☞ **95hr_AC-ISCP_Misc_pt10a**

☞ Details: Mental health parity information

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

1995-96
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance, Securities and Corporate Policy...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (October 2012)

A Report to

State of Maine
116th Legislature

on the

Financial Impact of
Public Law 881

Prepared By:

Blue Cross and Blue Shield of Maine
April 30, 1993

Executive Summary

Financial Impact of P.L. 881

Public Law 881 mandates expanded coverage for specific biologically based mental illnesses beginning July 1, 1993, and directs that the financial effects of these mandates on the State Employee Health Benefit Program be assessed and reported to the Maine Legislature. The benefit expansion, designed to achieve coverage for mental disorders at levels equal to those of other illnesses, is structured to occur incrementally over a four year period. Accordingly, the costs of implementing the mandate, will increase in each successive year and must be assessed individually and in total.

The mandate increases the number of days or services covered per patient and increases the percentage of charges covered for each service for a set of mental disorders which comprise one half of paid benefits. The extent to which these benefit enhancements add to the overall cost of the State's Health Benefit Program hinge on assumptions regarding the rate of utilization of services and the ability to continue to appropriately manage length of stay. A financial assessment conducted by Blue Cross and Blue Shield of Maine and based upon current utilization patterns demonstrated resulting net increases to the annual cost of mental health benefits for the State Employee Health Program of $153,023; $205,488; $410,967; and $832,882 for years one, two, three and four of the program, respectively. Total incremental costs to the State Health Program for the four year period are projected at $1,602,360. Net increases to annual premiums resulting from projected increases in claims expense are $8.40; $11.28; $22.56; and $45.72 for years one through four of the expansion representing an additional 10.9% in premium expansion at full implementation in 1996. Projections of the financial impact on the State Health Program substantially understate the effects of mandates on private coverage due to the relative "richness" of the State's current benefits which exceed current mandates. Further, due to the incremental phasing of the mandate, projected expenses of $1.6 million for the four year period 1993-1996, sizably understate the cost of the mandate for any subsequent multi-year period.

To support statistically valid projections, the assessment was based on an analysis of claims for the 12 month period October 1, 1991 through September 30, 1992. The assessment included the favorable effects on utilization and cost of changes in benefit design which occurred subsequent to the study period, including the addition of managed care programs for inpatient and outpatient mental health services and participation in the Green Spring Preferred Provider Arrangement. Utilization projections upon which cost estimates are based, assume continued participation in these managed care programs. Were the expansion of benefits to occur absent these programs, cost estimates will require sizeable upward adjustment.

FINANCIAL IMPLICATIONS OF P.L. 881

Purpose

This report has been prepared pursuant to the Public Laws of 1991, Chapter 881, Section 5 (P.L. 881) and is not designed to be used for any other purpose. This law specifically requests a report on the cost to the State of Maine for its employees as a result of the benefit changes required by the legislation. The impact on other enrollees has been assessed as well. P.L. 881 was formerly called L.D. 1553.

Diagnoses Impacted By P.L. 881

P.L. 881 requires specific benefit levels for certain mental illnesses beginning in July 1, 1993 and continuing through July 1, 1996 at which point benefits for these conditions must be equal to the benefits paid for other illnesses. A comparison of current benefits for State employees to those required by P.L. 881 is presented in Table 1. The particular illnesses included in the legislation are:

Schizophrenia
Bipolar Disorder
Pervasive developmental disorder; or autism
Childhood Schizophrenia
Psychotic depression, or involutional melancholia
Paranoia
Panic disorder
Obsessive-compulsive disorder
Major depressive disorder

For this report, the nine diagnoses defined in P.L. 881 were classified using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) system. Table 2 lists the diagnoses by ICD-9-CM code. Several of the diagnoses can be included in more than one of the categories shown. These diagnoses are included in parentheses under each possible category. However, for the purposes of this study, data for these diagnoses were included only in the category "ICD-9-Multiple Illnesses. "

Methodology

The legislation requested State of Maine claims experience from May 1, 1992 through March 31, 1993. However, using that time period presented several complications that would distort the analysis of the State's experience. First, the data for that period do not reflect a full year of claims. Second, many claims for services performed in that period have not been received. Additionally, during that time, the State of Maine began using a preferred provider arrangement (PPA) to manage mental health and substance abuse care. Under this PPA, outpatient care is managed in addition to the utilization review that was already in place for inpatient admissions. Several months of the proposed period included this new arrangement, and this mixture of benefit design would also distort the analysis.

The claims data used in this analysis were for services received from October 1, 1991 through September 30, 1992. This period was selected because it was the latest full year available with at least a three month runout period (enough time for most claims to be submitted and processed by Blue Cross.)

The cost of P.L. 881 to the State of Maine is based on a review of the actual claims experience for State group for the diagnoses specified in the legislation. Total claims experience for all mental health diagnoses were also reviewed. Total inpatient claims were analyzed separately from total outpatient claims. A similar assessment was made of the impact upon other groups affected by P.L. 881.

Assumptions

The costs of P.L. 881 are expected to be from two sources, the increased number of days or services covered per patient and the increased share of the total charges per service that would be paid.

In consideration of managed care activities, no increases were assumed in the number of inpatient cases per 1000 members for each of the four years included in the P.L. 881. However, increases are expected in the number of days covered per case.

Since the current outpatient benefits for the State under the PPA are more generous than the legislation requires until July 1995, the outpatient standards mandated by P.L. 881 are not expected to impact the State until that date. At that time, the coinsurance increases from 70% to 80%. No annual maximum is assumed in any year since the current benefits do not have an annual maximum benefit for outpatient services.

The cost trends used were consistently applied to each year. They assume 14% per year increases in inpatient benefits and 10.4% per year in outpatient benefits. The cost savings due to managed care are expected to be 14.1% per year and are assumed to be equal through July 1, 1996.

Reference materials used in this analysis are available upon request, subject to confidentiality constraints.

Observations

Two charts, one reflecting benefits paid and one reflecting charges submitted for each diagnosis are included in Table 3. The charts itemize benefit payments and charges by diagnostic category for inpatient and outpatient charges as well for all mental health diagnoses. The illnesses specified in P.L. 881 account for 50.2% of total benefits paid for all mental health claims by the State and 48.9% of the total charges submitted for all mental health claims by the State. Bipolar disorder accounted for the highest total benefits paid and the second highest in charges submitted. Psychotic Depression/Involutional Melancholia accounted for the second highest benefits paid and the highest charges submitted.

Summary of Findings

The effect of P.L. 881 will be to require the State of Maine to pay $1,602,369 in additional premium over the next four years. Due to the State's current coverage levels for mental health benefits, the overall impact of this legislation will be somewhat less for the State than for private industry. Table 4 shows the additional premium for an average State contract for each of the next four years. However, additional costs relating to these benefits will continue beyond July 1996. While the law does not impose any further changes, claims will continue to be paid for these illnesses at levels higher than under current benefits.

