



A Study of Assembly Bill A-333

A Report to the New Jersey State Assembly by the

Mandated Health Benefits Advisory Commission



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A Report to the New Jersey Mandated Health Benefits Advisory Commission, January 2005, by Mercer Oliver Wyman

Mandated Health Benefits Advisory Commission Statement

Introduction

The Commission undertook the study with the understanding that it was charged by law with investigating many facets of the impact of Assembly Bill 333 (A-333).

With this in mind, and considering the limited time and expertise of the Commission and Department staff, an actuarial firm with experience in such investigations was engaged to study this matter and to prepare a report addressing all of those facets. The Commission drew upon the report of the actuarial firm in developing its recommendation, but does not specifically endorse any portion of that report. Some members of the Commission objected to specific portions of the report. The Mercer Oliver Wyman (MOW) report to the Commission is attached.

The Commission understands that the Legislature specifically desires a discussion of the implications of this bill on the insurance market, including impact on price and on the availability of necessary medical services.

Background

We believe that this bill, if enacted, would result in average premium increases of .3% to .7% based on MOW's estimates. A certain number of people, perhaps up to 5,000, could lose coverage as a result of the increased cost, although the estimate of that response has much less support than the estimate of the premium increase.

We are unable to definitely quantify the extent to which the mandate would actually increase the amount of mental health, alcoholism, and substance abuse treatment obtained by covered individuals, or whether it would simply make the financial impact of that treatment more affordable.

What A-333 Requires

Scope

Assembly Bill 333 applies to the regulated insurance market and to self-funded and insured coverage provided by the State Health Benefits Plan (SHBP) to state employees and employees of local employers who opt to participate in the SHBP. The regulated insurance market includes individual and group contracts sold by hospital, medical, and health service corporations (e.g. Horizon Blue Cross Blue Shield), individual and group insurance policies sold by insurance companies, and contracts issued by health maintenance organizations (HMOs), including contracts and policies sold in the Individual Health Coverage (IHC) and Small Employer Health (SEH) markets and the small amount of SHBP coverage under contracts issued by insured HMOs. Because different types of carriers or programs are governed by different statutes, A-333, like all mandated health benefit legislation, repeats the same requirements multiple times to amend the sections of the various statutes applicable to each type of carrier or program.

Mental Health

The bill provides that if coverage is provided for any condition in the Diagnostic and Statistical Manual of Mental Disorders (DSMD) that is not a biologically based mental illness (BBMI), such condition must be covered under the same terms and conditions as any other illness. (This requirement presumes that coverage for BBMI is already mandated, which is the case as described below.) Consequently, the bill does not provide a “true” mandate for non-BBMI mental health coverage. Rather it permits carriers to determine if they will offer, and employers to determine if they will buy, coverage for some or all non-BBMI conditions. The bill would require that any **covered** non-BBMI conditions be subject to the same terms and conditions as other illnesses.

This is a subtle and confusing point. The Commission recommends to the Legislature that it confirm that this is its true intent, and that no more, and no less, flexibility was intended for insurers and employers.

Alcoholism and Drug Abuse

The bill requires that drug and alcohol addiction be covered and provides that such coverage must be the same as for any other illness. The bill requires that alcohol and drug addiction be covered when determined to be necessary by a physician or licensed addiction professional based on criteria of the American Society of Addictive Medicine. [This would appear to override any determination by a carrier of the medical necessity of coverage, but does not appear to override the carrier's payment of different compensation for in and out of network providers, or the requirement that care be provided in network, to the extent that such requirements are also imposed on physical illness.] The bill does not define "licensed addiction professional" and the Commission was unable to obtain a definition of this phrase from other state laws. Services that are covered include, but are not limited to, inpatient or outpatient treatment, including detoxification, screening and assessment, case management, medication management, psychiatric consultations and individual, group and family counseling, and relapse prevention; non-hospital residential treatment; and prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for alcohol or drug addiction.

The bill extends the current alcoholism mandate at N.J.S.A. 17B:27-46.1 to reach IHC, SEH, and HMO plans. The existing mandate requires group and individual policies sold by insurance companies to cover expenses incurred in connection with treatment of alcoholism when prescribed by a physician to the same extent as for any other sickness covered under the contract. However, the current alcoholism mandate does not apply to policies offered in the IHC and SEH programs, contracts sold by HMOs, or the SHBP. The law requires alcoholism benefits to include inpatient or outpatient care in a licensed hospital, treatment at a detoxification facility and confinement as an inpatient or outpatient at a licensed, certified, or State approved residential treatment facility. Treatment or confinement at any facility shall not preclude further treatment at other eligible facilities as long as the total number of benefit days under the contract is not exceeded.

The Current Insurance Market

Approximately 3.2 million people (out of the New Jersey population of 8.5 million) will be affected by the provisions of this bill. They are the 2.4 million in the regulated insurance market (including 900,000 in the SEH market and 75,000 in the IHC market) and approximately 800,000 additional in the SHBP self-funded programs. The current and proposed mandates have no direct effect on the people covered by self-funded plans (other than the SHBP), Medicare, Medicaid/Family Care, and the uninsured.

Mandates at the Federal level, described below, affect a wider market: insured and self-funded plans, including the SHBP.

The Current Situation

Mental Health

In all insured markets (large employer, SEH, IHC) and the SHBP, the state BBMI mandate, P.L. 1999, c.106, requires carriers to cover biologically based mental illness under the same terms and conditions as any other disease (deductibles, copays, and benefit maximums) — so-called full parity. Although the law cites some conditions that must be treated as BBMI, it also requires treatment of uncited conditions that satisfy the definition of biologically based. Biologically based mental illness is defined as a mental or nervous condition that is caused by a biological disorder of the brain and that results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including by not limited to:

- Schizophrenia
- Schizoaffective Disorder
- Major Depressive Disorder
- Bipolar Disorder
- Paranoia and other Psychotic Disorders
- Obsessive-Compulsive Disorder
- Panic Disorder
- Pervasive Developmental Disorder or Autism

Even though technically beyond the scope of our charge, the Commission suggests that the current mandate be kept in mind as A-333 is evaluated. First, the current mandate is considered to be a significant mandate, and there presumably has been some increase in premiums already reflecting this mandate. (The Commission did not try to estimate that increase as part of its work on A-333.) Second, while coverage for some conditions, such as those enumerated in the law, are clear, coverage for other conditions that may also be biologically based is less clear. Third, some Commission members consider the biologically based/non-biologically based distinction artificial and to fail to appropriately address the needs of the insured population.

Other than the BBMI mandate, there is no statutory requirement that plans offer any coverage for mental health. This means that in the large employer market, plans may provide additional mental health benefits only to the extent that (1) carriers offer the benefits (they are not required to), and (2) purchasers (employers) choose to purchase them. Large employer carriers typically offer, and employers typically purchase, some additional coverage for mental health but with limitations typically imposed on the number of days of inpatient treatment or the number of visits for outpatient treatment. These benefits may also be subject to different referral, pre-authorization, or utilization review requirements. At least one carrier offers additional benefits providing full parity with non-BBMI.

In the SEH market carriers must offer, as part of the standard SEH plans, non-BBMI benefits limited to 30 inpatient days and 20 outpatient visits per year. However, a carrier may offer modified coverage through a rider — reducing (or eliminating) the non-BBMI benefit (but not reducing the mandated BBMI benefits), or providing additional benefits. In fact, only one carrier offers a rider that reduces, but does not eliminate, the non-BBMI benefit, so this element of flexibility is not in fact exercised.

The IHC market also has standard plans, but no modification via rider is possible. BBMI is covered as a mandated benefit. The standard IHC plans also provide limited coverage for non-BBMI (30 inpatient days and 20 outpatient visits for HMO plans; \$5,000 a year and \$25,000 lifetime for non-HMO plans.)

The SHBP is subject to the BBMI mandate by law applicable to the SHBP. The SHBP determines in its plan design whether to offer additional benefits. The SHBP covers non-BBMI with benefit limits. In the preferred provider organization (PPO) plan offered by the SHBP, the most popular option, non-BBMI is subject to a combined in-network and out-of-network limit of \$15,000 per year and \$50,000 per lifetime. The indemnity plan offered by the SHBP has a limit for non-BBMI of \$10,000 per year and \$20,000 per lifetime. Both plans offer \$2,000 restoration of benefit per year. Dollar limits are used because the SHBP has opted out of the federal parity mandate as explained below. Alcoholism and drug abuse are covered in both plans, the same as physical illness. The HMO plans offered by the SHBP place day and visit limits on non-BBMI, alcoholism and drug abuse.

Self-funded plans are not subject to any state mandates (but may be subject to the Federal mandate). Furthermore, the benefit provisions of self-funded plans are set by the plan sponsor. Even though self-funded plans have the flexibility to exclude all coverage for mental illness, they typically offer some level of coverage for mental illness, but generally provide lower levels of coverage for mental illness than physical illness. They usually impose more restrictive day and visit limits (e.g. 30 inpatient days and 60 outpatient visits) for mental illness than for physical illness. Higher deductibles, copays, and/or coinsurance may be imposed on mental illness as compared to physical illness (e.g., 50% coinsurance for mental illness as compared to 20% coinsurance for physical illness), and, in managed care plans, larger reductions may be applied for out-of-network benefits for mental illness as compared to physical illness. Also, some plans do not include mental illness expenses in any out-of-pocket or coinsurance limits. These distinctions in coverage have their historical roots in a concern for the potential high cost of long term psychotherapy and extended hospital stays, as well as the perceived subjective nature of the need for treatment.

Federal Mandate

Plans provided by employers with more than 50 employees, whether self-funded or insured, are subject to the Federal Mental Health Parity Act of 1996, 42 USC 300gg-5. This act requires that any annual lifetime and dollar limits on mental health coverage be no more restrictive than such limits as applied to medical and surgical coverage. Even as applied to affected employers, this law does not provide much in the way of parity. Its provisions do not apply to coverage for alcoholism and substance abuse. It does not require that plans cover mental illness at all (although, as noted above, plans typically do.). Moreover, it does not prohibit the use of day or visit limits for mental illness that are more stringent than those for physical illness, nor does it prohibit the use of higher cost sharing (copayments, deductible, coinsurance, out of network differential) for mental illness as compared to physical illness.

Any plan may be exempted if its plan claim costs would increase by 1% as a result of compliance with the "mandate". In addition, any state or local government plan can elect exemption as the SHBP has done.

These Federal requirements do not preempt stronger state requirements applicable to insured plans under state regulations. (Any state regulation of self-funded plans is pre-empted under ERISA.)

Alcoholism and Drug Abuse

The current mandated requirement for alcoholism is described above. There is no similar mandate for drug abuse.

The SEH standard plans include the same limited benefits for treatment for drug abuse as are provided for non-BBMI mental illness (see above). As in the case of non-BBMI, a carrier may offer a rider that modifies this standard drug abuse benefit, but in reality only one carrier offers a rider that reduces the benefit.

The Federal Mental Health Parity mandate does not address alcoholism or drug abuse.

Impact on Premiums of A-333

The actuarial consultant, MOW, evaluated the cost impact of the proposed mandate on health care premiums. They evaluated estimates provided by carriers at the request of the Department, estimates provided by New Jersey Association of Health Plans and the New Jersey Psychological Association, experience in other states that have imposed similar mandates and experience in federal programs that provide parity. MOW arrived at an overall estimate of an increase of .3% to .7% of premium; the estimated increase due to the mental health mandate ranged from .2% to .5%; the estimated increase from the treatment of alcoholism and drug abuse ranged from .1% to .2%. Almost all estimates of the total were 1% or lower, although as further discussed, the impact for some markets and plans was higher. There was one very low (.04%) and one very high estimate (3%), both of which MOW addresses in its report. In evaluating these figures, it should be noted that rates in the insured market have increased over 10% per year for the past three years.

The impact of A-333 on costs can be expected to vary by market (IHC, SEH, or large group), type of carrier (HMO, insurance company, service corporation), and type of plan (HMO, Point of Service (POS), PPO, or Indemnity) because there are variations in the benefits that are currently required and differences in the management of current and future costs. Estimates of the cost impact become more difficult and variable for these subcategories.

For example, the estimates differed as to whether the cost impact for HMOs would be higher or lower than for less managed plans, such as PPO or Indemnity. Presumably, estimates that HMOs would have a lower cost impact were premised on the belief that managed care aspects of HMO contracts would limit the increased costs. Estimates that assumed that HMOs would have a higher cost impact may have noted that the cost increase is on a generally lower premium, and that HMOs are not currently subjected to the alcoholism mandate.

Estimates of the impact by market were more consistent, and tended to show a higher percentage impact in the large group market than in the IHC and SEH markets. This could reflect the fact that the standard plans in the IHC and SEH

markets already effectively establish a higher level of baseline coverage, and that (especially in the individual market) the premiums per member are higher, so an impact in terms of cost per member per month will be lower on a percentage basis. Except for the 3% estimate discussed previously, the highest impact estimated for any subcategory was less than 2%.

