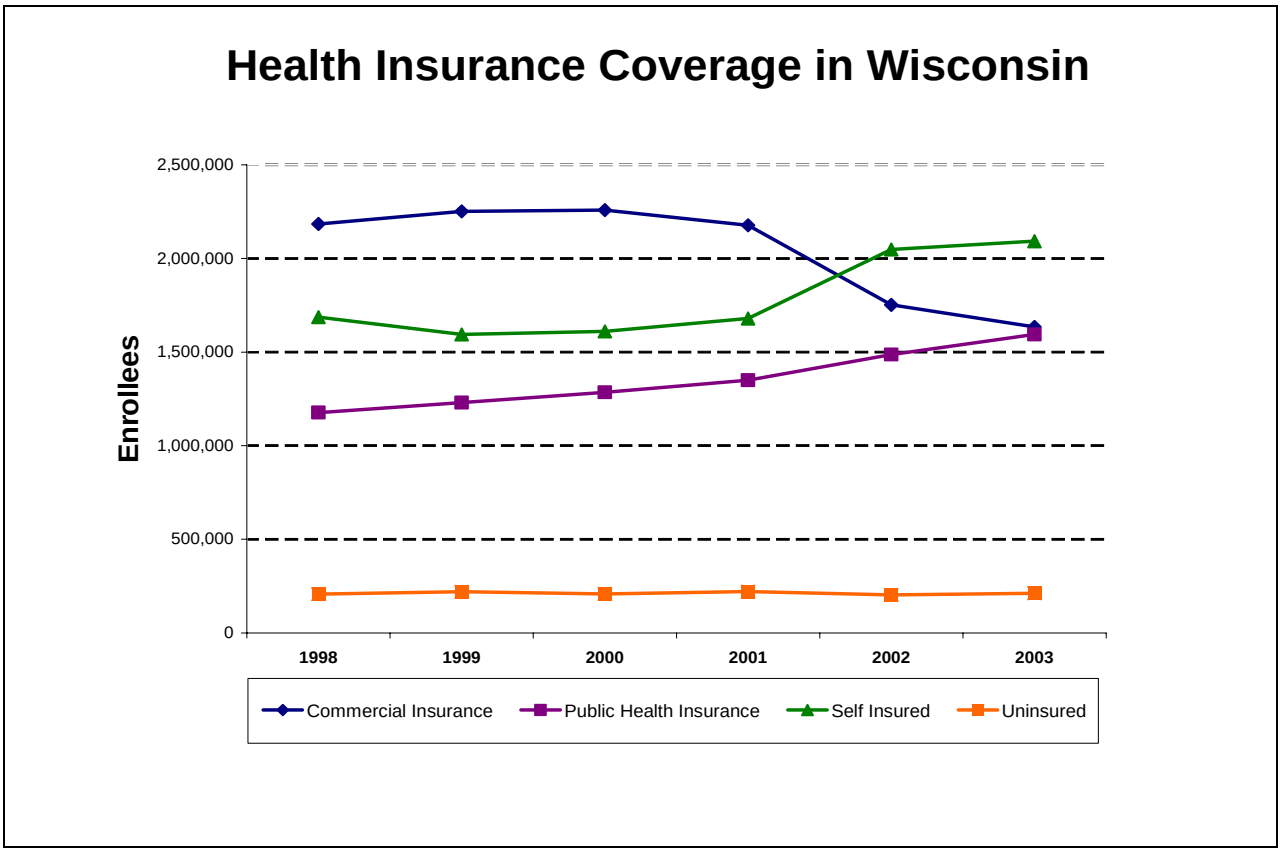

Figure 1. Health Insurance Coverage in Wisconsin 1998-2003.