In addition to the analysis of the financial impact of P.L. 881 on the State of Maine, an analysis of the financial impact on other groups was also conducted. For an average Blue Cross and Blue Shield of Maine contract for groups with more than 20 enrollees, P.L. 881 will cause an annual premium increase of $31.32 effective July 1, 1993, and significantly larger increases in subsequent years as the law is fully phased in. On a combined basis, the total increase in premium to subsribers of Blue Cross and Blue Shield of Maine in groups of 20 or more will be $11.3 million over the next four years.

The financial impact of P.L. 881 is directly linked to managed care activities currently in effect. As indicated, utilization review activities have resulted in a reduction in the estimated impact. In the absence of appropriate utilization management, the impact of P.L. 881 will be substantially higher.

TABLE 1

MENTAL HEALTH
COMPARISON OF CURRENT BENEFITS TO PROPOSED LEGISLATION
STATE OF MAINE

	Current Benefits	PL 881 July 1, 1993	PL 881 July 1, 1994	PL 881 July 1, 1995	PL 881 July 1, 1996
Deductible/calendar year	$0	$0	$0	$0	$0
Inpatient					
Limit of days/calendar year	31	60	90	120	equal to benefits provided for other illnesses and diseases
Coinsurance	100%	100%	100%	100%	
Outpatient					
Annual Maximum Benefit	none combined with day treatment	none combined with day treatment	none combined with day treatment	none combined with day treatment	equal to benefits provided for other illnesses and diseases
Coinsurance	70% of UCR	70% of UCR	70% of UCR	80% of UCR	equal to benefits provided for other illnesses and diseases
Lifetime Maximum Benefits (Outpatient Only)	$50,000	No maximum	No maximum	No maximum	No maximum

ICD-9 CODES FOR PL881 COVERED ILLNESSES

TABLE 2

Schizophrenia	Bipolar Disorder	Pervasive Developmental Disorder
295.0	296.4	299
295.1	296.5	299.0
295.2	296.6	299.1
295.3	296.7	299.8
295.4	(296.8)	(299.9)
295.6	(296.89)	315
295.7		315.0
295.8		315.1
295.9		315.2
Childhood Schizophrenia		315.3
(299.9)		315.31
		315.39
		315.4
		315.5
		315.8
		315.9

Psychotic Depression or Involutional Melancholia	Paranoia	Panic Disorder
(296.2)	297	300.01
(296.3)	297.0	
(296.8)	297.1	
296.9	297.2	
296.90	297.3	
296.99	297.8	
298.0	297.9	
300.4	298.8	
(309.0)	298.4	
(309.1)	298.3	
	301.0	

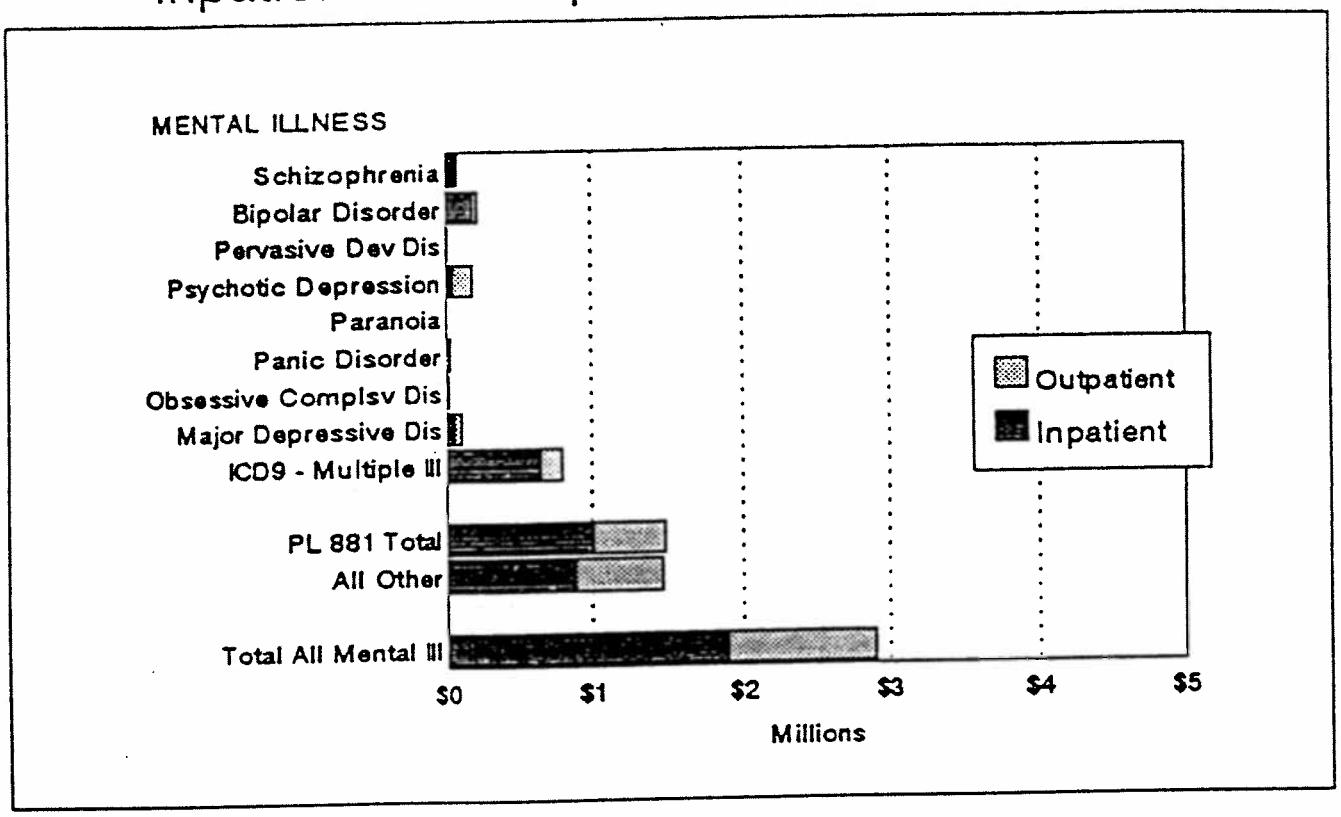
Obsessive Compulsive Disorder	Major Depressive Disorder	Diagnoses that fall into more than 1 category*
300.3	(296.2)	296.2
301.40	(296.3)	296.3
	(296.82)	296.8
	311	299.9
	(309.0)	309.0
	(309.1)	309.1

*ICD-9 codes is parentheses indicate diagnoses that fall into more than 1 category.
Codes at the 5 digit level are subsets of codes at the 4 digit level.