These estimates may appear low, and some explanation may be in order. The BBMI mandate already covers many significant mental health conditions. We did not ask carriers to evaluate the cost of the current mandate — however, it appears that carriers currently pay between *1% and 2%* of their costs for inpatient and outpatient mental health services, including those required by the BBMI mandate. This amount may appear low to many people, who may have a perception that runaway mental health costs are a significant component of rising health care premiums. By comparison, the cost of radiology and other imaging account for approximately *10%* of cost.

Some members of the Commission are concerned that the substance abuse portion of the cost estimate is too low, either because of very scarce carrier data (substance abuse benefits are currently a very small component of costs) or because of failure by the carriers to incorporate the cost significance of the requirement which appears to override any gatekeeper provisions.

Impact on Purchase of Coverage

For purposes of discussion, assume that the mandate causes a 1% increase in premiums. This is slightly higher than the estimate, but leaves room for variation by market and product.

As a general consideration, increases in premium will cause some policyholders to drop insured coverage. These policyholders may become uninsured, or form self-funded plans. The extent to which an increase in premium causes a decrease in coverage has not been precisely measured, and depends in part on the reason for the cost increase. In general, premium payers react differently to a price increase that reflects additional benefits than to a price increase that does not do so.

The term "elasticity" refers to the response of purchasers to a small price change that does not provide any additional value. Although the elasticity of demand for insurance is very difficult to measure, one study suggests that it is approximately -.2%. This means that for each 1% "valueless" increase in premium, .2% of customers will drop coverage. With approximately 2.4 million insured (3.2 million less 800,000 SHBP members), the prediction is thus that about 5,000 people would lose coverage.

This number could be conservatively high, because: (1) the estimated cost of the mandate is less than 1%, and (2) this cost increase is not "valueless"—additional coverage is provided as a result of the increase.

Impact on the Affordability and Utilization of Mental Health and Substance Addiction Services

It is much more difficult to estimate the impact on the affordability and utilization of mental health, alcoholism and drug abuse services than to estimate the impact on premium. The primary impact will be on the approximately 3 million people (35% of the population) with coverage from the regulated insurance market or from the SHBP.

Most of the affected population currently has limited benefits for non-BBMI, alcoholism and drug addiction. The MOW report notes that a high percentage of large employers (more than 95%) offer some coverage for mental health. Moreover, the standard plans in the SEH market require both the mandated BBMI coverage as well as additional coverage for non-BBMI, alcoholism and drug addiction. Therefore, the impact will be primarily to increase the amount of coverage for services for which there is already partial coverage.

Because clear evidence is not available for a full analysis, we are required to make some assumptions. Because we project that insured costs will increase if A-333 is enacted, we are assuming that people will seek and receive additional care. Unless we are willing to assume that this is the same amount of care that these people sought when the care was uncovered (or covered to a limited extent) and paid for by themselves, there will be an increase in the total amount of care provided to the group of insured individuals. We are not aware of any more detailed information, which would almost have to be at the patient level, that allows us to say more.

Unless we believe that all of the additional care received by the 3 million persons affected by the bill is unnecessary (driven solely by the availability of reimbursement rather than by need), we can also assume that the overall mental health of the population will be improved as a result of this additional care. As noted above, the mandate would almost certainly reduce the cost burden of care for persons requiring mental health, alcoholism or drug abuse treatment. Some studies have shown that mental health benefit mandates have led to offsetting utilization in acute care services or improved outcomes. For example, when Ohio implemented parity for state employees, there was an overall savings in health care costs.

Conclusion

A-333 presents a trade off for society: some people would benefit and others would pay more for coverage or perhaps lose coverage. Most of the affected insured population would experience increased health insurance premiums, some would drop coverage, and some would receive more care and experience better outcomes (or at least would have less financial burden related to the care they receive). There may also be modest positive indirect benefits for society such as reduced absenteeism in the work place. Columbia University's National Center of Addiction and Substance Abuse reports that substance abuse is implicated in 80% of adult felonies and estimates the cost of substance abuse to the juvenile justice system at \$14.4 billion per year. The data available to the Commission, and the difficulty of evaluating the net impact of a policy from which some groups gain and others lose, limit the Commission's ability to place a "bottom line" value or cost on the proposed mandate.

Despite these limitations, the Commission recommends enactment of A-333, with dissenting votes.

Other Considerations for the Legislature

The Commission discussed factors relating to A-333 other than those enumerated in N.J.S.A. 17B:27D-1 et seq., which might be useful to the Legislature in its consideration of A-333.

First, the Commission considered the distinction between biologically based mental illness and non-biologically based mental illness to be artificial and problematic in that both types of illnesses can be severe, of high morbidity and life threatening. The Commission noted as an example that eating disorders, which can result in death, are considered non-BBMI and therefore are not covered at parity under the current mandate. The Commission recommends that the distinction between BBMI and non-BBMI be eliminated or replaced by another distinction that differentiates between

severe and less severe conditions. However, the Commission was unable to craft a replacement distinction.

Second, the Commission believed that carriers should retain the right to review the medical necessity of services rendered to treat alcoholism and drug addiction. Carriers review the medical necessity of all services for physical illness and it would be inappropriate to deprive carriers of their ability to determine the medical necessity of services to treat alcoholism and drug addiction.

Finally, the Commission discussed the possibility of exempting the IHC and/or the SEH markets from A-333. These markets pay higher average premiums than the large group market but there are currently covered by the BBMI mandate.

A Report to the New Jersey Mandated Health Benefits Advisory Commission

*Review and Evaluation of Assembly Bill 333
An Act concerning health care coverage for mental health
services and alcohol and drug addiction and revising part of the
statutory law*

January 2005

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I. Executive Summary

The New Jersey Legislature has requested the New Jersey Mandated Health Benefits Advisory Commission to conduct a review of Assembly Bill 333 (A333), a bill that revises the statutory mental health coverage requirements and requires all health carriers to cover alcohol and drug addiction treatment under the same terms and conditions as for other diseases or illnesses. The review was conducted using the requirements stipulated under the Mandated Health Benefits Advisory Commission Act, N.J.S.A. 17B:27D-1 et seq.. This review was a collaborative effort of Mercer Oliver Wyman (Mercer or MOW), the New Jersey Department of Banking and Insurance (Department) and the New Jersey Mandated Health Benefits Advisory Commission (Commission).

A333 would amend sections of New Jersey Law pertaining to all health policies (including group policies, individual policies and HMO contracts). The bill would require that:

- All health carriers, as well as contracts purchased by the State Health Benefits Commission, that provide coverage for a disorder that is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders and is a non-biologically based mental illnesses, must provide this coverage under the same terms and conditions as any other illness.
- All health carriers provide coverage for the treatment of alcohol addiction. At the present time, individual, small employer and health maintenance organizations are excluded from the statutory alcoholism mandate.
- All health carriers are required to provide coverage for the treatment of drug addiction under the same terms and conditions as for any other illness.

Our interpretation is based on information provided by the Department. The current insurance law in New Jersey requires coverage for biologically based mental illnesses under the same terms and conditions as provided for any other illness. There are no specific requirements for the level of coverage for non-biologically based mental illness in the current law. Under A333, if a carrier chooses to provide coverage for a non-biologically-based mental illness, the level of coverage must be under the same terms and conditions as any other illness. Our interpretation of A333 does not specifically require carriers to cover non-biologically based mental illnesses, therefore carriers may choose to exclude them.

The survey performed by the Department shows the major health insurance carriers in New Jersey provide limited coverage in their policies for non-biologically based mental illnesses. We received responses from AmeriHealth, CIGNA, Horizon, WellChoice and Magellan (who manage the services for Horizon, Aetna and AmeriHealth). While some

carriers provide coverage for these illnesses, the coverage is generally subject to internal limits (either specified dollar amounts or number of visits/days). One carrier offers a mental health and substance abuse optional rider with the benefits described in A333. The survey showed similar results with respect to the treatment for drug addictions/abuse.

Only one carrier expressed concern with the proposed mandate. The company is concerned with the affordability of health insurance with the added costs for these mandates. The company stated they are opposed to any mandate that adds cost to health insurance. One managed care organization is concerned with the language of the legislation and its ability to manage the care.

The statistics regarding the number of people with mental health illnesses and/or addictions is difficult to obtain. We have estimated the number of New Jersey residents with these conditions to be approximately 26%. One explanation for the difficulty in obtaining meaningful statistics is the large number of people who do not seek treatment and/or diagnosis for a multitude of reasons. Approximately one-third of people with these conditions actually seek treatment. Therefore, the maximum percentage of residents utilizing the services would be approximately 9%.

The cost for these services is difficult to state. The average costs of substance abuse treatments range from approximately \$900 to over \$8,000 per condition per year. The actual costs will depend on the type of treatment and the severity of the addiction. However, given the limited benefits currently available under health insurance policies, the financial impact may be dramatic.

MOW estimates the cost impact on health insurance premiums to range from 0.3% to 0.7%. We expect most of the increase in costs to be attributed to the new mental health mandates. The estimated costs for these benefits range from 0.2% to 0.5%. The additional costs associated with the requirement to provide treatment for substance abuse range from 0.1% to 0.2%.

Four carriers, one behavioral health care management company and two associations provided estimates of the cost impact as well. AmeriHealth estimated the coverage to be approximately 0.7%. CIGNA estimated 3%, which was the highest. CIGNA based its costs on the experience of an optional rider that provides similar benefits. We would expect the cost of an optional rider to be higher than the cost for a mandate since the optional rider's experience reflects selection (i.e., those firms that perceive a need for the rider are the only ones who will purchase it.) Horizon estimates the cost impact to range from 0.4% to 1.6% depending upon the current benefit levels. Magellan, the behavioral health care management company, estimated the costs to be 0.04%. While Magellan did

not provide any specific verbiage why its estimate is so low, we are assuming that their estimate reflects in-network costs only. They may believe that the utilization and costs are controllable in-network and that many plans already provide parity when using in-network providers. The New Jersey Association of Health Plans estimated the costs to range from 0.5% to 1.0%. The New Jersey Psychological Association estimated the costs to be approximately 0.6%.

Self-funded plans, other than the State-sponsored plans, would not have to comply with A333 and therefore would not experience an increase in costs.

II. Background

The New Jersey Legislature has requested the New Jersey Mandated Health Benefits Advisory Commission to conduct a review of A333, a bill that revises the statutory mental health coverage requirements and requires all health carriers to cover alcohol and drug addiction treatment under the same terms and conditions as for other diseases or illnesses. The review was conducted using the requirements stipulated under the Mandated Health Benefits Advisory Commission Act. This review was a collaborative effort of Mercer Oliver Wyman (Mercer or MOW), the New Jersey Department of Banking and Insurance (Department) and the New Jersey Mandated Health Benefits Advisory Commission (Commission).

A333 would amend sections of New Jersey Law pertaining to all health policies (including group policies, individual policies and HMO contracts). The bill would require that:

- All health carriers, as well as contracts purchased by the State Health Benefits Commission, that provide coverage for a disorder that is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders and is a non-biologically based mental illnesses, must provide this coverage under the same terms and conditions as any other illness.
- All health carriers provide coverage for the treatment of alcohol addiction. At the present time, individual, small employer and health maintenance organization plans are excluded from the statutory alcoholism mandate.
- All health carriers are required to provide coverage for the treatment of drug addiction under the same terms and conditions as for any other illness.

Our interpretation is based on information provided by the Department. The current insurance law in New Jersey requires coverage for biologically based mental illnesses under the same terms and conditions as provided for any other illness. There are no specific requirements for the level of coverage for non-biologically based mental illness in the current law. Under A333, if a carrier chooses to provide coverage for a non-biologically-based mental illness, the level of coverage must be under the same terms and conditions as any other illness. Our interpretation of A333 does not specifically require carriers to cover non-biologically based mental illnesses, therefore carriers may choose to exclude them.

The current statutorily mandated coverage for the treatment of alcohol addiction excludes individual policies, small employer policies and health maintenance

organization contracts. Under A333, all insurance carriers would be required to provide coverage for alcohol addiction under the same terms and conditions as any other illness.

Finally, the current New Jersey insurance statutes do not have any specific requirements for the coverage of the treatment of drug addiction. [N.J.A.C. 8:38-5.2(a)17 requires HMOs to cover a minimum of 30 days inpatient substance abuse treatment per year.] A333 requires all carriers to provide coverage for drug addiction under the same terms and conditions as any other illness.

The survey performed by the Department shows the major health insurance carriers in New Jersey provide limited coverage in their policies for non-biologically based mental illnesses. We received responses from AmeriHealth, CIGNA, Horizon, WellChoice and Magellan (who manage the services for Horizon, Aetna and AmeriHealth). While some carriers provide coverage for these illnesses, the coverage is generally subject to internal limits (either specified dollar amounts or number of visits/days). One carrier offers a mental health and substance abuse optional rider with the benefits described in A333. The survey showed similar results with respect to the treatment for drug addictions/abuse.

The State Health Benefits Program (SHBP), which provides health insurance coverage to state and participating local employees, currently covers biologically-based mental illness and alcohol and drug additions on the same basis as any other illness in the Traditional Plan and the NJ PLUS plan (a PPO plan). The HMO plans offered by SHBP limit the number of days of coverage per occurrence. However, additional days may be covered if it is determined they are medically necessary. At the present time, there are limited benefits for the non-biologically based mental illnesses. The limits vary by plan and are determined by a flat dollar amount or number of visits/days.

