State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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July 8, 2003

Senator Mary Panzer
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 72

Dear Senator Panzer and Representative Gard:

SB 72 increases the minimum dollar amounts that must be covered for inpatient, outpatient, 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.

Proposed Coverage Changes

SB 72 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 72 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 $16,800 minus applicable cost sharing or $15,100 with no cost sharing.

b. Increase the minimum for outpatient treatment of NM/AODA from $2,000 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 $3,000 annually to $4,600 minus applicable cost sharing or $4,100 with no cost sharing.

d. Increase the minimum for all treatment of NM/AODA from $7,000 annually to $16,800 minus applicable cost sharing or $15,100 with no cost sharing.

e. Require the Department of Health and Family Services to annually report the change in the coverage limits necessary to conform to the change in the federal consumer price index for medical costs.

Impact of Mandates

Wisconsin has long benefited from a healthy and competitive insurance market. The state currently has the lowest uninsured rate in the country, according to the U.S. Census Bureau. Increasing the amount of mandated coverage for NM/AODA could have an adverse effect on our current health insurance market. Traditionally, as the number of benefit mandates increase the cost of coverage rises, and as costs rise, fewer and fewer individuals and businesses can afford to insure.

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, an overly generous benefit could lead to over utilization for a specific treatment simply because payment is available. Taking these two factors into account, OCI's survey and analysis projects the following impacts of this mandate.

- **The mandate will add approximately $9.2 to $30.8 million per year to premium costs for group health insurance consumers, borne mostly by small businesses.**

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

- **The increase in costs could increase the disparity between insured plans and non-state regulated self-insured plans, decreasing the effectiveness and protections afforded by state regulation.**

Social Impact Factors

Fully insured group health insurance products cover approximately 2.5 million state residents. This mandate will expand coverage for those individuals. However, 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 the mandates.

Because self-funded plans do not have to offer state-mandated benefits, this option offers self-funded plans the opportunity to save as much as 10% to 15% on premium costs, or choose which benefits to offer. Anytime mandates are added to insurance products, it will increase the propensity of employer groups to switch to self-funding.

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. Larger employers are able to spread these costs over a larger base when self-funding and typically do not experience the same impact.

Increasing the disparity between insured and self-funded plans costs could increase the incidence of such switching. The potential of this occurring through mandated mental health treatment is very possible.

According to testimony before the 2002 Study Committee on Mental Health Parity, as many as 1.2 million Wisconsin residents are diagnosed with either a mental disorder or a substance abuse problem which is roughly 22% of the population of the state. The number of these residents with group health insurance coverage that would be covered under SB 72 is unknown at this time.

There is no risk of employers dropping MH/AODA coverage under SB 72 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.

Financial Impact Factors

In estimating the costs of the coverage proposed in SB 72, OCI reviewed 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 and the University of South Florida. Additionally, Data from the OCI 2001 Study of Certain Mandated Benefits in Insurance Policies 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.

- **.15% to .50%, or $9.2 to $30.8 million, increase in insurance premiums resulting from the modifications to existing mental health requirements.**

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 72 does not require full parity. Premium data used in the calculation was obtained from the 2001 Wisconsin Insurance report which indicated that group health insurers $6.1 billion in premiums for that year.

- Several insurers indicated that they did not include prescription drug costs in the calculation of the minimum coverage amounts as a matter of policy. It is not determinable at this time if those insurers may choose to begin including those costs against the limits once they are raised to the levels described in SB 72.

- 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.

- 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. Nearly 70% of employees and their dependants are enrolled in managed care plans in 2001.

- The Ohio State Employee Health Insurance Program established full parity benefits in 1991. After 10 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% (PricewaterhouseCoopers).

SB 72 requires the Department of Health and Family Services to annually adjust the minimum limits to increase with the change in the federal consumer price index for medical costs. For 2002 the CPI-Medical increased 4.69%. This would increase the minimum coverage amount for all services by $787.92 and increase the minimum amount to over $17,500 in the second year of the mandate should the CPI-Medical trend continue. The CPI Medical has a five and ten year average increase of just over 4% annually. An attachment showing monthly changes to the CPI medical is included for your information.

Impact on the Uninsured

According to Congressional Budget Office estimates - for every 1% increase in premiums, approximately 200,000 persons nationally could become uninsured. While it would be difficult to predict the number of persons affected, it is reasonable to assume that an increase in premium costs to small and medium-sized employers certainly will have a negative impact on the number of people insured in Wisconsin.

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