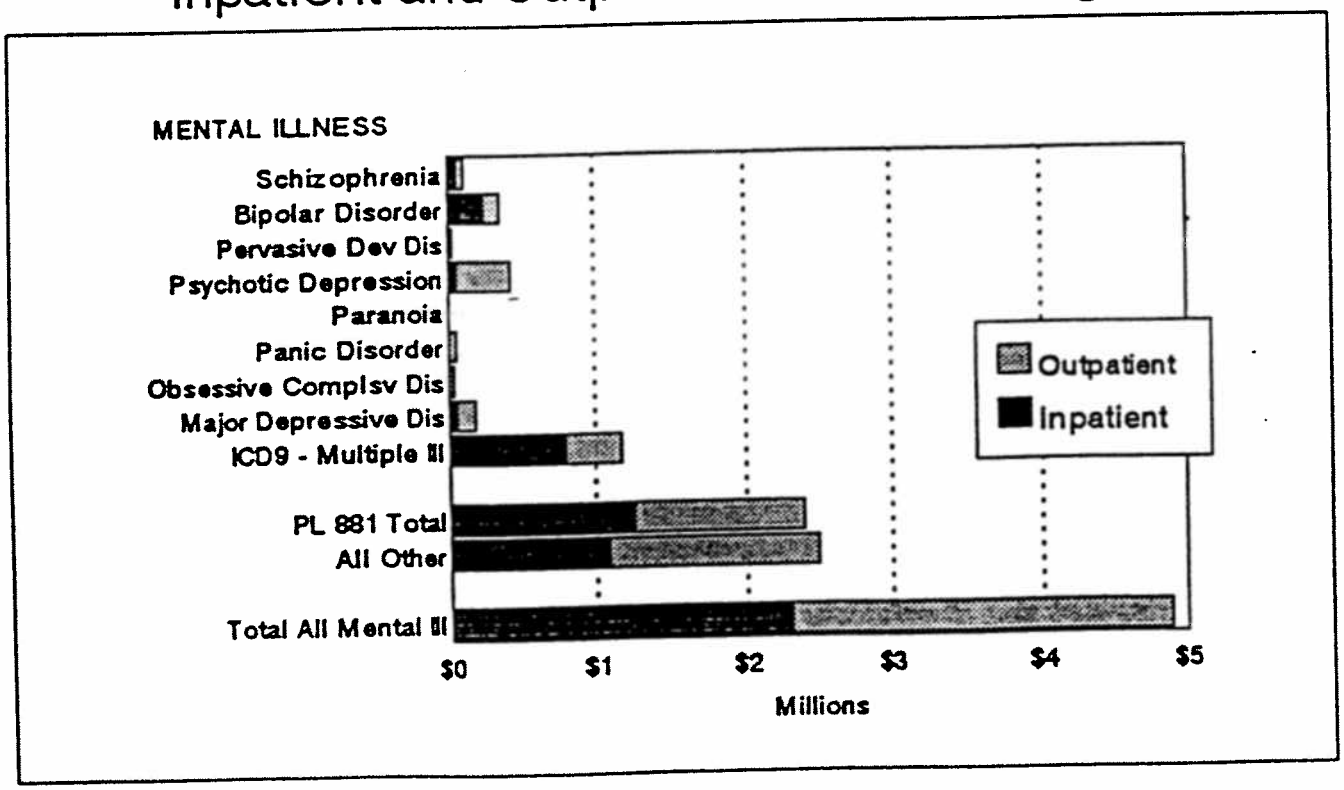
STATE OF MAINE

TABLE 3

Inpatient and Outpatient Benefit Payments



Inpatient and Outpatient Benefit Charges



Services received from 10/01/91 through 09/30/92

FINANCIAL IMPLICATONS of PL 881 on the COST of PROVIDING MENTAL HEALTH COVERAGE for STATE of MAINE

TABLE 4

ANNUAL RATES PER CONTRACT

	Historical Data*	Projected for Year Beginning 07/01/93	07/01/94	07/01/95	07/01/96
PL 881 Total	$87.12				
Other	$85.92				
All Mental Illnesses	$173.04	$261.60	$294.36	$331.20	$372.84
Adjusted for the Cost of PL 881		$270.00	$305.64	$353.76	$418.56
Net Cost Increase		$8.40	$11.28	$22.56	$45.72
Average Number of Contracts	18,048	18,217	18,217	18,217	18,217

TOTAL ANNUAL COST FOR STATE of MAINE CONTRACTS

	Historical Data*	Projected for Year Beginning 07/01/93	07/01/94	07/01/95	07/01/96
Current Benefits	$3,123,026	$4,765,567	$5,362,356	$6,033,470	$6,792,026
Current Benefits Adjusted for PL 881	$3,123,026	$4,918,590	$5,567,844	$6,444,446	$7,624,908
Financial Impact of PL 881	$0	$153,023	$205,488	$410,976	$832,882

*Historical Data includes services received from October 1, 1991 through September 30, 1992.

To: Kenneth Lehman, Esq.

From: John C. Kelly, FSA, MAAA

Re: Attached Report on Cost of Improved Mental Illness Benefits

Date: May 31, 1993

Dear Mr. Lehman:

Attached is an update of my analysis of Blue Cross Blue Shield of Maine's estimate of the costs of enhanced mental illness benefits for the state employees' plan that will result from P.L. 881. This update reflects information received from BCBS on Friday, May 28, 1993.

There is a remaining open question that I will direct to Blue Cross Blue Shield on Tuesday, June 1, but I thought that it would be most useful to provide you with the report pending the resolution of that question so we can review it as soon as possible. This open question would affect only the plan year beginning 7/96, and may result in an increase in my estimate of the incremental cost of P.L. 881.

I found that my year-to-year estimates of the incremental cost of P.L. 881 were similar to BCBS, when expressed as a percentage of the corresponding costs without P.L. 881. The main reason that their numerical results were so much higher than mine was that their baseline was higher, due to the unexplained 50%+ increase in costs from the experience period (10/91- 9/92) to the upcoming plan year (7/93 - 6/94). I believe that it is now time to press BCBS on how they came up with that result.

I will be expecting a conference call at 1:45 PM on Tuesday, June 1, @ 413-596-2280. I hope to have BCBS's answer to the open question by then.

Best regards,

John C. Kelly

An Analysis of the Maine Blue Cross Blue Shield Report of the Cost of Improved Mental Illness Benefits

Summary

This report summarizes the current status of my analysis of Blue Cross Blue Shield of Maine's report on the costs of improving mental illness benefits for the state employees as required by P.L. 881. This report reflects the information provided by BCBS on May 28, 1993.