Medicare provides coverage for mental health and substance abuse benefits. The level and limits for these benefits varies by the location in which the service is rendered and type of service. In general, mental health services provided in an inpatient setting are covered in the same manner as other inpatient hospital services. However, services provided in a specialty psychiatric hospital have a lifetime limit on the number of days. Outpatient services for mental health conditions have a 50% coinsurance payment where other outpatient services require a 20% coinsurance payment. Outpatient services related to the treatment of alcohol and drug addictions require a 50% coinsurance as well.¹ Therefore Medicare does not provide parity of benefits for mental health and substance

¹ Centers for Medicare and Medicaid, "Your Medicare Coverage", www.medicare.gov

abuse.

There are additional government programs that do not provide parity level benefits for mental health and substance abuse services. Besides Medicare, TRICARE (the program for active duty members of the armed forces and their dependents, military retirees and surviving spouses) does not provide these benefits at parity. Another example is CHAMPVA, the program for dependents and survivors of veterans who are disabled or died during active duty, which also has limitations on mental health benefits.²

The State's Medicaid program provides coverage for mental health and alcohol and drug addiction on a fee-for-service basis. In general, there are no limits for these services. Therefore in most cases the Medicaid program does provide benefits at parity. However, the Adult Family Care Medicaid expansion program does have limits on the amount of benefits provided. These recipients have a limit of 35 inpatient days and 20 outpatient visits per calendar year.

There are several other entities that require parity for mental health benefits. For example, the health plans participating in the Federal Employee Health Benefit Program (FEHBP) are required to provide mental health benefits at the same level as any other benefit. The Department of Veteran Affairs covers mental health services under the same terms and conditions as any other illness. Finally, the Indian Health Services does not have any special limits with regard to mental health services.³

There are six states, Connecticut, Delaware, Minnesota, Vermont, Virginia and West Virginia that require health insurers to cover alcohol or drug treatment under the same conditions as any other illness.⁴ In addition, two states (North Carolina and South Carolina) offer parity for alcohol or drug treatment to the state's employees but do not require private health insurers to provide parity benefits.

There are 36 states that have adopted some type of parity for mental health services.⁵ Of these, 7 states have specified that the parity is for biologically based mental health illnesses or severe mental illnesses only. In addition, three states (North Carolina, South

² Maxfield, Myles, et. al., US Department of Health and Human Services, "National Estimates of Mental Health Insurance Benefits"

³ Ibid

⁴ National Conference of State Legislators, "Mental Health and Substance Abuse Parity", December 2002

⁵ Higa, M., The Auditor, State of Hawaii, Study of Proposed Mandatory Parity in Health Insurance Coverage for Additional Serious Mental Illness and Substance Abuse, April 2004

Carolina and Texas) offer parity to the state employees.⁶

However, even though many of these states have adopted some type of parity for mental health services, the requirements for each state vary. For example, many states do not require all health insurers to provide this coverage. Some states exempt smaller employers or insurance purchased by individuals from the mandate.⁷

The trend for most states passing mental health parity mandates is to limit the parity to specific types of mental illnesses. The most common definitions used for these mental illnesses are “biologically based” mental illnesses or severe mental illness. Generally, there is a list of conditions that are covered. To our knowledge, no other state is considering expanding the mental health parity mandated benefits in the manner New Jersey has proposed.⁸ In fact, there were two states in 2003 that passed legislation that weakened the existing parity laws. South Dakota’s law allows purchasers of individual health insurance to opt out of mental health parity. Montana’s law allows the Commissioner of Insurance to approve a demonstration project that will allow the current uninsured to purchase a policy with limited mental health benefits.⁹

There are only a handful of states that offer alcohol and substance abuse parity as a mandated benefit. The trend for most states in this case is to require a minimum benefit package or require an offer of benefits.

⁶ National Conference of State Legislators

⁷ Maxfield, Myles, et. al.

⁸ American Academy of Child and Adolescent Psychiatry, “AACAP State Parity Update”, October 2003, www.aacap.org

⁹ Ibid

III. Social Impact

A. Social Impact of Mandating the Benefit

1. *The extent to which the treatment or service is utilized by a significant portion of the population.*

The number of residents in New Jersey requiring mental health and substance abuse services is difficult to determine. The 2004 study, “Mental Health Needs and Services in New Jersey” (NJ2004 MH Needs), states that the federal government conservatively estimates there are over 75,000 children in New Jersey with “serious emotional disturbances” (SED) and 350,000 adults with “serious mental illnesses” (SMI)¹⁰. The adult statistic does not include individuals with developmental disabilities (DD) and substance abuse (SA) disorders who do not also have other diagnosed mental illnesses. Using other sources, this report projects that there could be as many as 1.6 million New Jersey citizens, including 400,000 children and adolescents aged 9-17, who have diagnosable psychiatric disorders. There are approximately 8.4 million residents¹¹ in New Jersey. Therefore, the number of potential residents that are afflicted with mental health illnesses is approximately 19% of the New Jersey population. However, this assumes 100% of those afflicted by such illnesses seek treatment.

Even with the large number of children estimated to have mental health conditions, very few of them exhibit the symptoms required to meet the biologically based diagnoses covered in the current law. NJ2004 NJ Needs cited a survey that estimated at least half of New Jersey children with SED and 70% of the seriously ill group (adults) are not being adequately treated. As many as 62% of children and young adults in New Jersey are not having their mental health treatment needs met. This translates into 172,000 young people.¹² Nationally, it is estimated that approximately 20% of children may have a mental health problem, but 75% of them do not receive treatment.¹³

¹⁰Dang, Jagdish, MD, et. al., New Jersey Psychiatric Association Task Force to Assess Mental Health Needs and Services in New Jersey and the NJPA Mental Health Services Committee, “Mental Health Needs and Services in New Jersey”, May 2004

¹¹ US Census Bureau, “Statistical Abstract of the United States: 2003”, Table 17

¹² Dang, Jagdish, MD, et. al.

¹³ National Mental Health Association, “Can’t Make the Grade”, 2003

The number of New Jersey persons needing but not receiving treatment for illicit drug abuse is estimated to be greater than 110,000. Many of these individuals have other diagnosable mental illnesses for which they may or may not be receiving treatment.¹⁴ This generates a rate of approximately 1% of residents with the need for treatment of substance abuse who are not receiving care. There were less than 29,000 hospital admissions (95% for adults) in the first six months of 2002 for substance abuse treatment in New Jersey.¹⁵ This illustrates the large percentage of residents that are not receiving treatment.

Based on a 1993 telephone survey of New Jersey residents, it is estimated that approximately 8% of the population of adults are in need of treatment for alcohol abuse or dependence.¹⁶ This translates to approximately 7% when children are included in the mix. In generating this estimate, we have assumed only 3% of children need treatment for alcohol or drug addiction.

The total estimated percentage of residents with these conditions (mental illness and addictions) is approximately 26% of the population. On a national basis, the National Mental Health Association estimates that approximately 28% to 30% of the population has a mental disorder, substance abuse disorder or both.¹⁷

These statistics do not include estimates for the number of individuals who have problems with compulsive gambling which is made more problematic by the presence of numerous casinos in New Jersey.

2. *The extent to which the service or treatment is available to the population.*

The New Jersey Psychiatric Association report reviewed the current access to mental health services in New Jersey. Its report concluded that there is a shortage of providers in the state for both mental health and substance abuse treatment.

Specifically, there have been an increasing number of complaints regarding access to inpatient admissions for emergency and/or crisis situations. Several respondents complained about being denied access to inpatient services. One of the reasons cited for the denied admissions is the lack of hospital beds for mental

¹⁴ Dang, Jagdish, MD, et. al.

¹⁵ *ibid*

¹⁶ Mammo, Abate, New Jersey Department of Human Services, Division of Addictive Services, "Need for Alcohol and Drug Treatment in New Jersey, 1993"

¹⁷ National Mental Health Association, "Mental Health Month 2004 – General Mental Health Facts

health services. The number of state hospital beds and psychiatric beds is approximately 1,557 and 1,129, respectively. However, the report notes that the total public inpatient system has been full to capacity with an average census of 3,100.¹⁸

Outpatient services were more difficult to summarize and it appears to depend upon the type of respondents. For example, consumers with sufficient resources provided favorable ratings. However, other consumers did cite certain factors that impeded their access to care. Specifically, the report cited the average waiting time for appointments to be 41 days.

Substance abuse services were cited as being in short supply. Detoxification and long-term residential programs are scarce and intensive outpatient day treatment programs do not exist. In addition, there are long waiting lists for treatments. For example, in Essex and Hudson counties the waiting list is approximately 900 and 700 individuals, respectively.¹⁹ The Executive Director of the Addiction Treatment Providers, Mr. Jim O'Brien, testified before the State Budget and Appropriations Committee, that providers turned away residents due to the shortage of beds. Mr. O'Brien stated that more than half of the people trying to get into treatment are turned away because the system is undercapitalized and filled to capacity. The long waiting period can often lead to addicted individuals reconsidering admission for treatment.²⁰

There is a national crisis in the shortage of child psychiatrists. New Jersey appears to follow that trend. In addition, the number of new child psychiatrists is small. Of the five psychiatric residency training programs in New Jersey, only two train child psychiatrists.²¹

3. *The extent to which insurance coverage for this treatment is already available.*

For employers that offer health insurance, over 83% of those employers cover some type of mental health. However, the percentage varies by the size of the employer group. For example, the smallest employers (2 to 19 employees) have the lowest percentage that offer coverage (77% for inpatient, 80% for outpatient)

and Stats", www.nmha.org/may/fastfacts.cfm

¹⁸ Dang, Jagdish MD, et. al.

¹⁹ Ibid

²⁰ Addiction Treatment Providers of New Jersey, testimony of Executive Director Jim O'Brien, www.charityadvantage.com/atpnj/Testimony.asp

²¹ Dang, Jagdish MD, et. al.

and the largest groups (100+ employees) have the highest percentage that offer coverage (96% for inpatient, 99% for outpatient).²² However, this survey does not address the level of coverage for mental health services. We are confused by the statistics in this survey since New Jersey currently mandates coverage for mental health services for small groups and individual policies.

Based on information the Department has obtained from the key health insurance providers in New Jersey, most policies provide limited coverage for non-biologically based mental illnesses. The following table contains the information obtained from the survey.

Insurer	Average Coverage Levels
AmeriHealth	Typically limit benefits, 30 days for inpatient services, 20 visits for outpatient services
CIGNA	Optional rider available with benefits of A333
Horizon	Benefits limited with various levels; coverage depends on the market (individual, small group)
WellChoice	Coverage limited; 30 days for inpatient services, 20 visits for outpatient services

The percentage of employers offering coverage for alcohol and substance abuse treatment is slightly lower than those offering coverage for the treatment of mental health illnesses. Overall approximately 81% of employer groups offer coverage for alcohol and substance abuse. The percentages vary by group size. The smallest employers have the smallest percentage offering coverage (73%) while the largest employers have the greatest percentage offering coverage (96%).²³ However, this survey does not address the level of coverage.

The Department surveyed the key health insurance carriers in New Jersey to determine the coverage provided for alcohol and substance abuse treatment. The results of the survey show that while most employers have some type of coverage for these treatments, generally the coverage is limited. The table below shows the results of the survey.

²² Biddle, Christopher, "NJ Employers Hit with 13% Spike in 2003 Health Costs", 2004 Health Benefit Survey

²³ Ibid

Insurer	Average Coverage Levels
AmeriHealth	No information provided
CIGNA	Optional rider available with benefits of A333
Horizon	Benefits limited with various levels; coverage depends on the market (individual, small group)
WellChoice	Coverage limited; 30 days for inpatient services, 20 visits for outpatient services

In general, most individuals covered by insurance have a limited level of coverage for non-biologically based mental illnesses and substance abuse. Only one carrier appears to offer a rider that provides coverage similar to that required by A333.

4. *If coverage is not generally available, the extent to which the lack of coverage results in a person being unable to obtain the necessary health care treatment.*

Even though most insurance coverage provides some benefits for services for non-biologically based mental health and substance abuse illnesses, in general the benefits are limited. The New Jersey Psychiatric Association's report on the current environment in New Jersey included interviewing patients, families and providers. The study noted the shortage of inpatient beds in the state. One of the reasons cited for the shortage of beds in the state is the poor reimbursement for these types of services. Specifically, reimbursement levels for medical services are much higher than the corresponding reimbursements for mental health and substance abuse services.²⁴

Patients cited several factors that impeded their ability to obtain outpatient services from New Jersey providers. Among those cited was the lack of insurance coverage. Patients also complained about the quality of services, specifically the rationing of services.²⁵

Much of the funding for mental health services is provided by Medicaid. On a national level Medicaid accounted for about 50% of total spending on mental illness treatment. in 2002. However, as states are trying to balance their budgets they are faced with difficult decisions. Of the states surveyed in 2002, 29

²⁴ Dang, Jagdish MD, et. al.

reported making cuts to mental health budgets in 2002 and 35 were anticipating cutting funding in 2003.²⁶ In order to qualify for benefits under the Medicaid program, an individual must meet the eligibility requirements.

