



*An Actuarial Analysis
of
Comprehensive
Mental Health and Substance Abuse
Benefits
for the State of New York*

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Executive Summary

The New York State Psychological Association engaged PricewaterhouseCoopers, L.L.P. (PwC) on behalf of Fair Insurance Today to provide actuarial analysis and consulting advice on the mental health benefit proposal introduced in the 2002 New York legislative session. This report presents a detailed discussion and cost analysis of the primary proposal – **Comprehensive Parity**, defined as coverage of insured mental health and substance abuse benefits on the same basis as medical care coverage (parity). This report also includes the cost of mental health parity only. The purpose of including this option is to more accurately frame the broader discussion of mental health benefits and to provide a documentation of costs as legislative questioning and debate develops in New York.

In general, the New York bill proposes parity in order to protect the financial concerns of covered members of insured plans. Except for an estimate of less than 2% of plans that do not offer any mental health benefits, the parity bill will not add new eligible expenses for mental health or substance abuse coverage. Under the New York bill for mental health and substance abuse parity, medically necessary benefits as currently defined and applied by insurers are left unchanged. Managed care controls are not affected by this legislation. Carve-out plans and separate managed behavioral health care programs can be used, even if no comparable managed care plan exists for medical or surgical benefits.

The bill removes arbitrary and artificial limits to the reimbursements of mental health and substance abuse benefits. This is an extension of the Federal mental health legislation (the Mental Health Parity Act of 1996) that requires parity for annual and lifetime dollar amounts. However, different deductibles, coinsurance, copayments, out-of-pocket maximums, separate day and visit limits are not protected by the Federal Act. Managed care cost controls and use of various utilization management techniques are not affected by this state legislation or the federal parity legislation.

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

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

While the PwC cost analysis is appropriate for all categories of required coverage, the variation from expected costs is greatest for small groups. However, New York requires modified community rating in the small group market. Therefore, a statewide requirement for parity creates a level playing field for all insurers and should provide adequate risk sharing over an aggregated population of small group participants that minimize any cost increase applicable to the experience of any one group.

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

The four delivery systems assumed are:

Delivery System 1. Generally, Fee-for-Service indemnity plans with utilization review found on typical medical plans. There is no special mental health or substance abuse focus and review (preadmission certification and continued stay review) generally only applies to inpatient care.

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

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

Delivery System 4. Generally, 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.

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

Within this matrix of delivery systems, the proposed New York Act (Comprehensive MH & SA Parity) is priced as well as parity for mental health only:

1. **Current** - typical mental health and substance abuse benefit design in current market.
2. **Comprehensive Mental Health Only Parity** - financial parity with mental health benefits reimbursed under health insurance plans on the same basis as medical/surgical benefits.
3. **Comprehensive Mental Health & Substance Abuse Parity** - financial parity with mental health and substance abuse benefits reimbursed under health insurance plans on the same basis as medical/surgical benefits.

The following table summarizes the actuarial modeling results. The Gross Composite Market Impact on the health insurance market ranges from 1.7% for MH Only Parity to 2.0% for Comprehensive MH&SA Parity. For MH&SA Parity, the cost increases range from 3.5% for Fee-For-Service to 1.3% under HMO & Gatekeeper programs.

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

The following table summarizes the actuarial modelling results:

Table 1
Summary Costs for MHETA
Before Consideration of Recent State Parity Laws and Before Migration

Delivery System	Generic Description	Percentage Increase in Base Medical Plan for Change to Type of Parity		
		Current Distribution	Comprehensive MH Parity Only	Comprehensive MH&SA Parity
Delivery System 1	Fee for Service	5%	2.8%	3.5%
Delivery System 2	Managed Indemnity	15%	2.3%	2.8%
Delivery System 3	PPO	30%	2.3%	2.7%
Delivery System 4	HMO/POS & Gatekeeper	50%	1.0%	1.3%
Gross Composite Market Impact			1.7%	2.0%
Gross Composite PMPM			\$2.63	\$3.14
Net Composite Market Impact			0.7%	0.8%
Net Composite PMPM			\$1.05	\$1.26

The PwC study includes conservative assumptions that tend to overstate the expected costs. The PwC report follows generally accepted actuarial principles and recognizes normal cost management techniques. We do not assume:

1. Any Medical Offset,
2. Any Disability Savings,
3. Any Productivity Savings, or
4. Any Savings from Public Sector Mental Health Programs.

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

The Congressional Budget Office (CBO) typically estimates that these employer responses to required coverages would result in cost offsets of about 60% of the Gross Composite Market Impact estimates. Using the standard CBO economic modeling approach, the Net Composite Market Impact on employer contributions for health costs would rise about 40% of the Gross Composite Market Impact estimate or only 0.8 percent (MH & SA Parity).

Migration can also be a key reason that the actual Net Impact of parity has been lower than many traditional actuarial models has predicted. Migration from current levels of management to more intense management of behavioral health benefits is typical following state passage of mental health parity laws. We can assume the same dynamic will occur upon passage of the New York legislation. As stated in "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":

"Parity experience of States studied to date suggests that introducing parity nationwide would induce insurance companies to introduce managed behavioral health care approaches wherever they are not already in place."

As an example, consider the following migration pattern or movement from the current distribution of delivery systems (pre-passage) to more intensive management of the mental health benefits following passage of parity (post-passage). The first line of this table can be read as follows: Assume that 5% of the population with current mental health benefits managed in Delivery System 1 (From Table 1) moves or migrates such that only 10% of the 5% remain in Delivery System 1, 60% migrate to Delivery System 2, 20% migrate to Delivery System 3, and 10% migrate to Delivery System 4.

Table 2
Estimated Migration to More Intensive Managed Behavioral Health

Pre-Passage	Percentage of Pre-Passage Delivery Systems Shifting Post-Passage			
	Del #1	Del #2	Del #3	Del #4
Delivery #1	10%	60%	20%	10%
Delivery #2		35%	40%	25%
Delivery #3			50%	50%
Delivery #4				100%

Note: These migrations are the result of employers seeking lower cost delivery of their plan's mental health benefits. These migrations can substantially mitigate the cost impact an employer's plan would otherwise experience. For example, integrating this migration pattern into the Table 1 cost analysis, the Gross Composite Market Impact would drop from 2.0% to 1.5%.

The expected Net Composite Market Impact of passage of the proposed New York Act, using the same CBO impact rate of 40% and the migration assumption, would be 0.56% for MH only and 0.61% for MH & SA.

Based upon an analysis using generally accepted actuarial practices, the Gross Composite Market Impact of the proposed New York mental health parity bill is equal to 2.0% of current employer claims or about \$3.14 per member per month. However, the employer will respond in various ways to partially offset any potential cost increases. Therefore, the expected employer plan healthcare costs (Net Composite Market Impact) will rise about 0.8% or \$1.26 per member per month. Including a migration estimate lowers this impact to 0.61% or \$0.96 per member per month.