Based on the assumptions defined by Maine BCBS, I've attempted to duplicate their results. I also showed another set of results with a revised inflation assumption, based on my own observations. My results for the plan year from 7/96 - 6/97 are tentative, as the P.L. 881 requires that the biologically-based mental illnesses be reimbursed at the same level as any other illness, and I did not ask BCBS what that reimbursement level was. I assumed 80%, but the correct answer may be higher. I will ask this question the next time I speak with them and will modify my results if necessary.

Their results, and my two sets of results, can be summarized as follows

Incremental Cost of P.L. 881 ($000s)

	BCBS Study	My Result, BCBS Assumptions	My Result, with Revised Inflation Assumption*
7/93-6/94	153	124	114
7/94-6/95	205	165	146
7/95-6/96	411	295	255
7/96-6/97	833	569	478
4 Year Total	1,602	1,153	993

* 9% Inpatient, 7% Outpatient

In addition to the lower incremental costs shown above for the improvements mandated by P.L. 881, my projected total costs, under for both scenarios (i.e. the current benefit plan and P.L. 881), were significantly below BCBS's for all four years.

The derivation of my results are summarized in Exhibits I-IV.

Background

BCBS released their report on April 30, 1993. Limited details were included. In their report, BCBS offered to make all reference materials used in the analysis available upon request, subject to confidentiality constraints. After several requests, they provided the

material shown in Exhibit V at 2 PM Friday afternoon, May 28. Most of what I had requested was not provided. Of the information provided, only the distribution of hospital days by patient was useful, although it was not the information that had been requested.

Summary of BCBS Assumptions

Based on their original report, BCBS assumed that cost increases due to P.L. 881 would be attributable to:

1. Increased hospital days, due to the increase in the annual maximum each year required by P.L. 881

2. Increased outpatient costs due to an increase in reimbursement from 70% currently to 80% in the 1995-6 plan year and "equal to benefits provided for other illnesses and diseases" for plan years after 7/96. I assumed that this was still 80% after July, 1996, but it is a remaining question to ask BCBS. Based on a comparison of my year-by-year results with BCBS, I suspect that they used something higher than 80%.

3. BCBS assumed 14% inflation for inpatient benefits and 10.4% inflation for outpatient benefits. They assumed that there would be no utilization increases, because of the effectiveness of their managed care.

4. BCBS assumed that managed care would reduce costs 14.1% relative to the experience period of 10/91 - 9/92.

5. BCBS apparently did not assume any impact from the elimination of the $50,000 lifetime maximum.

Data Requested; BCBS's Response

The attached Exhibit VI was the additional information requested from BCBS. The handwriting is BCBS's.

In response to Item 1, BCBS indicated that little additional data was provided to the consulting actuary who concurred with BCBS's estimates. When I asked how the consultant could do a valid estimate without data such as I had requested, BCBS indicated that the consultant used a proprietary data base of his firm to develop certain factors used in his analysis, rather than data based on the Maine state employees plan's own experience.

Item 2 was intended to help estimate the impact of the improved hospital benefits. BCBS provided a useful report, although different than the one requested.

Item 4 was intended to evaluate the effect of eliminating the lifetime maximum, but BCBS indicated that this data was not available. It is unclear to me how their claim department

can administer the current lifetime maximum without knowing the information I requested.

I had hoped to validate their inflation assumptions with the data requested in Item 5, but BCBS said that it was not available. I made a verbal request for alternative backup for their inflation assumption, but none was provided.

In response to Item 6, I was provided with a document that asserted 14.1% savings from managed care, but contained nothing that could be construed as documentation.

Several of the reports I had requested are apparently not currently produced by BCBS for their own use. BCBS raised the issue of who would pay for the production of these reports if they were to be produced for my use. We left this unresolved pending my analysis of the data that was produced.

Analysis of Data and Assumptions

Inflation Assumption: BCBS assumed annual inflationary expense increases of 14% for inpatient expenses and 10.4% for outpatient expenses. My own observations of health care claim trend (which includes both inflation and utilization increases) indicates that overall medical care trend has declined from the mid-to-high teens in the late 1980s to single digits in the second half of 1992. Again, this result includes both inflation and increased utilization. Inflation alone is even lower.

My observations were based on overall medical expenses, not just mental illness expenses, so some difference with the BCBS assumption can be explained. However, BCBS's assumption is so far removed from my observations that I am unwilling to accept their assumption as reasonable without any documentation of how their mental illness claims have increased with time recently.

One of my estimates of the incremental cost assumed inflation @ 9% for inpatient expenses and 7% for outpatient expenses, which is more consistent with my observations. In the absence of any documentation from BCBS, I believe that this is a more reasonable assumption.

Distribution of Hospital Days: BCBS provided a distribution of hospital days by patient. It was described as the calendar 1991 experience for all BCBS contracts. Use of this report to predict the impact of improving the current 31 day maximum for a plan year is complicated by the following concerns:

1. I don't know how annual limitations of covered hospital days may have affected this distribution. Presumably, the different BCBS contracts have varying provisions, and some may have no maximums.

2. When there is a annual maximum that is administered for a plan year that is not a calendar year, the distribution of hospital days per patient in a calendar year will tend to be more widely dispersed than in a plan year. For example, a plan with a July 1 anniversary (such as the state employees plan) and a 31 day annual plan year hospital maximum could show as many as 62 days in a given calendar year for an individual patient, because the patient could hit the plan year maximum of 31 days in the portion of each of the plan years that overlaps with the calendar year. Therefore, the use of a calendar year hospital day distribution would contribute an upward bias to the estimate of the portion of hospital days in excess of any specific amount for a plan year that is not the same as a calendar year.

I had requested that BCBS provide the hospital days distribution for the state employees plan for a 12 month plan year rather than a calendar year to eliminate this source of bias, but this information was not provided. In my study, I assumed that there were no maximums inherent in the data provided, to minimize the bias resulting from use of a calendar year distribution rather than a plan year. The effect is that I may have understated the impact of the improved hospital provisions, but an inspection of their hospital days distribution data suggests that the savings resulting from the annual maximum are not significant. Only 13% of the hospital days indicated in this distribution are days in excess of 30, and a significant portion of those may be attributable to the presence of two plan years (and potentially a 62 day maximum) within the calendar year. The absence of a large concentration at the 31 day maximum suggests to me that the distribution of hospital days if all BCBS contracts had no maximum would not look significantly different.

The % Increase Factors developed below were used in Exhibits II and IV to estimate the increase in hospital days each year resulting from the increased maximum:

Maximum	#Days Below Maximum	% Increase
31 Days	7,000	
60 Days	7,762	10.9%
90 Days	7,893	1.7%
120 Days	7,946	0.7%
No Maximum	8,046	1.3%

Reliance on BCBS Data

I relied on much of the BCBS data, such as the claim data from the experience period, the ICD-9 codes assumed to be affected by P.L. 881, and their description of the current state employees plan and how it differs from the mandates of P.L. 881. There is a remaining open question about the current benefits (coinsurance percentage) for other illnesses and diseases, which could affect my estimate for the plan year beginning July, 1996.