(Source: OCI, DOA, DHFS)

Financial Impact Factors

In estimating the costs of the coverage proposed in SB 128/AB 252, OCI reviewed the Social and Financial Impact report that was submitted to the Wisconsin Legislature on July 8, 2003 for Senate Bill 72 which contained the same language as 2005 SB 128/AB 252 (although the minimum amounts were different).[5] The report for 2003 SB 72 contained data from states that have implemented parity legislation and the results of state employee health plans that have instituted mental health parity for state employees. This information was contained in reports compiled by PriceWaterhouseCoopers, LLP[6] and the University of South Florida[7]. Additionally, data from the OCI 2001 Study of Certain Mandated Benefits in Insurance Policies[8] and the testimony of Roland Sturm PhD, Senior Economist from RAND Health, to the Health Insurance Committee, National Conference of Insurance Legislators were used in preparing this statement. Subsequent to the Report for 2003 SB 72, additional studies were made available on the

[5] Gomez, J. (July 8, 2003). *Social and Financial Impact Report to Senator Mary Panzer and Representative John Gard*. Madison, WI. Office of the Commissioner of Insurance.
[6] Bachman, Ronald E. (2000). *Mental Health Parity: "Just the Facts" -- Actual Data and Experience Reports.* Prepared for the American Psychological Association, 2000 State Leadership Conference (Atlanta, GA: PriceWaterHouseCoopers).
[7] Levin, B.L., Hanson, A. & Coe, R.D., (2001), *Mental Health Parity; National and State Perspectives 2001: A report to the Florida Legislature*, Tampa, Flaorida; The Louis de la Parte Florida Mental Health Institute
[8] Office of the Commisisoner of Insurance (October 2001). *Study of Costs of Certain Mandated Benefits in Insurance Policies 2001*. Madison, WI.

cost of changes in mental health coverage legislation in Missouri[9], New Jersey[10] and Utah[11]. The information contained in these new surveys has not caused OCI to alter the financial impact estimate that was proposed in 2003 SB 72 for 2005 SB 128/AB 252.

- **Insurance premiums would increase .15% to .50%, or $10.9 to $36.6 million, as a result of the modifications to existing mental health requirements. Again, this represents .15 to .50% of total premium or a per individual monthly increase of $0.64 to $2.17 in increased premium costs**

The above mentioned increase is based on the following assumptions:

- OCI's Survey of Certain Mandated Benefits in Insurance Policies collected data from insurers regarding the level of benefits paid in excess of the mandated benefits for MH/AODA. Eight of the insurers surveyed indicated that they paid out MH/AODA benefits in excess of the mandate. These insurers indicated that the additional cost of those benefits ranged from .01% to .47% of total benefits paid under their group health plan. The insurers did not indicate if the benefit levels were the cost of full parity or of a benefit level less than full but more than the mandate requires. SB 128/AB 252 does not require full parity. Premium data used in the calculation was obtained from the 2003 Wisconsin Insurance Report which indicated that group health insurers $7.3 billion in premiums for that year.

- Several insurers in the OCI survey indicated that they did not include prescription drug costs in the calculation of the minimum coverage amounts as a matter of policy. Wisconsin Act 178, which became effective on April 21, 2004, prohibited the inclusion of prescription drug costs or diagnostic costs in the calculation of mandated costs. However, Act 178 did not apply to policies in force until those policies became renewable, which means Act 178 was not fully in effect until April 20, 2005. Health insurance policies are typically one year contracts. It is too early to tell what type of impact Act 178 has had on the current mandate. However, because mental health and substance abuse treatments have a strong pharmaceutical component, it would be reasonable to assume that Wisconsin Act 178 could serve to dampen cost increases experienced as a result of SB 128/AB 252.

- While the number of people in Wisconsin with commercial health insurance coverage has decreased dramatically, the cost of health care in Wisconsin has increased just as dramatically. With this in mind, greater weight was given to percentage estimates of cost rather than increases estimated on a per member/per month basis as this latter method may underestimate the potential increases applicable to SB 128/AB 252. This is due to the decrease in the number of covered lives which limit the ability to spread increases over a larger pool.

- The states listed in the studies showed per member/per month premium costs increased from a low of $.06 in Maryland and California to $.33 per member/per month in Rhode Island. Other states list percentage increases rather than per member/per month costs. For those states the percentage changes in premium costs vary from .08 percent in Maine to 3% in Vermont and Connecticut.