Many of the non-profit agencies depend heavily on state money. These entities provide the bulk of the mental health services to the poorest and most vulnerable citizens. Community hospitals are also expected to provide emergency care for residents without regard to their ability to pay. As budgets continue to be cut, the availability of services from these types of entities will become scarcer.

For individuals with non-biologically based mental health illnesses or substance abuse illnesses who are covered by health insurance on a limited basis, the proposed mandate A333 may provide easier access to care. However, the need for mental health services is not evenly distributed across the New Jersey population. Special populations, such as the homeless or incarcerated, have a highly concentrated need for these services.²⁷ It has been estimated that approximately one-third of the homeless have a serious mental illness.²⁸ The magnitude of the impact that proposed mandate A333 will have on these needy populations is questionable.

5. *If coverage is not generally available, the extent to which the lack of coverage involves unreasonable financial hardship.*

Most insurance companies provide limited benefits for non-biologically based mental illness services and substance abuse services. Only large employers are required to cover alcohol abuse treatment under the same terms and conditions as any other illness.

In general, benefits for these services are limited to 30 days for inpatient services and 20 visits for outpatient services. In other cases there is an annual maximum or a lifetime maximum that applies to these treatments. The magnitude of financial hardship will vary by the intensity of services that are required and the income level of each individual. In the more severe cases, the individual will exhaust the insurance benefits and will be required to finance the difference. For example, one New Jersey resident testified to the legislature regarding bill A-2487 that at times up to 20% of her income was required to pay for medications

²⁵ Dang, Jagdish MD, et. al.

²⁶ National Mental Health Association

²⁷ Dang, Jagdish MD, et. al.

²⁸ National Mental Health Association

and other treatments not covered by her private health insurance.

The analysis of the experience in Vermont shows that the level of insureds' out-of-pocket costs declined significantly after parity was implemented. The following table shows the out-of-pocket payments as a percentage of the total mental health charges²⁹.

Annual Level of Mental Health Charges	Prior to Parity %	After Parity %
\$1-\$500	50%	19%
\$501-\$1,000	32%	20%
\$1,001-\$2,500	27%	20%
\$2,501-\$5,000	18%	14%
\$5,000+	9%	4%

The Alcohol and Drug Services Study obtained information regarding costs and revenues of 280 facilities nationwide. Its study found that the average cost per admission for outpatient methadone treatments ranged from \$3,650 to \$8,238. The average cost for residential care ranged from \$2,532 to \$3,736 and the average cost for outpatient non-methadone facilities ranged from \$867 to \$1,415.³⁰ While some of the costs may be covered to a limited extent under health insurance, these costs can be significant to receive the type of treatment required.

6. *The level of public demand and the level of demand from providers for this treatment or service.*

The estimated percentage of New Jersey residents who have a mental health condition is approximately 19%. We would expect the number of residents seeking services to be significantly less. Estimates on a nationwide basis expect only one-third of this population to seek treatment. Therefore, we would expect the percentage of residents seeking services to be 6% (19% x 1/3). The demand for these services is moderate.

We have estimated the percentage of New Jersey residents that have an alcohol

²⁹ Rosenbach, Margo, et al, U.S. Department of Health and Human Services, "Effects of The Vermont Mental Health and Substance Abuse Parity Law", 2003.

³⁰ Shepard, Donald S, PhD, "Determinants of Cost of Substance Abuse Treatment", presentation at the 130th Meeting of APHA, www.apha.confex.com/apha/130am/techprogram/paper_51271.htm

or substance addiction to be approximately 7%. We estimate that only one-third will seek treatment or 2%.

In total, we estimate the number of potential residents who have a mental illness or addiction to be approximately 26%. The estimated number of residents utilizing the services is approximately about 8%. However, not all of these residents will be covered under commercial insurance as discussed previously.

The Department of Personnel for the State of New Jersey, the Employee Advisory Service provided input on A333. In their response, they stated that approximately 25% of their referrals for substance abuse treatment require services that extend beyond the amount allowed by the insurance carrier.

7. *The level of public demand and the level of demand from the providers for individual or group coverage of this treatment.*

At the present time there has been only one public hearing regarding A333. The opportunity for the additional public testimony will occur after the release of this report. However, we have obtained comments from insurance carriers in their responses to the Department's survey. In addition, we have provided a summary of some of the testimony that was provided with respect to Assembly Bill 2487 (A2487), which expanded the mental health parity to cover other conditions listed in the Diagnostic and Statistical Manual of Mental Disorders. We believe this information is relevant in that bill A333 is similar to A2487.

Summary of Carrier Responses

AmeriHealth opposes any proposals that it believes will add to the cost of health insurance premiums. The funding of the new benefits will be the responsibility of the purchasers of health insurance. While the arguments for mandating health insurance benefits are persuasive, the needs go beyond the commercial insurance market. Imposing these benefits only on employers who are doing the right thing by providing employee health insurance is unfair. In addition, this will only affect about 30% of the State's population. Individuals with Medicare, self-funded plans or no insurance will be excluded.

Magellan, a managed mental health provider, provided a list of concerns regarding the proposed legislation. Specifically, the company is concerned with the plan's ability to utilize care management techniques with respect to the language regarding alcohol and drug addiction. They suggest the language be

clarified to indicate that nothing in the verbiage is intended to limit the ability of the plan to manage this benefit.

No other carriers provided comments regarding their support or opposition to the proposed bill.

Public Testimony regarding A333

The New Jersey Hospital Association (NJHA) submitted public support for A333 to the Commission on November 18, 2004.

The Division of Pensions and Benefits, which administers the State Health Benefits Plan, also provided comments regarding A333. It opposes the bill for the following reasons. The bill will increase the costs of providing health insurance to State and local participating employers. This in turn will generate affordability issues for employers. They also recommend that all mental health services be subject to a Utilization Management Review to determine the medical necessity of treatments.³¹

The New Jersey Association of Health Plans (NJ AHP) submitted comments in opposition to A333. NJ AHP engaged Reden & Anders, LTD., a consulting actuarial firm, to project the additional costs association with A333. NJ AHP summarized the results of these costs and included costs associated with the SHBP in a letter to the Mandated Health Benefits Advisory Commission. NJ AHP's letter indicates the total additional cost for A333 will be about \$96 million, that the bill will increase cost shifting from employers to employees, aggravate strained State and local budgets and exacerbate the number of uninsured citizens in New Jersey³².

The National Council on Alcoholism and Drug Dependence—New Jersey (NCADD New Jersey) submitted comments supporting the bill and citing several sources indicating the cost of full parity to be minimal.³³

Addiction Treatment Providers of New Jersey, Inc. submitted a letter supporting A333. They, too, cited estimates indicating the cost of the proposed mandate is minimal.³⁴

³¹ Division of Pensions and Benefits, Bill Comments

³² Michele Guhl, President of NJ AHP, December 16, 2004 letter to Carol Miksad

³³ John Hulick, Director of NCADD New Jersey, November 20, 2004 letter to Carol Miksad

³⁴ Jim O'Brien, Executive Director of Addiction Treatment Providers of New Jersey, November 24,

Summary of Responses from A2487

The New Jersey Business & Industry Association (NJBIA) opposed bill A2487. NJBIA believes employers should not be forced to provide unlimited coverage for the expanded list of mental health conditions and addictions. Employers are facing runaway health insurance inflation as well as struggling to survive in a weak economy. The NJBIA believes we should be looking for ways to control costs of healthcare and rein in the impact of these legislative mandates.³⁵

The New Jersey School Boards Association opposed A2487. It stated that the bill does not provide local school districts with an efficient, economical and flexible health insurance plan, is not a means of cost containment, is a mandate and does not provide state funding for the full cost of the state mandate and does not contain any statement of financial impact on those employers in the State Health Benefit Plans.³⁶

The Southern New Jersey Chamber of Commerce provided testimony in opposition to A2487.

The Drug Policy Alliance was in favor of the proposed mandate. They cite research that shows other health care costs are reduced after the treatment for drug and alcohol addiction begins.

- One emergency visit costs as much as a month of drug treatment.
- A 1994 cost/benefit analysis of drug and alcohol treatment in California found that the state realized \$1.5 billion in savings from \$209 million spent.
- Drug abuse treatment reduces drug use and the risk of becoming infected with HIV. The lifetime costs for medical care for HIV is now over \$200,000.
- The cost effectiveness of methadone treatment has been shown to be greater than many other widely offered medical therapies.

The New Jersey Protection and Advocacy, Inc. a consumer directed, federally funded, non-profit organization provided testimony regarding bill A2487. The organization is in favor of full parity. In addition, the New Jersey Psychiatric Association provided written testimony in favor of bill A2487.³⁷ Testimony on behalf of the New Jersey Psychological Association was provided in favor of the bill.

2004 letter to New Jersey Mandated Health Benefits Advisory Commission

³⁵ "NJBIA Blasts Costly Healthcare Bill at Assembly Health Committee Hearing", NJBIA News, February 27, 2002

³⁶ New Jersey School Boards Association Position Statement Opposing A-2487, January 27, 2003

In addition one member of the public also provided testimony in favor of bill A2487. A woman diagnosed with bipolar affective disorder provided testimony. When she learned her health insurance policy would not cover the treatment required, she initially chose to forego treatment due to affordability issues. She eventually sought treatment. However, the costs were burdensome, at times up to 20% of her annual income. Treatment helped her back to a healthy productive life.³⁸

8. *The level of interest in and the extent to which collective bargaining organizations are negotiating privately for the inclusion of this coverage by group plans.*

No information is available.

9. *The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.*

No information was provided.

10. *Alternatives to meeting the identified need.*

The proposed mandate will only impact those New Jersey residents with fully-insured group health insurance or individual health insurance. It will not impact those residents with coverage under the self-insured employers, those covered by Medicare and those without insurance. In addition, mental health illnesses and addictions are highly concentrated among certain populations, the homeless and incarcerated, which may not be affected by the proposed mandate.

Most of the mental health coverage is currently provided by publicly funded means. For example, Medicaid programs generally cover over half of the services provided. There is the option to increase the levels of public funding to more adequately treat the New Jersey residents with these illnesses. This funding could be in the form of Medicaid programs or other community out-reach programs to solve these social problems.

There are alternative approaches that are being tested in various areas of the

³⁷ New Jersey Psychiatric Association written testimony, February 2, 2002

country that use alternative types of care. Some of these programs are experiencing great success. For example, Wraparound Milwaukee is a program designed to treat children in the juvenile justice system. The program uses funds obtained from a variety of sources and system partners which take into account the many needs of each child. The approach has shown signs of success. For example, the use of residential treatment has decreased 60% since it was initiated and inpatient hospitalizations have dropped 80%. The program reinvests the money saved into supporting more children each year. For example, the program now serves 650 children with the same fixed monies that previously served 360 children in residential treatment centers.³⁹

12-Step programs are widely used and accepted for many addictions and behavioral problems. Their success rates may be subject to debate, but many believe this is an acceptable and effective treatment program.⁴⁰

11. *Whether the benefit is a medical or a broader social need and whether it is inconsistent with the role of insurance and the concept of managed care.*

The proposed benefit is not inconsistent with the role of insurance. These benefits are generally covered presently, although at a limited level. In addition, it has been recognized that mental health conditions as well as substance abuse are illnesses in the same sense as a physical illness.

The benefit is not inconsistent with managed care. In fact, the experience exhibited in other states shows managed care techniques have been used to effectively control the costs of these benefits. The bill requires managed care organizations to provide these services. One managed care entity requested language clarification in bill A333 to ensure that managed care techniques can still be applied.

12. *The impact of any social stigma attached to the benefit upon the market.*

There has been a social stigma attached to mental health illnesses and addictions throughout history. Nationally representative surveys have traced public attitudes regarding mental illness from the 1950's through the 1990's. The surveys

³⁸ Written testimony by Marie D. Verna, February 27, 2003

³⁹ Kamradt, Bruce, "Wraparound Milwaukee: Aiding Youth With Mental Health Needs", *Juvenile Justice Journal*, Volume VII, Number 1, April 2000

⁴⁰ A. Orange. "The Effectiveness of the 12-Step Program", <http://www.orange-papers.org/orange-effectiveness.html>

showed that by 1996, Americans had achieved a better scientific understanding of mental illness. However, the increase in knowledge did not defuse social stigma. In some ways, the stigma has intensified over the last forty years. One reason cited for the continued social stigma associated with mental illness is the fear of violence. People with mental illness are perceived to be more violent than in the past when in fact, there is little risk of violence or harm to a stranger from casual contact.⁴¹

Nearly two-thirds of all people with diagnosable mental disorders do not seek treatment. One of the many barriers that discourage people from seeking treatment is social stigma.⁴²

One other aspect of the social stigma is the willingness of the public to pay for the treatment of mental illnesses. While the public is willing to pay for the treatment of the severe mental disorders, such as schizophrenia and depression, the public is much less willing to pay for the less severe conditions. In addition, the support generally decreases when the public realizes they will have to fund the cost of the treatments either through tax dollars or health insurance premiums.⁴³

Approaches to reduce the social stigma include programs of advocacy, public education and contact with persons with mental illnesses. In addition, the discovery of the causes and effective treatments for the disorders will reduce the stigma.⁴⁴

There is a social stigma related to alcoholism as well as mental health illnesses. This stigma has blocked the road to understanding alcoholism more than any other disease. Physicians are inclined to ignore the symptoms and victims deny its existence. However, recent scientific breakthroughs (the evidence that the disease has its root in biological causes) should help diminish the social stigma attached to it.⁴⁵ In addition, the social stigma attached to alcohol and drug use is reinforced through very visible societal effects of use, namely, criminal activity

⁴¹ Surgeon General, "Mental Health: A Report of the Surgeon General", 1999, www.surgeongeneral.gov/library/mentalhealth

⁴² Surgeon General

⁴³ Surgeon General

⁴⁴ Surgeon General

⁴⁵ HealthPlace Addictions Community, "Substance Abuse Overview", www.healthplace.com/communities/addictions/site/substance_abuse_overview.htm

and unhealthy social and familial functioning.⁴⁶

13. *The impact of this benefit upon the other benefits currently offered.*

Currently, health insurance plans in New Jersey provide benefits for biologically based mental illnesses under the same terms and conditions as other illnesses. These conditions are the most severe and have the greatest potential to have the highest cost impact. Therefore, the new requirement for parity for non-biologically based conditions is not expected to have a significant impact on the other benefits currently offered.