Because the information requested from BCBS was not provided until late in the day on May 28, I was not able to complete my analysis before the start of the holiday weekend, and therefore was unable to ask any followup questions of BCBS. Because of the timing constraints, I felt it was most useful to provide this report with the question relating to the coinsurance percentage for other diseases/illnesses unanswered. I will ask this question on Tuesday, May 1, and will notify you if my results need any modification. This issue only affects my results for the plan year beginning July, 1996.

Other Financial Impacts of P.L.881

I have only attempted to evaluate the impact of P.L. 881 on the state employee's medical plan. There is evidence to suggest that employees can return to work more quickly if they receive the most appropriate medical care that is not restricted by limitations. I am not prepared to quantify this impact, but it is likely P.L. 881 will lead to some savings in the state's sick pay plan, which will offset a portion of the increase in medical expenses.

Conclusion

In the absence of the best possible information on claim inflation and the distribution of hospital days, I believe that this report represents a realistic estimate of the cost to the state of P.L. 881. By completely disclosing my assumptions and calculations, I am trying to promote an informed decision making process. I welcome any information that would improve the validity of my assumptions, and will revise my results promptly if such information becomes available.

John C Kelly

John C. Kelly, FSA, MAAA

MAINE PSYCHIATRIC ASSOCIATION ANALYSIS OF THE MAINE BLUE CROSS BLUE SHIELD REPORT OF THE COST OF IMPROVED MENTAL ILLNESS BENEFITS

On behalf of the Maine Psychiatric Association, I have analyzed the report of Blue Cross Blue Shield of Maine on the costs of providing mental illness benefits for state employees as required by P.L. 881. This report is based on information provided by BCBS pursuant to requests made by the Maine Psychiatric Association. This information was provided on May 28, 1993, as well as in a meeting with BCBS on June 2, 1993.

Summary

We believe that the Maine BCBS report significantly overstates the impact of P.L. 881 on the cost of providing mental illness benefits.

1. Relying on Maine BCBS assumptions, we calculated a baseline cost before considering the impact of P.L. 881, for the plan year beginning in July, 1993 that is 5% below Maine BCBS's estimate. Therefore, the BCBS numbers should be reduced by 5% for this reason.

2. Maine BCBS's inflation assumption is also too high. BCBS assumed 14% for inpatient claims and 10.4% for outpatient claims. Based on recent observed claim trends, 9% for inpatient and 7% for outpatient is a more reasonable assumption. The effect of this correction is to <u>further reduce</u> BCBS's baseline estimate as follows:

7/93-6/94	6.4%
7/94-6/95	10.1%

3. Maine BCBS's analysis reflected the cost of the benefit improvements associated with the implementation of a Preferred Provider Organization (PPO), effective December 1, 1992. However, BCBS <u>did not make an explicit adjustment</u> for the fee discounts that were negotiated with the PPO provider network. These discounts should offset a large portion of the cost of improved benefits. BCBS says that these discounts are already included as a component of the 14.1% savings attributable to managed care. If this is so, the number is far too low.

A more reasonable assumption is that managed care will yield a 14.1% savings beyond the affect of PPO discounts. This is more consistent with industry experience. We believe that an additional reduction of 15% should be included to reflect the cost savings resulting from PPO discounts.

Summary of Results

For the reasons set forth above, the BCBS estimate of the impact of P.L. 881 should be modified as follows:

	7/93-6/94	7/94-6/95
Maine BCBS Estimate	$153,023	$205,488
Adjust for		
1. Baseline Calculation	- 5.0%	- 5.0%
2. Revised Inflation Assumption	- 6.4%	-10.1%
3. PPO Discounts	-15.0%	-15.0%
Total Adjustment (Cumulative)	- 24.4%	-27.4%
Reduction	$ 37,365	$ 56,316
Modified Estimated	$115,658	$149,172

The costs of P.L. 881 for the next two years will be $93,681 less than predicted by Maine BCBS. The reduction relative to BCBS's estimate will be much greater for subsequent years.

June 2, 1993

John C. Kelly, F.S.A., M.A.A.A.

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BCBS.sum

AN ACTUARIAL ANALYSIS OF THE IMPACT OF LD 183 ON PRIVATE INSURANCE PLANS, PREPARED FOR THE MAINE PSYCHIATRIC ASSOCIATION

Brief Summary of PL 881

LD 183 will put into effect hte provisions of PL 881. PL 881 requires that medical insurance programs, for employers with 20 or more employees, provide improved benefits for certain biologically-based mental illnesses. PL 881's requirements can be summarized as follows:

1. Any annual maximums for inpatient treatment must be increased as follows:

   Year 1 - 60 days
   Year 2 - 90 days
   Year 3 - 120 days
   Year 4 - same as any other illness

2. The Coinsurance percentage/annual maximum for outpatient treatment must be at least the following:

   Year 1 - 60%/$2000
   Year 2 - 70%/$3000
   Year 3 - 80%/$4000
   Year 4 - same as any other illness

3. No lifetime maximum for biologically-based mental illness

PL 881 does not prevent medical insurance plan sponsor from lowering its medical insurance plan's cost by any of the the following:

1. Imposing a deductible
2. Having a coinsurance percentage of 80% (rather than 100%)
3. Having employees share in the cost of the plan

PL 881 does limit the plan sponsor's ability to restrict coverage for mental illness. The cost effect can be mitigated by any of the above responses.

Analysis of Impact of PL 881

The purpose of this analysis is to illustrate the impact of PL 881 on a typical insured plan. The following 3 exhibits clarify the impact of PL 881 on a typical plan. They are derived from data contained in the Blue Cross Blue Shield (BCBS) of Maine report released April 30, 1993, that showed their estimate of the impact of PL 881 on the state employees plan.

What is a Typical Plan?

The current state employees plan is a very rich plan. It has no deductibles. It pays 100% for most diagnoses, with mental illness a major exception. It pays up to 31 days of hospitalization @ 100% with no deductible, and pays outpatient charges @ 70%, with a $50,000 lifetime outpatient max. The state went to this plan when it adopted a PPO (preferred provider arrangement). In general, PPO arrangements lead to cost savings due to negotiated discounts with providers. These cost savings permit a more generous benefit structure for the employee with little net increase in cost to the plan sponsor.