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[9] Missouri Department of Insurance (2004). *Study to Assess the Impact of the Mental Health and Substance Abuse Insurance Act* (HB 191). Jefferson City, MO.

[10] Mandated Health Benefits Advisory Commission (February 2005). *A Study of Assembly Bill A-333-A Report to the New Jersey State Assembly*. Trenton, NJ.

[11] Hawley, J.E. (February 2004). *2004 Catastrophic Mental Health Report.* Salt Lake City, UT. Utah Insurance Department

- Other states such as Colorado, North Carolina and the Texas State Employee health plan experienced declines in premium costs related to mental health parity. Also, individual insurers in Maryland, Minnesota and New Hampshire also experienced declines in premium costs related to mental health parity.

- These studies and others have established a link between the level of managed care market penetration and the level of increases in premium costs for mental health and substance abuse (MHSA). In the examples above, states that have high levels of managed care market penetration experienced low levels of premium increases, or even premium decreases, due to MHSA. In states where there was less managed care market penetration, premium increases were greater. Also, other factors, such as minimal or inadequate regulation of MHSA in the examples of Vermont and Connecticut also contributed to higher premium increases. Wisconsin has substantial market penetration by managed care insurance plans. For 2004, 1,307,094 employees and their dependants are enrolled in commercial managed care products (Health Maintenance Organization, Preferred Provider Plan or Point of Service Plan).[12]

- The Ohio State Employee Health Insurance Program established full parity benefits in 1991. After 13 years, the program has not experienced a significant growth in MH/AODA costs and the level of benefits has stayed constant. The Ohio employee program is significant in its reliance on managed care.

- Characteristics of managed care for MHSA include declines in average inpatient stays, decreased outpatient visits and decreases in costs for both inpatient and outpatient visits. This trend is evident in a survey of Wisconsin insurers that was compiled by OCI in January 2001. That survey showed decreases in outpatient utilization of .2% and decreases in costs per service of 9.2%. Together these factors contributed to a –1.3% effect on overall insurance premiums for the period surveyed. Increases in other elements, however, outweighed the decline in MHSA and no actual decrease in health insurance premiums was experienced. These characteristics were also evident in Maryland and Minnesota. Both states implemented parity laws in 1995 and experienced neither large cost explosions or flight of employers to ERISA sponsored plans. Cost increases in both states averaged 1-2%.

- Most estimates of mandating full parity in mental health coverage as defined in S. 543, the Paul Wellstone Mental Health Parity Act range from .9% (CBO) to 1%.

Another financial impact factor that OCI is not able to quantify is the amount of productivity gains would be realized by the passage of this bill. It is known that once employees are able to get help for their mental health and/or substance abuse conditions, productivity will increase and related medical costs associated with untreated mental health and substance abuse that goes untreated will decrease. According to the final report of the President's New Freedom Commission on Mental Health, indirect cost of mental illness is $79 billion, with $63 billion of that amount related to lost productivity[13]. There are too many variables that are unknown for OCI to provide a credible estimate that would apply to the State of Wisconsin. Such variables would include the number of patients in group health insurance plans that are also being treated for mental health or substance abuse conditions; what the amount of lost productivity is caused by those patients; or what is the eventual medical cost if these people went untreated. It is possible that an actuarial study could provide a credible estimate of that opportunity cost.

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[12] Office of the Commissioner of Insurance (June 2005). *Health Insurance Coverage in Wisconsin* (PI-094 (R 06/2005) p. 14. Madison, WI.

[13] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

Impact on the Uninsured

There are many factors that go into an employer's decision to discontinue offering health insurance benefits. As indicated earlier, the number of those with commercial insurance coverage in Wisconsin has decreased dramatically over the past 5 years, while the number of uninsured has remained fairly static. At the same time, however, fewer mandates have been passed by the legislature. It is difficult to estimate what the effect of an additional .15% to .5% increase in health care premiums would be to an employer who would has experienced yearly double digit premium increase without the mandate.

Please contact Eileen Mallow at 266-7843 or Jim Guidry at 264-6239 if you have any questions regarding this report.

Sincerely,

Jorge Gomez
Commissioner

JAG/jrg