However, our interpretation of A333 does not require insurance carriers to provide coverage for non-biologically based benefits. Under A333, insurance carriers have the option to provide these benefits. If they choose to provide these benefits, all non-biologically based mental illnesses must be covered under the same terms and conditions as any other illness. In this case, some carriers may provide lesser benefits than they are currently offering.

Benefits for the coverage of alcohol abuse are currently provided by large group employers. Therefore this portion of A333 will not have an impact on the current benefits for these groups.

At the present time, benefits for substance abuse are not required to be provided the same as any other illness for all groups. Individual coverage, small group coverage and HMOs also are not required to provide benefits for alcohol addiction at parity. Many proponents of expanding addiction coverage state that the treatment of these conditions will ultimately lower the cost of other medical conditions. In testimony given by the Executive Director of Addiction Treatment Providers, the following examples are cited⁴⁷:

- Xerox Corporation was able to lower its health costs and insurance premiums on its worksite wellness program which included limiting alcohol consumption. After 4 years, the company realized a 500% return.
- A worker-based committee in a GM plant promoted a program regarding confidential consultations about cardiovascular disease

⁴⁶ Maria Bruni, PhD, Beth-Anne Jacob, Sylvan Robb, Office of Alcoholism & Substance Abuse, "The Effectiveness of Substance Abuse Treatment in Illinois: Results of the Illinois Statewide Outcomes Project", September 2001

⁴⁷ Addiction Treatment Providers of New Jersey

risk. The results showed that 42% of the at-risk drinkers became “safer level” drinkers. The result was that GM’s medical costs dropped by 13%.

- Kaiser Permanente in California (the state’s largest HMO) provides unlimited treatment for addiction and alcoholism. Kaiser’s experience shows that by 18 months after treatment, the costs for such treatment have been recouped in reduced medical costs for that population.

Even if the benefits for the treatment of alcohol and substance abuse do not provide the additional savings as the proponents argue, the benefits will not have a significant impact on other benefits currently provided. The number of people that will utilize these benefits in the insured population is small. The greatest impact would be for those individuals who receive treatment, and for whom the additional claims associated with these services currently are denied pursuant to limits not imposed on other illnesses.

14. *The impact of the benefit as it relates to employers shifting to self-insurance and the extent to which the benefit is currently being offered by employers with self-insured plans.*

It is not anticipated that the mandated benefits for mental health coverage for non-biologically based illnesses and substance abuse alone would impact premiums sufficiently to cause employers to shift to self-insurance. We do not know the percentage of self-insured plans that presently cover services for non-biologically based mental illnesses and substance abuse under the same terms and conditions as any other illness.

In Vermont only 0.1% of employers reported that parity played a role in their decision to self-insure.⁴⁸

However, state legislation that imposes benefit mandates will heighten an employer’s concern with regard to future costs and make self-insurance a more attractive alternative. The 2002 Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans indicates that over 50% percent of the large employers (500 or more employees) in the Northeast self-insure health plans.

⁴⁸ M. Rosenbach, et. al.

In addition, a significant percentage of employers in the New Jersey market have seen their health insurance premiums rise dramatically. In 2002 and 2003, approximately 69% and 65% of employers, respectively, have seen their premium increase by double digits. More than half of the respondents expected their premiums to increase by at least 10% in 2004.⁴⁹ While the magnitude of this increase is not inconsistent with what we are observing elsewhere, the nature of the sampling techniques employed by the NJBIA survey may tend to skew the results upward.⁵⁰ In order to combat the increasing health insurance premiums, employers have become more aggressive in controlling costs by shopping around, reducing benefits or passing additional premium costs onto the employees. Additional mandated benefits will continue to add to the affordability pressures employers are feeling.

15. *The impact of making the benefit applicable to the state employee health insurance program.*

Currently, the SHBP covers alcohol and drug addiction treatments the same as any other illness in their Traditional Plan and the NJ PLUS plan. Therefore for these plans, the alcohol and drug addiction requirements would have no impact on these plans. The HMOs that participate in the program however do limit the number of days of coverage per occurrence. Additional days may be granted if the services are determined to be medically necessary.

SHBP also provides some coverage for non-biologically based mental illnesses. The following table contains the coverage by type of plan.

Plan	Coverage
Traditional Plan	\$10,000 limit per year; \$20,000 lifetime limit
NJ PLUS	\$15,000 limit per year; \$50,000 lifetime limit
Participating HMO's	Inpatient – 30 to 35 days per year Outpatient – 30 visits per year

The SHBP estimates an increase in total claims of 0.5% if these mandates are required.

⁴⁹ Biddle

⁵⁰ The survey results are based upon the first 1,468 responses. Those companies that have received significant increases are much more likely to respond quickly than companies that have not incurred significant increases.

IV. Financial Impact

B. Financial Impact of Mandating Benefits.

1. *The extent to which the proposed insurance coverage would increase or decrease the cost of the service or treatment over the next five years.*

It is an accepted insurance maxim that the costs of services increase when there is a third-party payer funding the majority of the costs. This is consistent with the results of a Factiva study which shows that members who perceive a high need for health care will purchase the richest plan, resulting in a third party funding the majority of the costs.⁵¹

Furthermore, coverage limitations may have forced individuals to curtail or forgo treatment. To the extent that coverage for treatment is increased, more individuals may be able to afford additional treatment.

In its survey, the New Jersey Psychiatric Association estimates there are hundreds of thousands (by extrapolation of a 1999 Surgeon General's Report on Mental Health figure of over one million) New Jersey residents that are in need of mental health and/or addictive disorders services. This survey concludes that the majority of these individuals have not accessed psychiatric treatment. Lack of parity in private insurance is one of the reasons cited for this.⁵² Thus, there is an unmet need. This same report also showed that there is a shortage of psychiatric inpatient beds available for psychiatric patients. One of the reasons cited for the closure of inpatient psychiatric units is that hospitals receive higher reimbursement levels for medical or surgical services than for mental health services. To the extent that mandating parity for mental health diagnosis increases the demand, coupled with a limited supply of providers, the basic economic theory indicates that costs will increase.

A 1997 study of 24 behavioral health managed care carve-out plans that offered unlimited mental health coverage and minimal copayments found that the number of individuals who received mental health services increased about seven percent over the preceding fee-for-service benefits. However, the number

⁵¹ Schoenbaum, Michael, et. al., "Health Plan Choice and Information about Out-of-Pocket Costs: An Experimental Analysis", April 1, 2001, Inquiry, Volume 38, Issue 1

of visits or hospitalizations per user decreased. The total cost of mental health care was lower due to the reduced rates of inpatient hospitalization, the shift to outpatient care and lower payments per service.⁵³

The study of the Vermont market after parity also found the mix of services between inpatient and outpatient as well as between mental illness and substance abuse changed after parity resulting in negligible changes in total cost.⁵⁴

2. *The extent to which similar mandated health benefits in other states have affected charges, costs and payments of services.*

Experience in other states does not demonstrate that expansion of benefits for mental health services results in higher provider reimbursement costs or significantly increased utilization.

Vermont

In 1998 Vermont was the first state in the nation to implement a comprehensive mental health parity law which encompassed both mental health and substance abuse services. Experience after the first two to three years of implementation shows the following⁵⁵:

- The number of individuals receiving outpatient mental health services increased by 6% to 8%.
- Fewer people received any substance abuse treatment after parity was implemented. The percentage of users per 1,000 members decreased by 16% to 29%.
- Consumers paid a smaller share of the total amount spent on MH/SA (mental health/substance abuse) services following parity. The out-of-pocket share paid by Blue Cross Blue Shield of Vermont (BCBSVT) insureds prior to parity was 27% of the total allowable charges. After parity the out-of-pocket share paid by BCBSVT insureds decreased to 16%.
- Spending by BCBSVT for MH/SA services increased by 4% following parity. This equates to \$0.19 per member per month.
- Kaiser/CHP, the largest HMO in the state, spending for MH/SA services actually decreased by 9%, mainly due to decreases in SA treatment services.

⁵² Jagdish Dang, MD., et. al.

⁵³ Sturm, R. "How Expensive is Unlimited Mental Health Care Coverage Under Managed Care?", JAMA, November 12, 1997, Vo.1278, No.18 as reported in "Assessment of Delaware Mental Health Parity.", March 2001.

⁵⁴ Rosenbach, et. al.

⁵⁵ Rosenbach, et. al,

- The adoption of managed care for MH/SA services by BCBSVT as a result of parity was a critical factor in controlling costs. Prior to parity, BCBSVT had very little managed care for behavioral services. After parity, it carved-out virtually all of these services to a behavioral health managed care vendor. This change increased the likelihood of BCBSVT insureds receiving treatments as well as decreased the number of treatments per insured.

The proposed New Jersey mandate should have less impact since parity for biological mental health services is already mandated, and the vast portion of the insured population has some, be it limited, benefits for other mental health and/or addictive behaviors.

Another important conclusion from this study is that consumer and employer awareness of the parity law was very low.

Delaware

Delaware implemented full parity for biologically based serious mental illnesses (SMI) in 1998. In 2001 the Delaware Health Care Commission engaged William M. Mercer, Incorporated to conduct a confidential study regarding the costs of this bill as well as estimating the costs for expanding parity to substance abuse. The Delaware Health Care Commission provided the State of New Jersey a copy of this study.

The study showed that implementing parity for SMI increased total medical claims by less than 0.3%. Adding substance abuse and dependence diagnoses, including alcoholism, was estimated to add between 0.1% and 1.0% to total medical claims, depending upon the underlying existing benefit.⁵⁶ Based upon the current benefit plans in New Jersey, we would expect the costs for substance abuse, including dependence diagnosis, to be toward the low end of this range.

The Delaware study also showed that provider reimbursement levels did not increase significantly as a result of parity.

Hawaii

In 2004 The Auditor of the State of Hawaii completed a “Study of Proposed Mandatory Parity in Health Insurance Coverage for Additional Serious Mental

⁵⁶ Giesa, Kurt, FSA, et. al, William M. Mercer, Inc., “Assessment of Delaware Mental Health Parity”, Delaware Health Care Commission, March 2001.

Illnesses and for Substance Abuse.”⁵⁷ Hawaii requires parity for serious mental illnesses and basic coverage for other mental disorders and substance abuse. The basic coverage is a minimum of 30 days inpatient services and 30 visits per year to a physician. Hawaii was considering expanding its list of serious mental illnesses to include delusional disorder, major depression, obsessive compulsive and dissociative disorder as well as substance abuse. As part of its 2004 study, the Auditor requested information from insurers regarding the number of claims attributable to these new categories as well as claims that exceeded existing benefits for these conditions. Less than 0.5% of insureds reached the existing maximum levels. Costs for substance abuse were even less. This indicates that adding full parity for these services would not add significantly to health care costs.

Massachusetts

In 2004 Massachusetts considered adding parity for substance abuse benefits. The Lewin Group estimated the impact of substance abuse parity to be an increase in premium of 0.2%. The range in costs was a low of 0.10% to a high of 0.41%. Approximately 0.2% of premium equates to \$0.83 per member per month increase in claims.

Oregon

In 2000 the Public Employees Benefit Board (PEBB), the agency that selects and provides oversight to Oregon’s state employee’s health plans, requested quotes to add full mental health parity as well as parity for chemical dependency treatment. The underlying benefits provided inpatient benefits for about 14 days and outpatient benefits of 52 visits every 24 months. PEBB received quotes ranging from 1.03% to 5.20% for full mental health parity and 0.14% to 0.79% for chemical dependency parity. The 1999 estimates for similar parities were 2.55% to 7.04% for mental health services and 2.13% to 7.36% for chemical dependency services. The 2000 estimates had decreased significantly from the 1999 levels.^{58,59}

Ohio

In 2001 the State of Ohio considered implementing full parity for mental illness and substance abuse. An independent actuarial analysis concluded that full parity

⁵⁷ Higa, M.