PPOs tend to be located in areas of high population density, where there is intense competition among health care providers. The PPO exploits this competition to negotiate provider discount. A rural area will have fewer providers, which limits the PPO's ability to negotiate discounts. It seems likely that Maine, as a rural state, will adopt PPOs more slowly than the nation as a whole. **Accordingly, this analysis assumes that a typical plan will not have a PPO arrangement and the associated PPO provider discounts.**

Medical plans lacking access to a PPO will most likely try to manage utilization through a combination of deductibles and coinsurance. This is probably the most common practice in Maine. This analysis assumes that the typical medical insurance plan in Maine will have the following characteristics:

80% coinsurance
A deductible that reduces claims 5%
5% claim reductions due to UCR (usual customary and reasonable) limits

31 day hospital limit for mental illness
50% coinsurance for mental illness outpatient

In effect, this assumes that the typical plan is similar to the state employees plan, except with 80% coinsurance for inpatient care instead of 100%, instead of 100%. This assumption will simplify the estimates of paid claims vs. submitted charges that are contained in Exhibits II & III.

Description of Exhibits

Exhibit I: Exhibit I was derived from Tables III & IV of the BCBS report of April 30, 1993. The submitted charge and paid claim figures are for the diagnosis codes that are subject to PL 881. Table III was a bar chart; hence the approximate nature of the submitted charges and paid claims. Lines 1-3 are BCBS figures, and Lines 6-7 show these results on a per employee basis. Line 9 shows the difference between the charges submitted and the claims paid. The difference is attributable to the effect of the coinsurance, deductible, limits and maximums, and adjustments for UCR. Lines 12-16 represent a reasonably educated estimate of how the difference can be broken down.

Exhibit II: Exhibit II is based on BCBS's inflation assumption (14% inpatient/10.4% outpatient). Lines 1-3 show the claims for the state plan in the historic date period (10/91 - 9/92), as well as in calendar years 1993 and 1996 (the periods addressed in last week's press release). The inflation adjustments are shown in the intervening columns. Lines 7-16 show the expected claims for the state's old plan in each of the three periods, as if no benefit changes were required by the mandate, and expresses these claims as a percent of submitted charges. These percentages contain the effect of UCR, deductibles, coinsurance, and maximums.

The objective of Exhibit II is to estimate these percentages for various future scenarios. These percentages will then be applied to submitted charges, an easily determinable number, to arrive at an estimate of projected paid claims. By evaluating the reasonableness of these percentages, an opinion as to the reasonableness of the overall result can be formed.

Line 14 shows that inpatient paid claims are assumed to be a constant percentage of submitted charges. Line 15 shows that outpatient paid claims are a declining percentage of submitted charges, because of the effect of the fixed maximum ($1,000). Again, these percentages are independent of any mandated benefit improvements.

Lines 25-26 show the assumed factors for a typical plan, again with no mandated improvements. The inpatient factors are 80% of state plan inpatient factors, and the outpatient factors are set at a constant 36.4%, which assumes that a typical plan will modify deductibles and maximums to pay a constant percentage of submitted charges over time. The resulting dollar claims are shown in Lines 20-22.

Lines 29-38 illustrate the impact of mandated improvements on this typical plan. this section reflects the following assumptions:

Inpatient Coinsurance = 80%
Outpatient Coinsurance = 60% in Year 1, 80% in Year 4
Deductibles will be set so that a 5% reduction in paid claims is achieved
UCR will reduce claims 5%

The resulting percentages are shown in Lines 36-38, and the resulting paid claims are shown in lines 31-32. This represents a reasonable estimate of the impact of the mandates on a typical plan. Comparing the percentages in Lines 25-26 to those in Lines 36-36 show that this analysis has made a significant provision for the increase in outpatient benefits resulting from the mandates.

Exhibit III: Exhibit III is exactly the same as Exhibit II, except that inflation assumptions are lower (9% for inpatient, 7% for outpatient).

Summary of Results

The results of this analysis, for a typical plan, can be summarized as follows:

	BCBS Inflation		Modified Inflation	
	Year 1	Year 4	Year 1	Year 4
Claims w/o Mandate	$77	$111	$74	$94
Claims with Mandate	$94	$151	$89	$128
Indicated Increase per Employee	$17	$40	$15	$34

These results can be compared with the Chamber of Commerce's indicated costs of as much as $50 per employee in Year 1 and **as much as $220 per employee in Year 4.**

Further Adjustments

These costs are expressed in paid claims. To estimate total costs, the estimates of incremental paid claims can be increased 3% to reflect that the incurred claim runout was not completed in the historic data period. An additional small adjustment is permissable for increased administrative expenses, but this will be minor (2% of incremental claims?). The mandated benefits should have little impact on administrative costs, as the largest component of administrative costs is the work involved in entering data related to submitted charges into the claim paying system. As the magnitude of submitted charges is unaffected by the mandate, there should be no increase in these costs. Most other expenses (underwriting, contracts, actuarial, overhead) should be unaffected also.

The Chamber of Commerce's $220 Estimated Impact for 1996

The Chamber of Commerce has estimated a cost impact of "as much as $220 per employee" in 1996. Based on these exhibits, $220 might be a reasonable estimate for the total submitted charges and administrative expenses for 1996, if BCBS's inflation assumptions are used. In this case, **$220 is only a reasonable estimate of incremental costs if current costs are zero, i.e. no health insurance plan at all.** In other words, the Chamber of Commerce has apparently assumed that the effect of the mandate will be to motivate an employer who currently has no medical insurance at all on its employees to implement a medical plan that pays all submitted charges @ 100%, with no deductible and no reduction for UCR. This is hardly a reasonable assumption.

This analysis also ignores cost savings associated with managed care (estimated as 14.1% by BCBS), and, as previously stated, provider discounts for PPO (typically 15%) for cases with PPO arrangements.

June 15, 1993

John C. Kelly
Fellow, Society of Actuaries
Member, American academy of Actuaries

EXHIBIT I

Assumptions (derived from BCBS Report of April 30, 1993)

	Historic Data - BCBS Report of April 30, 1993 for Claims Affected by PL 881	TOTAL	INPATIENT	OUTPATIENT	Location in 4/30/93 BCBS Report
1	Submitted Charges (1091-9/92)	2,300,000	1,200,000	1,100,000	Table 3
2	Paid Claims	1,400,000	1,000,000	400,000	Table 3
3	Average Employees	18,048	18,048	18,048	Table 4
4					
5	Per Employee				
6	Submitted Charges	127.44	66.49	60.95	L1/L3
7	Paid Claims	77.57	55.41	22.16	L2/L3
8					
9	Charges not Paid	49.87	11.08	38.79	L6-L7
10					
11	Estimated Not Paid due to:				
12	UCR Reduction	6.37	3.32	3.05	5% of Submitted Charges
13	Annual Maximum	18.47	7.76	10.71	Balancing Item
14	Deductible	2.86	0.00	2.86	94% of UCR Savings (if applicable)
15	Coinsurance	22.16	0.00	22.16	L13 (50% outpatient)
16	Lifetime Maximum	0.00	0.00	0.00	Assumed Zero
17	Total	49.87	11.08	38.79	
18					
19					
20					
21					
22					

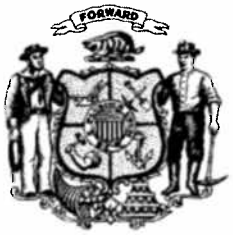
Submitted Charges per BCBS Inflation Assumptions
Paid Claims for Several Benefit Plans

		PL 881 Submitted Charges per Employee 10-91-9/92	15 Months Inflation @ BCBS Assumption	PL 881 Submitted Charges per Employee 1993	36 Months Inflation @ BCBS Assumption	PL 881 Submitted Charges per Employee 1996
1	Inpatient	$66.49	1.178	$78.32	1.482	$116.04
2	Outpatient	$60.95	1.132	$68.97	1.348	$92.81
3	Total	$127.44		$147.30		$208.85
4						
5	Paid Claims for Various Benefit Plans					
6						
7	I. State Plan in Effect for Historic Period (100% Inpatient up to 31 Days, 50% Outpatient up to $1000)					
8						
9	Inpatient	$55.41		$65.27		$96.66
10	Outpatient	$22.16		$23.82		$28.85
11	Total	$77.57		$89.09		$125.51
12						
13	% Charges					
14	Inpatient	0.833		0.833		0.833
15	Outpatient	0.364		0.345		0.311
16	Total	0.609		0.605		0.601
17						
18	II. Typical Plan - 80% Inpatient					
19						
20	Inpatient	$44.33		$52.22		$77.36
21	Outpatient	$22.16		$25.11		$33.78
22	Total	$66.49		$77.32		$111.14
23						
24	% Charges					
25	Inpatient	0.667		0.667		0.667
26	Outpatient	0.364		0.364		0.364
27	Total	0.522		0.525		0.532
28						
29	III. Typical Plan - adjusted for Mandate					
30						
31	Inpatient			$56.55		$83.78
32	Outpatient			$37.35		$67.01
33	Total			$93.90		$150.79
34						
35	% Charges					
36	Inpatient			0.722		0.722
37	Outpatient			0.542		0.722
38	Total			0.637		0.722

Submitted Charges per Modified Inflation Assumptions
Paid Claims for Several Benefit Plans

		PL 881 Submitted Charges per Employee 10-91-9/92	15 Months Inflation @ Modified Assumption	PL 881 Submitted Charges per Employee 1993	36 Months Inflation @ Modified Assumption	PL 881 Submitted Charges per Employee 1996
1	Inpatient	$66.49	1.114	$74.05	1.295	$95.90
2	Outpatient	$60.95	1.088	$66.33	1.225	$81.26
3	Total	$127.44		$140.38		$177.16
4						
5	Paid Claims for Various Benefit Plans					
6						
7	I. State Plan In Effect for Historic Period (100% Inpatient up to 31 Days, 50% Outpatient up to $1000)					
8						
9	Inpatient	$55.41		$61.71		$79.88
10	Outpatient	$22.16		$22.91		$25.26
11	Total	$77.57		$84.62		$105.14
12						
13	% Charges					
14	Inpatient	0.833		0.833		0.833
15	Outpatient	0.364		0.345		0.311
16	Total	0.609		0.603		0.594
17						
18	II. Typical Plan - 80% Inpatient					
19						
20	Inpatient	$44.33		$49.37		$63.94
21	Outpatient	$22.16		$24.14		$29.58
22	Total	$66.49		$73.51		$93.51
23						
24	% Charges					
25	Inpatient	0.667		0.667		0.667
26	Outpatient	0.364		0.364		0.364
27	Total	0.522		0.524		0.528
28						
29	III. Typical Plan - adjusted for Mandate					
30						
31	Inpatient			$53.47		$69.24
32	Outpatient			$35.92		$58.67
33	Total			$89.38		$127.91
34						
35	% Charges					
36	Inpatient			0.722		0.722
37	Outpatient			0.542		0.722
38	Total			0.637		0.722


WISCONSIN STATE LEGISLATURE


FORWARD

Alliance for the Mentally Ill of Maine

MEMORANDUM

TO: NAMI - Miami Workshop Attendees
FROM: Michael J. Fitzpatrick, Executive Director
DATE: September 10, 1993
RE: PARITY INSURANCE MATERIAL

==========

Enclosed you will find some of the material that was requested by a number of you at our NAMI Convention Workshop on Parity Insurance.

Below you will find copies of the following:

- BC/BS Analysis of the "Maine Bill"
- Our Coalition's Analysis' reaction to the BC/BS Study
- Copies of the initial Dore Bill as well as the most recent "sunset bill" and the resulting law.

We have much more detailed material related to Maine's bill battles. If you need additional information, please let me know.

Thanks.

MJF/lb
Enclosure

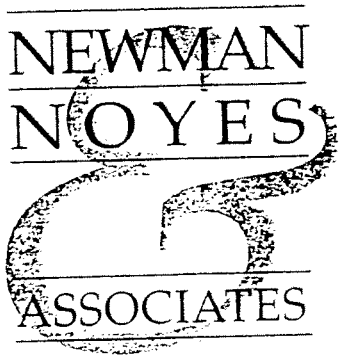
Box 222, Augusta, ME 04332
(207) 622-5767 1-800-464-5767

Estimate of Added Cost of Covering Biologically-Based Mental Illnesses on the Same Basis as All Other Illnesses

Prepared for:

The Alliance for the
Mentally Ill of New Hampshire

April 1994



The purpose of this report is to quantify the cost to insured residents of the state of New Hampshire for bringing private insurance coverage for serious mental illness to a level equal to that for other physical illnesses. While in some instances data for such a study were not available specifically for New Hampshire, similar studies have been conducted either nationally or in selected states, and data and methods from these should act as reliable surrogates for New Hampshire. In all instances where multiple sources existed for any individual piece of data, this report has relied on that source which is most current or most closely comparable to New Hampshire.

AFFECTED POPULATION

There are approximately 1.1 million residents of the State of New Hampshire. Of these, the Office of the Insurance Commissioner (OIC) estimates that approximately 11% of the population, or 121,000 residents are age 65 or older and, as such, are covered for their medical costs by the Medicare program, which is administered by the Federal government. The OIC additionally estimates that roughly 50,000 residents, or 4.5% or the population are covered by the State's Medicaid program. Of the 929,000 residents not covered by these public programs, the OIC estimates that 129,000 are uninsured and the remaining 800,000 are covered by some form of private insurance. It is these 800,000 residents on whom the expansion of benefits to parity coverage for serious mental illness would have a direct impact.