⁵⁸ Joint Interim Task Force on Mental Health and Chemical Dependency Treatment, State of Oregon, A Publication of Legislative Administration Committee Services, December 2000

⁵⁹ “Review and Evaluation of Proposed Legislation Entitled: ‘An Act to Provide Equitable Coverage

would result in an average increase in premium of 1.0% to 1.5%. The increase to any specific employer could be as much as 5% or more, if the employer currently provided a very low level of coverage. The report also indicated that the introduction of managed care for behavioral benefits could cut the average increase in premiums in half, to 0.5% to 0.75%.

Texas

Texas has two serious mental illness mandates. The first requires all group plans to provide coverage for 45 days of inpatient treatment and 60 visits for outpatient treatment for serious mental illness each calendar year. These claims represented 0.50% of all health claims in 2003. The second mandate requires full parity of serious mental illness for universities, local governments and state employees. At the time this report is being written, we have not received information regarding the cost of the second mandate.

Indiana

Indiana has full parity for mental health benefits for fully insured employers with fifty or more employees. Insurers must offer to provide substance abuse parity to this market as well. There is a clause in the law that allows insurers to request an exemption if they can show that premiums would increase by 4% or more as a result of parity for mental health benefits. No insurer has met this criteria and the mandate has been in place for all applicable policies written or renewed after December 31, 1999.⁶⁰

Maryland

Maryland implemented full parity in 1995. Immediately after parity, one insurer experienced an increase in inpatient admissions. This was offset by a decrease in the average length of stay. One insurer reported that mental health claims decreased as a percentage of total claims by 0.2%. Another reported an increase of 1.0%. By 1997, costs had decreased to pre-parity baseline levels.⁶¹

Minnesota

Minnesota's parity law became effective August 1995. The Minnesota

for Substance Abuse' Senate Bill No. 872." June 2004

⁶⁰ E-mail from Joy Long, Indiana Department of Insurance to Gale Simon, Assistant Commissioner, Life & Health, New Jersey Department of Banking and Insurance, November 9, 2004.

⁶¹ Varmus, H. "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." National Institute of Mental Health, April 1997 as reported in "The Cost of Full Parity: One to Two Percent, or Less, Period." www.apa.org/practice/cost_parity.html.

Department of Commerce estimated mental health costs to be 1% of total health care costs. Minnesota has a significant penetration of managed care plans which may have helped in controlling costs. Medica, an independent consulting organization, estimated the cost for mental health parity is \$.26 per member per month.⁶²

National Studies

A 1999 study of state mental health parity laws and their impact on costs and utilization shows that the “difference in use of mental health services between states before and after [parity] legislation is almost identical.” This report also concluded that parity laws are unlikely to impact utilization and access for the general population, partly because the awareness of insureds and employers of parity is very low.⁶³ This is consistent with the results in the Vermont study.

The U.S. Surgeon General’s 2000 report on mental health concludes that managed care coupled with parity offers cost controls without unfairly restricting coverage to limits or cost sharing provisions different from those for other illnesses. This report suggests that continued use of unnecessary limits or overly aggressive management may lead to under-treatment or to restricted access to services and plans.⁶⁴

3. *The extent to which the proposed mandated health benefit would increase the appropriate use of the treatment or service.*

The Vermont experience demonstrates that the introduction of managed care into behavioral services can improve access while controlling costs. Controlling costs were largely due to the implementation of managed care techniques in the mental health arenas. For example, large employers, including the Federal Government, have incorporated managed behavioral care approach in their employee health benefit plans for several years. Their experience has shown an increase in the quality of services being provided even though most of the day and lifetime limits were eliminated and copays were decreased. The employee utilization of mental health and substance abuse services has increased for the outpatient and alternative treatment settings while the services performed in the traditional inpatient settings have decreased. Through managed care techniques

⁶² Varmus

⁶³ Sturm, R, Pacula, L., “State Mental Health Parity Laws: Cause or Consequences in Use?” Health Affairs, Vol. 19, No. 5 as reported in “Assessment of Delaware Mental Health Parity.:

⁶⁴ U.S. Surgeon General

coordination of care can be increased.⁶⁵

4. *The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.*

This mandate could result in less emphasis being placed on free, 12-step programs currently available for many types of addictive behaviors.

There has been concern that the introduction of parity will result in a cost shift from public programs to private health insurance payers. A study of state programs in Maryland, Minnesota, New Hampshire and Rhode Island shows that parity results in no decrease in state spending on mental health and substance abuse. One of the reasons given for this is that publicly financed mental health and substance abuse services are provided to individuals who are unable to work because of these disorders and therefore, do not have insurance. The second reason for the lack of cost shifting is that public systems finance many services that private insurers will not cover even under parity such as life-skills training or court-ordered services.⁶⁶

According to Joseph Califano, President of the National Center on Addiction and Substance Abuse at Columbia University (CASA), abuse and addiction involving illegal drugs, alcohol and cigarettes are implicated in virtually every domestic problem in our nation. Of the two million prisoners in the nation, more than 1.8 million are in state and local institutions requiring state taxes to fund. Approximately 70% of the cases of child abuse and neglect stem from alcohol and drug-abusing parents. Of \$620 billion states spend on various services, \$81.3 billion or 13.1% was used to deal with substance abuse and addiction. Of every one of these dollars, \$0.96 was spent on the consequences (such as courts, prisons, etc.) and only \$0.04 was spent on prevention and treatment. Each American paid \$277 per year in state taxes to deal with the burden of substance abuse and addiction in their social service programs and only \$10 per year for prevention and treatment.⁶⁷

⁶⁵ Apgar, K. "Large Employer Experiences and Best Practices in Design, Administration and Evaluation of Mental Health and Substance Abuse Benefits—A Look at Parity in Employer-Sponsored Health Benefit Programs." Washington Business Group on Health, March 2000.

⁶⁶ National Mental Health Information Center, "The Cost and Effects of Parity for Mental and Health Substance Abuse Insurance Benefits" www.mentalhealth.samhsa.gov/_scripts/prinpage.aspx

⁶⁷ "Shoveling Up: The Impact of Substance Abuse on State Budgets", The National Center on Addiction and Substance Abuse at Columbia University, January 2001.

New Jersey incarcerates drug offenders at a much higher rate than the national average. While 36% of New Jersey's inmate population consists of drug offenders, nationally drug offenders comprise only 20% of the inmate population.⁶⁸ In 1999, 48% of all prison admissions in New Jersey are for drug offenses. The New Jersey Department of Corrections (NJDOC) estimated that it costs New Jersey \$28,000 to incarcerate someone for a year. New Jersey spends more to incarcerate drug offenders than a third of the states spend on their entire corrections system.⁶⁹

Treatment for illegal drugs saves medical dollars as well. Treatment programs resulted in a lower incidence of HIV. The incidence of positive tests for cocaine use was cut almost in half for pregnant drug users given treatment compared to pregnant drug users not receiving treatment. Following delivery, 10% of the infants of the treated group required neonatal intensive care compared with 26% of the infants in the untreated group. Average costs of care were \$14,500 for the treated group and \$46,700 for the untreated group.⁷⁰

A study of nine industries in New Jersey found that they employed 2.12 million people with alcohol or drug problems. These industries paid more than \$2 billion in alcohol-related health care costs. Health care costs declined by 22 to 55% following alcohol or drug treatment, resulting in savings of over \$680 million to \$1.6 billion. These savings do not take into consideration another \$1 billion in losses attributable to absenteeism and reduced productivity associated with substance abuse.⁷¹ Some have estimated the return on "investing" in addiction treatment is more than \$7 for every \$1 spent. For the vast majority of insured citizens, alcoholism is already subject to parity, so these cost savings are overstated to this extent.⁷²

5. *The methods which will be instituted to manage the utilization and costs of the proposed mandate.*

There appears to be confusion regarding the exact interpretation of the proposed benefit. Some insurers have assumed that the proposed mandate requires parity

⁶⁸ Schiraldi, V. and Ziedenbers, J., "Costs and Benefits? The Impact of Drug Imprisonment in New Jersey", Policy Report, October 2003.

⁶⁹ Schiraldi

⁷⁰ McLellan, et.al, "Drug Dependence, a Chronic Medical Illness, Implications for Treatment, Insurance and Outcomes Evaluation, JAMA, December 4, 2000, Vol 284, No.13

⁷¹ National Council on Alcoholism and Drug Dependence New Jersey, "Access to Quality Treatment"

for only those non-biological mental illnesses that they currently cover. Others have interpreted the proposed mandate to require parity for all non-biological mental illnesses. If a policy covers any non-biological mental illness, it must cover all non-biological mental illness. Thus, if allowed, (such as large groups), a company could drop coverage for all non-biological illness and be in compliance with the law.

The Division of Pensions and Benefits recommend the establishment of Utilization Management Review (UMR) prior to implementing the provisions of this bill. UMR would be required to determine the medical necessity of treatment (pre-certification) to control costs.

Virtually all of the carriers indicated they are assuming that the verbiage included in the bill enables them to introduce and/or continue behavioral managed care for these types of services.

A study of best practices of large employers implementing mental health and substance abuse benefit improvements indicate that the essential mechanisms required to manage quality of care are⁷³:

- preferred provider networks
- pre-approval for treatment
- a full continuum of treatment settings in the network
- referral mechanisms to connect employees to correct services
- utilization review and financial accountability of providers

This demonstrates that the introduction and/or continuation of managed care for these services is critical to maintain quality and control costs.

6. *The extent to which insurance coverage may affect the number and types of providers over the next five years.*

To the extent that “reliable” funding encourages the presence of providers of any specialty, full parity should result in an increase in the number of mental health and addictive providers. The 2004 Mental Health Needs and Services in New Jersey survey cited shortages of trained professionals as one of the current problems facing New Jersey.

⁷² Addiction Treatment Providers of New Jersey

⁷³Apgar, K.

7. *The extent to which the insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium or administrative expenses of policyholders.*

The following is a summary of the responses we received from insurance carriers, behavioral care management companies and interested parties regarding the impact of A333.

Impact of A333

Company	% of Premium
AmeriHealth	0.67% ¹
CIGNA	3% ²
Horizon	0.4% to 1.6%, depending upon the type of benefit and existing benefits
WellChoice	0.3% to 0.4%
Magellan (Behavioral care management company for Horizon, Aetna and AmeriHealth)	0.04% ³
New Jersey Association of Health Plans (NJ AHP) Analysis completed by Reyden & Anders	0.5% to 1.0%
New Jersey Psychological Association (NJPA) Analysis completed by PriceWaterhouseCoopers	0.6%

¹% of Premium was estimated by MOW based upon 2003 premium levels for AmeriHealth derived from State statistics, projected to 2005 using 10% per year and AmeriHealth’s estimated cost of \$2.00 PMPM and target loss ratio of 85%..

²CIGNA based the cost for the mandated upon its current pricing for an optional rider providing similar benefits.

³Magellan estimated the impact on mental health and substance abuse premiums would be an increase of 3.5%. Based upon the information provided by Magellan and the State, we translated this into an impact on total premium. No estimate in change in utilization has been assumed

The proposed mandate will have varying impacts depending upon the market. For instance, either through current law or through minimum benefit regulations, individual policies provide parity for biologically based illnesses (BBMI). However, for other mental health and substance abuse conditions only limited benefits are required (30 days inpatient and 20 outpatient visits with copays, deductibles and coinsurance). Large employer groups covered by insurance companies are required to provide parity for BBMI and alcoholism. For other mental health and substance abuse conditions, no minimum benefits are required, although it is reasonable to assume that many companies provide some benefits. Large companies insured by HMOs are only required to provide parity for BBMI.

Some carriers/interested parties provided detailed analyses describing the impact on each of these markets.

NJAHP

NJAHP through its consultant, Reden & Anders, provided the detailed cost estimates by market.

Employer Group Situation	Increase Cost as % of Total Plan Premium			
	Individual	Small Group	Large Group	
			HMO	Insurer
1. Group now has some coverage for non-BBIMI conditions and non-alcoholism SA conditions	0.7%	0.6%	1.0%	0.8%
2. Group does not provide any MH/SA benefit beyond the current NJ mandate	N/A	N/A	1.0%	0.5%

Initially the results of this table may appear confusing. It is NJAHP’s interpretation of the proposed legislation that if a group provides any non-BBIMI benefits, the proposed mandate requires that they expand coverage to include parity for all non-BBIMI services. However, if a large group currently does not provide any non-BBIMI benefits, then the proposed mandate requires only that it provide parity only for substance abuse and/or other addictions. Thus, the marginal cost to include parity, according to this interpretation, is actually higher for large groups that currently provide some non-BBIMI benefits than for large groups currently not providing any non-BBIMI benefits.

Horizon

Horizon provided the following estimates by market.