PREVALENCE

A 1993 report by the National Advisory Mental Health Council (NAMHC) estimates that 2.8% of the population of the United States is affected by serious mental illness. However, data from the National Institute of Mental Health (NIMH) indicates a link between income level and serious mental illness. This does not suggest any causal relationship between income level and prevalence of serious mental illness, but is more likely the result of the fact that those with serious mental illness are often either unable to work or at least impaired in their ability to work and thus have lower incomes and are less likely to be covered by private health insurance. Citizens above national poverty levels made up 90.5% of the population in 1989, but represented only 79% of those reported to have serious mental illness. That would suggest that those above the poverty line are only 87% (79% / 90.5%) as likely to experience serious mental illness.

Assuming a prevalence rate of 2.8% for the population at large, those who are privately insured and generally above the poverty level are thus likely to have a prevalence rate closer to 2.4% (87% of 2.8%). A prevalence rate of 2.4% on a privately insured population of 800,000 equates to 19,554 privately insured New Hampshire residents with serious mental illnesses.

UTILIZATION OF SERVICES

The NAMHC report indicates that only 60% of those afflicted with serious mental illness would use mental health services within a given year, given current insurance coverage, but suggests that with better coverage, utilization would likely increase to 80%, which is more in line with utilization of services by insured individuals who have physical illnesses. On that basis, the number of privately insured New Hampshire residents with serious mental illness receiving services on an annual basis would rise from 11,732 to 15,643.

The annual cost of services used by SMI patients was derived from a May 1993 actuarial study performed on behalf of the Maine Psychiatric Association. This study was preferred over NAMHC, as the data in the NAMHC report was based on older data (1990) and was national in scope. The Maine study was based on Blue Cross/Blue Shield claims data from October 1, 1991 through September 30, 1992, and Maine is more similar to New Hampshire, demographically, than the U.S. population at large.

Applying to the Maine data the same prevalence assumptions outlined above indicated that Maine patients with SMI used, on average, $3,476 each during the claim period. A gross check on the reasonableness of the $3,476 per patient was performed using data from NIMH. This data indicates that in 1988, New Hampshire spent approximately $3,500 per SMI patient. Given recent reductions in length of stay in inpatient psychiatric hospitals, it is reasonable to assume that cost reductions have offset inflation over the period from 1988 to 1992, and that the $3,476 per patient experienced in Maine is an acceptable figure for use in our analysis of New Hampshire utilization. Based on inflation rates also estimated in the Maine report, the 1994 cost for those same services would be $4,058 for each SMI patient annually.

COVERAGE

In order to calculate the incremental cost of parity coverage for SMI, we must first define the current level of coverage, and next define the level of coverage considered to be "on par" with coverage for other physical illnesses.

On the basis of the Maine study and other supporting sources, coverage for inpatient and outpatient services assumed in this study are outlined below for both a "typical plan" and for "parity coverage":

	Typical Coverage	Parity Coverage
Inpatient services	31 days @100%	100%, no maximum
Outpatient services	50% coinsurance after deductible $50,000 lifetime maximum	80% coinsurance after deductible No maximum or very high ($1 million)

Additionally, it is assumed in either case that deductibles and usual and customary rate (UCR) limits reduce claims by 5% each.

Splitting the $4,058 in annual claims per SMI patient into inpatient and outpatient services based on Maine's claims experience and applying the above coverage plans, the typical plan would cover $2,470, or 60.9% of the cost. The parity plan would cover $3,409, or 84.0%.

INCREMENTAL COST

Combining the prevalence, utilization, and coverage figures outlined above, it is estimated that privately insured New Hampshire residents currently spend $47.6 million annually for treatment of SMI. Of that $47.6 million, $29 million is covered by insurance, while the remaining $18.6 million is borne by the patients and their families. Requiring insurance plans to offer coverage of SMI equal to physical illnesses would increase total utilization to $63.5 million. Of that $63.5 million, $53.3 million (84%) would be covered by insurance, and patients and families would pay for the remaining $10.2 million (16%).

The $24.3 million increase in services covered under insurance from $29 million to $53.3 million, spread over 800,000 privately insured individuals, would increase annual health insurance premiums by $30 for an individual or $81 for a family plan, assuming 2.7 members per family. 1991 data from Families USA Foundation indicated that employers paid approximately 76% of health insurance premiums, with employees paying the remaining 24%. On that basis, the increased coverage for serious mental illness would increase an employee's contribution to health insurance premiums by $19.44 annually, or $1.62 per month. Employers would pay $61.56 annually, or $5.13 per month per family contract.

It should again be pointed out that charges not covered by insurance would drop from $18.6 million to $10.2 million. This $8.4 million savings to insured individuals would more than offset the $6 million in incremental health insurance premiums paid by employees.

OFFSETS TO INCREMENTAL HEALTH CARE COSTS

In addition to the cost to the families of the seriously mental ill, society bears a great cost for not treating these illnesses. A recent study conducted by a team of economists at the Massachusetts Institute of Technology (MIT) and published in the November 1993 Journal of Clinical Psychiatry estimates the annual cost of depression in the United States at $43.7 billion. That number includes only $12.4 billion for the cost of treating patients with depression. The remaining $31.3 billion reflects the cost of neglected or inadequate treatment, including lost income from suicides, missed work days, and lost productivity on days when depressive patients manage to go to work. That same study also estimates the annual cost of schizophrenia at $33 billion.

The MIT study clearly indicates that the largest part ($31.3 billion out of $43.7 billion) of the cost of depression is the indirect cost of neglecting or inadequately treating those patients. As such, it is simple to infer that the cost of treating these patients should be more than offset by reducing or eliminating those indirect costs. This is made readily apparent by a companion paper to the MIT study which estimates that the productivity and lost work days alone cost $180 per year for every employee in the U.S. The recoupment of that $180 per employee reflects that New Hampshire employers investment of $75 for increased coverage of serious mental illness could be recovered as much as 2.4 times over. Even if the study is subject to criticism, there is significant room for adjustment before reaching a point where the savings do not outweigh the costs.

COST TO THE STATE OF NEW HAMPSHIRE

Approximately 60% of State employees are currently covered by Blue Cross and Blue Shield of New Hampshire's Blue Choice plan, which already offers coverage for serious mental illness equal to coverage for other physical illnesses. The remaining 40% are enrolled in one of two managed care programs which do impose some restrictions on mental health benefits, but offer more coverage than the "typical" plan used in this analysis. If those enrolled in the plans other than Blue Choice experienced the full increase of $81 per family plan per year, that would represent a premium increase of 1.25% on 1994 rates.

Based on $63 million in total health insurance premiums for the State, roughly $25 million are paid to plans other than Blue Choice. A 1.25% increase on $25 million equates to $312,500. Assuming 5% inflation (the State average premium increase for the past three years), and January 1, 1995 effective date, the cost to the State of New Hampshire would be $164,062 for fiscal year 1995, $344,531 for fiscal year 1996, $361,758 for fiscal year 1997, and $379,846 for fiscal year 1998.