Estimated Impact of Mental Health Requirements vs. Total Costs								
Individual		Small Group			Large Group			
HMO	Ind	HMO	POS	PPO	HMO	POS	PPO	Ind
1.3%	0.2%	0.9%	0.4%	0.5%	1.4%	0.3%	1.2%	0.6%
Estimated Impact of Alcohol & Drug Addiction Treatment Requirements								
Individual		Small Group			Large Group			
HMO	Ind	HMO	POS	PPO	HMO	POS	PPO	Ind
0.2%	0.0%	0.1%	0.1%	0.1%	0.2%	0.1%	0.2%	0.1%
Estimated Total Impact								
Individual		Small Group			Large Group			
HMO	Ind	HMO	POS	PPO	HMO	POS	PPO	Ind
1.5%	0.2%	1.0%	0.5%	0.6%	1.6%	0.4%	1.4%	0.7%

WellChoice provided the following estimates by market.

Product	% of Premium		
	Mental Health	Chemical Dependency	Total
Small Group HMO	0.21%	0.12%	0.33%
Large Group HMO	0.38	0.03	0.41
Small Group PPO	0.28	0.05	0.33

NJPA through its consultant, PriceWaterhouseCoopers, provided the following details regarding variation of costs by market segment.

NJPA Estimate provided by PriceWaterhouseCoopers

Type of Delivery System	Distribution	% Increase Due to A333
Fee-for-service (indemnity with no specialized MH/SA utilization review)	5%	1.1%
Managed Indemnity (indemnity with specialized MH/SA utilization review)	15%	0.8
PPO & POS (Specialized MH/SA networks)	35%	0.5
HMO & Gatekeeper (Access to MH/SA provided through primary care gatekeeper)	45%	0.5
Total	100%	0.6

AmeriHealth provided \$PMPM by market. We have translated these into percentages of premiums for comparison purposes.

Product	% Impact
HMO	0.5% to 0.84%
POS	0.7% to 1.17%
PPO	1.0% to 1.67%
Indemnity	1.0% to 1.67%

It is important to put these cost estimates into the proper perspective. To complete this, we have estimated 2005 premium for New Jersey for each market segment, where possible, by trending 2003 premiums by 10% per year.

The following table shows our 2005 premium estimates by market segment.
Fully Insured Premium Only

Segment	Estimated 2005 Health Premium (millions of dollars)
Individual	\$421
Small Group	3,371
Large Group	5,366
Total	9,158

The next table shows the dollar impact reflected by each of the carriers' and/or interested parties' estimated costs.

**Estimated Costs of Proposed Mandated
(Millions of \$)**

Carrier and/or Interested Party		Individual	Small Group	Large Group	Total	Percent
AmeriHealth						
	Low	\$3.1	\$24.8	\$39.7	\$67.60	0.74%
	High	5.2	41.4	66.1	112.7	1.23
NJPA		3.3	26.3	39.5	69.1	0.76
NJAHF						
	Low	2.9	20.2	40.5	63.6	0.70
	High	2.9	20.2	48.4	71.5	0.78
CIGNA		12.6	101.1	161.0	274.7	3.00
Horizon		4.2	20.0	62.8	87.0	0.95
WellChoice		Did not Provide	11.1	22.0		0.38
Magellan		0.2	1.2	1.9	3.3	0.04

This shows that carriers and/or interested parties are estimating the range in costs, prior to considerations of benefit changes, to be \$3 million (Magellan) to \$275 million (CIGNA). However, CIGNA did not provide details showing the assumptions and/or sources for how they arrived at their estimate. Magellan provided the lowest estimate. Magellan's response was "No adjustments have been made ... for the switch to unlimited benefits for non-BBMI cases." We have interpreted this as meaning that they do not anticipated additional utilization.

If we eliminate the outliers, CIGNA on the high side and Magellan on the low side, the estimated costs provided by carriers and/or interested parties are:

**Estimated Costs of Proposed Mandated
(Millions of \$)
Excluding Outliers**

Carrier and/or Interested Party		Individual	Small Group	Large Group	Total (Millions of \$)	Percent
AmeriHealth						
	Low	\$3.1	\$24.8	\$39.7	\$67.60	0.74%
	High	5.2	41.4	66.1	112.7	1.23
NJPA		3.3	26.3	39.5	69.1	0.76
NJAHP						
	Low	2.9	20.2	40.5	63.6	0.70
	High	2.9	20.2	48.4	71.5	0.78
Horizon		4.2	20.0	62.8	87.0	0.95
WellChoice		Did not Provide	11.1	22.0		0.38

Excluding the outliers significantly reduces the range in cost estimates provided by carriers and/or interested parties.

Up to this point in time, we have not incorporated any action that employers may take to partially offset any increase in premiums due to increase in mandated benefits. NJPA's study cited a Congressional Budget Office estimate that "employer responses to required coverages will result in cost offsets of about 60% of gross cost estimates." We are interpreting "cost offsets" to mean purchasing plans that require higher cost sharing of employees and dependents. This is also referred to as "buying down" benefits. NJPA reduced their cost estimate shown previously by 60% to show composite impact of 0.24% of premium. This generates a total cost for the insured market of about \$22 million or \$0.55 PMPM.

The buy down cited by NJPA is high by industry norms which historically have been running anywhere from 1% to 3% of premiums.⁷⁴ Buy downs increase

⁷⁴ Press Release by Mercer Human Resource Consulting, "Employers Will Cut Health Benefits to Slow Cost Growth in 2005", September 26, 2004.

during periods where health insurance premiums are increasing in double-digit levels, which has been the case recently in New Jersey⁷⁵. If premium increases are occurring at a rate of 13%, we would expect about 3% in buy downs, or roughly about 25% of the increase will be negated by employer action as opposed to 60%. This equates to estimate costs ranging from \$3 million (Magellan) to \$211 million (CIGNA), with the average cost being \$68 million. If we eliminate the highest and the lowest estimate, then the range in costs after buy downs for insured plans is \$27 million to \$87 million or \$0.67 PMPM to \$2.17 PMPM, using MOW's estimate of premium distribution by product type.

The New Jersey Division of Pensions and Benefits (NJDPB) estimate the cost of A333 to be an increase in claim costs of 0.5%. Since the bill language provides that the "provisions of this bill will be effective 90 days after enactment and shall apply to contracts renewed after the effective date," NJDPB indicated there is no impact to fiscal year 2005. Fiscal year 2006 costs are estimated to be \$6.8 million for state employees and \$7.1 million for local employees.

8. *The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the cost and benefits of coverage.*

As discussed in earlier sections of this report, effective treatment of mental illnesses and addictive disorders can result in reduced health care costs, incarceration costs, absenteeism, and accidents.

The impacts on premiums may be leveraged if employers pass along the entire cost of the increase to employees. The number of employees who work for firms that offer insurance but elect not to participate has risen in recent years. Between 2000 and 2002 the percent of workers who elected coverage under their employer's plan decreased from 74.5% to 72.4%. Even among large firms (500 or more employees where employers historically have contributed a larger portion of total costs), the participation percentage decreased from 93% to 89%⁷⁶. While the marginal costs for the proposed benefit are minimal when considered as a percentage of total dollars, any increase may exacerbate the participation trend.

⁷⁵ Biddle

⁷⁶ Cook, Julie, "Opting Out", Human Resource Executive, August 19, 2004.

9. *The impact on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness.*

As discussed previously, parity can result in earlier treatment of addictions which may result in fewer addiction-related incarcerations and fewer accidents. Studies have shown that treatment of mental illness and/or addiction results in lower medical costs for these same individuals.

10. *The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers.*

MOW has independently estimated the impact the proposed mandate will have on aggregate premium. Our estimate is based upon a review of pertinent literature, emerging experience in states and/or entities that have passed similar legislation and our internal cost models. We estimated the impact on premiums to be as follows:

Prior to Employer Buy Down		
	Low (% of Premium)	High (% of Premium)
Mental Health	0.3%	0.5%
Addiction	0.1%	0.2%
Total	0.4%	0.7%
Total (2005 \$PMPM)	\$0.89	\$1.70
Total 2005 Dollars (Millions)	\$35.5	\$68.1
After Employer Buy Down		
Mental Health	0.2%	0.4%
Addiction	0.1%	0.2%
Total	0.3%	0.6%
Total(2005 \$PMPM)	\$0.68	\$1.31
Total 2005 Dollars (Millions)	\$27.3	\$52.4
Division of Pensions and Benefits adjusted by 10% to reflect 2005 dollars (millions)		
State	\$6.2	\$6.2
Local	\$6.5	\$6.5
Total (Before Buy Down)	\$48.2	\$80.8
Total	\$40.0	\$65.1

Part of these costs may be offset by adoption of aggressive behavior health care management. Magellan's estimates of the costs for this mandate are less than \$3 million. BCBSVT saw an increase in behavioral health claims of \$0.19 PMPM when parity was passed in 1998.

If access to treatment is improved, then the State could expect to experience a decrease in the number of incarcerations associated with illicit drugs and other addictions. However, these savings will occur in the long run as opposed to an immediate decrease. Employers should also experience improvements in absenteeism. Statistics show that individuals with untreated mental health/addiction conditions use medical resources at higher rates than individuals undergoing treatments.

11. *The effect of the proposed mandate on cost-shifting between private and public payers of health care coverage and on the overall cost of the health care delivery system in this State.*

As indicated previously, there has been concern that the introduction of parity will result in a cost shift from public programs to private health insurance payers. A study of state programs in Maryland, Minnesota, New Hampshire and Rhode Island shows that parity results in no decrease in state spending on MH/SA. One of the reasons given for this is that publicly financed MH/SA services are provided to individuals who are unable to work because of these disorders and therefore, do not have insurance. The second reason for the lack of cost shifting is that public systems finance many services that private insurers will not cover even under parity, such as life-skills training or court-ordered services.⁷⁷

⁷⁷ National Mental Health Information Center

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit.

1. *The contribution of the benefit to the quality of patient care and the health status of the population, including any research demonstrating the medical efficacy of the treatment or service compared to the alternative of not providing the treatment or service.*

Mental illness and addiction respond to treatments. In a study of the treatment of its employees for the past ten years, American Airlines disclosed that recovery rates to be 80% for alcohol abuse and 70% for drug abuse. After treatment, 75% to 80% remain sober for the first year.⁷⁸

Hypertension, diabetes and asthma are chronic disorders, like mental illness and addictions, which require continuing care throughout a patient's life. Effective treatments for these illnesses are also heavily dependent upon adherence to medical regimens. Studies have shown that less than 60% of adult patients with type 1 diabetes fully adhere to their medication schedule and less than 40% of patients with hypertension or asthma adhere fully to their medication regimens.⁷⁹ Some studies show that 40% to 60% of patients treated for alcohol or drug abuse return to active substance abuse within a year following treatment, which is comparable to treatments for other chronic illnesses.⁸⁰

The incidence of HIV has decreased in the population of substance abusers that have undergone treatment. The birth weights of babies whose mothers tested positive for cocaine and received treatment were higher than the birth weights of mothers who tested positive for cocaine who did not undergo treatment.⁸¹

⁷⁸ Testimony from CT Senator Toni N. Harp before American Bar Association Standing Committee on Substance Abuse and Join Together for Discrimination Policy Panel Report

⁷⁹ McLellan

⁸⁰ McLellan

⁸¹ McLellan

2. *If the legislation seeks to mandate coverage of an additional class of practitioners relative to those already covered.*

a. *The results of any professionally acceptable research demonstrating medical results achieved by the additional practitioners relative to those already covered.*

This is not applicable since the legislation does not mandate coverage of an additional class of practitioners.

b. *The methods of the appropriate professional organization that assure clinical proficiency.*

This is not applicable since the legislation does not mandate coverage of an additional class of practitioners.

VI. Balancing the Effects

D. The Effects of Balancing the Social, Economic, and Medical Efficacy Considerations.

1. *The extent to which the need for coverage outweighs the cost of mandating the benefit for all policyholders.*

There are a significant number of New Jersey residents that are afflicted with mental illness and/or substance addictions. Our analysis estimates that approximately 26% of the population suffers from these conditions. Some residents already receive benefits for these conditions at parity.

- For example, those residents with biologically based mental illnesses receive full coverage.
- Those residents with fully insured coverage from large employers also receive treatment for alcoholism at full parity.
- Those residents covered by Medicaid and the Veterans Administration receive benefits at full parity as well.

There will be a significant amount of residents that will not be impacted by this bill such as employees of self-insured employers, beneficiaries of Medicare and the uninsured. We estimate that approximately 70% of the residents in New Jersey will not be impacted by this bill. In addition, studies have shown that the people afflicted with these conditions are highly concentrated in special populations such as the homeless or the incarcerated. Many of the residents that need these services may not be impacted by A333.

At the present time, many of the estimated residents with these conditions are not receiving treatment for a multitude of reasons. It is estimated that as much as two-thirds of these residents are foregoing treatment. Some do not seek treatment because of the social stigma attached to the illnesses, others do not seek treatment because they are ignoring or avoiding the condition or symptoms and others cannot afford the cost of the treatment.

Another way of measuring unmet needs is to study the number of claims that are currently being denied for substance abuse and/or mental illness.

**AmeriHealth
Substance Abuse Denied Claims**

	2003 Denied Admissions	2003 Denied Days	2003 Denied Days/1,000 Member Years
HMO/POS	46	90	0.6
PPO/Indemnity	29	54	0.9

These statistics show there are not a huge number of inpatient hospital admissions for substance abuse that are being denied by AmeriHealth. AmeriHealth did not provide analogous statistics for mental health claims.

There were 47 claim appeals for substance abuse claims in 2003 and 14 for the first six months of 2004. These statistics do not represent a huge unmet need. Of course, they could also indicate that consumers are not totally cognizant of their rights to appeal claim decisions.

CIGNA reported 453 claim denials for substance abuse in 2003. CIGNA did not provide details regarding whether the claim was inpatient or outpatient. This represents a denial rate of over 65 claims per thousand member years. CIGNA did not provide any statistics regarding the dollar amount that these claims represent.

Horizon provided the following reports on claims denied from January 2002 through June 30, 2004. We generated the incidence of denied claims per thousand member years based upon Horizon's 2003 membership.

Horizon
MH/SA Denied Claims

	Mental Health			Alcohol and Drug Addiction			Total
	Biological	Non-Biol.	Total	Alcohol	Drug	Total	
# Claims	24,181	25,728	49,909	7,554	5,162	12,716	62,625
Incidence per 1000 Member Years	13.6	14.5	28.2	4.3	2.9	7.2	35.3

WellChoice provided the following statistics regarding claims denied from January 2002 through June 30, 2004. We generated the incidence rate based upon the 2003 WellChoice membership. The incidence rates for years other

than 2003 could be misstated to the extent that WellChoice's membership varied significantly from its 2003 levels.

**WellChoice
Denied Claims**

Mental Health					
	Year	Inpatient	Outpatient	Medical	Total
# Claims	2004	4			4
	2003	4	45	297	346
	2002	6	24	262	292
	Total	14	69	559	642
Incidence per Thousand Member Years	2004	0.8	0.0	0.0	0.8
	2003	0.4	4.8	31.4	36.6
	2002	0.6	2.5	27.7	30.9
	Average (2002-2004)	0.6	2.9	23.6	27.1
Substance Abuse					
	Year	Inpatient	Outpatient	Medical	Total
# Claims	2004	3	7	0	10
	2003	4	13	0	17
	2002	1	23	0	24
Incidence	2004	0.6	1.5	0.0	2.1
	2003	0.4	1.4	0.0	1.8
	2002	0.1	2.4	0.0	2.5
	Average	0.3	1.8	0.0	2.2
Total					
# Claims	2004	7	7	0	14
	2003	8	58	297	363
	2002	7	47	262	316
	Total	22	112	559	693
Incidence	2004	1.5	1.5	0.0	3.0
	2003	0.8	6.1	31.4	38.4
	2002	0.7	5.0	27.7	33.4
	Average	0.9	4.7	23.6	29.3

The additional costs associated with the proposed benefits of A333 are very small. All of our estimates produce additional costs that are under 1% of the current health insurance premium. However, New Jersey employers have been faced with double-digit rate increases in their health insurance premiums

for the last three years. Many are struggling with the ability to provide this insurance for their employees.

While the overall cost estimates for these benefits are low in total, the financial burden to the specific residents with these conditions can be devastating. The financial hardship for each resident will vary by the type and severity of their condition and the family's income level.

It has been demonstrated that treatments for mental illness and addictions are successful. However, mental illness and addictions are chronic conditions that must be treated throughout the lifetime of the individual. The successful treatment of these conditions can have a dramatic impact on many aspects of the community. For example, many of the incarcerated are estimated to have addiction conditions. Treating these individuals can increase the productivity of the community. Studies have shown there is less absenteeism and accidents at work. In addition, one HMO found that providing unlimited coverage for alcohol abuse treatment lowered the other medical expenses for these individuals and paid for these expenses in just 18 months.

2. *The extent to which the problem of coverage can be resolved by mandating the availability of coverage as an option for policyholders.*

If this benefit is to be provided as a mandatory offer as opposed to a mandatory benefit, then the costs would be considerably higher because only those who perceive a need will purchase the coverage.

VII. Appendices

Appendix A: Letter Requesting Study with Proposed Legislation



NEW JERSEY GENERAL ASSEMBLY

MAJORITY CONFERENCE LEADER
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October 4, 2004

COMMITTEES
CHAIRWOMAN
HEALTH AND HUMAN SERVICES
VICE CHAIRWOMAN
FAMILY, WOMEN AND CHILDREN'S SERVICES
MEMBER
NJ HISTORICAL COMMISSION
LEGISLATIVE SERVICES COMMISSION
NJ ISRAEL COMMISSION

Joel Cantor, Chairman
Mandated Health Benefits Advisory Commission
N.J. Department of Banking and Insurance
PO Box 325
Trenton, NJ 08625-0325

Dear Chairman Cantor,

Pursuant to P.L.2003, c.193 (17B:27D-3 et seq.), I hereby refer the following bill to the Mandated Health Benefits Advisory Commission:

A-333 (Weinberg/Johnson)--Revises statutory mental health coverage requirements and requires all health insurers to cover alcohol and drug addiction treatment under the same terms and conditions as for other diseases or illnesses.

Sincerely,

Loretta Weinberg
Chair Assembly Health and Human Services Committee

A333
ASSEMBLY, No. 333

STATE OF NEW JERSEY

211th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2004 SESSION

Sponsored by:
Assemblywoman LORETTA WEINBERG
District 37 (Bergen)
Assemblyman GORDON M. JOHNSON
District 37 (Bergen)
Assemblywoman MARY T. PREVITE
District 6 (Camden)

Co-Sponsored by:
Assemblyman Barnes, Assemblywomen Watson Coleman, Vandervalk, Assemblymen
McKeon, Blee, Cryan, Assemblywoman Quigley and Assemblyman Munoz

SYNOPSIS

Revises statutory mental health coverage requirements and requires all health insurers to cover alcohol and drug addiction treatment under same terms and conditions as for other diseases or illnesses.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

An Act concerning health care coverage for mental health services and alcohol and drug addiction treatment and revising parts of the statutory law.

Be It Enacted by the Senate and General Assembly of the State of New Jersey:

1. Section 1 of P.L.1999, c.106 (C.17:48-6v) is amended to read as follows:

1. a. Every individual and group hospital service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act shall provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract.

In addition, if the hospital service corporation contract provides coverage for a disorder that is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders and is not a biologically-based mental illness, the contract shall provide coverage for that disorder under the same terms and conditions as provided for any other sickness under the contract; however, coverage for alcohol and drug addiction treatment shall be subject to the provisions of section 1 of P.L.1977, c.115 (C.17:48-6a).

"Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Same terms and conditions" means that the hospital service corporation cannot apply different copayments, deductibles or benefit limits to biologically-based or other mental health benefits, as applicable, than those applied to other medical or surgical benefits.

b. Nothing in this section shall be construed to change the manner in which a hospital service corporation determines:

(1) whether a mental health care service meets the medical necessity standard as established by the hospital service corporation; or

(2) which providers shall be entitled to reimbursement for providing services for mental illness under the contract.

c. The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium. (cf: P.L.1999, c.106, s.1)

2. Section 2 of P.L.1999, c.106 (C.17:48A-7u) is amended to read as follows:

2. a. Every individual and group medical service corporation contract that provides hospital or medical expense benefits that is delivered, issued, executed or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act shall provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract. In addition, if the medical service corporation contract provides coverage for a disorder that is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders and is not a biologically-based mental illness, the contract shall provide coverage for that disorder under the same terms and conditions as provided for any other sickness under the contract; however, coverage for alcohol and drug addiction treatment shall be subject to the provisions of section 1 of P.L.1977, c.117 (C.17:48A-7a).

"Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Same terms and conditions" means that the medical service corporation cannot apply different copayments, deductibles or benefit limits to biologically-based or other mental health benefits, as applicable, than those applied to other medical or surgical benefits.

b. Nothing in this section shall be construed to change the manner in which a medical service corporation determines:

(1) whether a mental health care service meets the medical necessity standard as established by the medical service corporation; or

(2) which providers shall be entitled to reimbursement for providing services for mental illness under the contract.

c. The provisions of this section shall apply to all contracts in which the medical service corporation has reserved the right to change the premium. (cf: P.L.1999, c.106, s.2)

3. Section 3 of P.L.1999, c.106 (C.17:48E-35.20) is amended to read as follows:

3. a. Every individual and group health service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act shall provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract.

In addition, if the health service corporation contract provides coverage for a disorder that is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders and is not a biologically-based mental illness, the contract shall provide coverage for that disorder under the same terms and conditions as provided for any other sickness under the contract; however, coverage for alcohol and drug addiction treatment shall be subject to the provisions of section 34 of P.L.1985, c.236 (C.17:48E-34).

"Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to,

schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Same terms and conditions" means that the health service corporation cannot apply different copayments, deductibles or benefit limits to biologically-based or other mental health benefits, as applicable, than those applied to other medical or surgical benefits.

b. Nothing in this section shall be construed to change the manner in which the health service corporation determines:

- (1) whether a mental health care service meets the medical necessity standard as established by the health service corporation; or
- (2) which providers shall be entitled to reimbursement for providing services for mental illness under the contract.

c. The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the premium. (cf: P.L.1999, c.106, s.3)

4. Section 4 of P.L.1999, c.106 (C.17B:26-2.1s) is amended to read as follows:

4. a. Every individual health insurance policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to chapter 26 of Title 17B of the New Jersey Statutes, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act shall provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract.

In addition, if the individual health insurance policy provides coverage for a disorder that is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders and is not a biologically-based mental illness, the policy shall provide coverage for that disorder under the same terms and conditions as provided for any other sickness under the policy; however, coverage for alcohol and drug addiction treatment shall be subject to the provisions of section 1 of P.L.1977, c.118 (C.17B:26-2.1).

"Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Same terms and conditions" means that the insurer cannot apply different copayments, deductibles or benefit limits to biologically-based or other mental health benefits, as applicable, than those applied to other medical or surgical benefits.

b. Nothing in this section shall be construed to change the manner in which the insurer determines:

- (1) whether a mental health care service meets the medical necessity standard as established by the insurer; or
- (2) which providers shall be entitled to reimbursement for providing services for mental illness under the policy.

c. The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium. (cf: P.L.1999, c.106, s.4)

5. Section 5 of P.L.1999, c.106 (C.17B:27-46.1v) is amended to read as follows:

5. a. Every group health insurance policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to chapter 27 of Title 17B of the New Jersey Statutes, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act shall provide benefits for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the policy.

In addition, if the group health insurance policy provides coverage for a disorder that is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders and is not a biologically-based mental illness, the policy shall provide coverage for that disorder under the same terms and conditions as provided for any other sickness under the policy; however, coverage for alcohol and drug addiction treatment shall be subject to the provisions of section 1 of P.L.1977, c.116 (C.17B:27-46.1).

"Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Same terms and conditions" means that the insurer cannot apply different copayments, deductibles or benefit limits to biologically-based or other mental health benefits, as applicable, than those applied to other medical or surgical benefits.

b. Nothing in this section shall be construed to change the manner in which the insurer determines:

(1) whether a mental health care service meets the medical necessity standard as established by the insurer; or

(2) which providers shall be entitled to reimbursement for providing services for mental illness under the policy.

c. The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium. (cf: P.L.1999, c.106, s.5)

6. Section 6 of P.L.1999, c.106 (C.17B:27A-7.5) is amended to read as follows:

6. a. Every individual health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) or approved for issuance or renewal in this State on or after the effective date of this act shall provide benefits for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the health benefits plan.

In addition, if the health benefits plan provides benefits for a disorder that is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders and is not a biologically-based mental illness, the plan shall provide benefits for that disorder under the same terms and conditions as provided for any other sickness under the plan; however, coverage for alcohol and drug addiction treatment shall be subject to the provisions of section 18 of P.L. , c. (C.)(pending before the Legislature as this bill).

"Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Same terms and conditions" means that the plan cannot apply different copayments, deductibles or benefit limits to biologically-based or other mental health benefits, as applicable, than those applied to other medical or surgical benefits.

b. Nothing in this section shall be construed to change the manner in which the carrier determines:

(1) whether a mental health care service meets the medical necessity standard as established by the carrier; or

(2) which providers shall be entitled to reimbursement for providing services for mental illness under the plan.

c. The provisions of this section shall apply to all health benefits plans in which the carrier has reserved the right to change the premium. (cf: P.L.1999, c.106, s.6)

7. Section 7 of P.L.1999, c.106 (C.17B:27A-19.7) is amended to read as follows:

7. a. Every small employer health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) or approved for issuance or renewal in this State on or after the effective date of this act shall provide benefits for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the health benefits plan.

In addition, if the health benefits plan provides benefits for a disorder that is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders and is not a biologically-based mental illness, the plan shall provide benefits for that disorder under the same terms and conditions as provided for any

other sickness under the plan; however, coverage for alcohol and drug addiction treatment shall be subject to the provisions of section 19 of P.L. , c. (C.)(pending before the Legislature as this bill).

"Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Same terms and conditions" means that the plan cannot apply different copayments, deductibles or benefit limits to biologically-based or other mental health benefits, as applicable, than those applied to other medical or surgical benefits.

b. Nothing in this section shall be construed to change the manner in which the carrier determines:

(1) whether a mental health care service meets the medical necessity standard as established by the carrier; or

(2) which providers shall be entitled to reimbursement for providing services for mental illness under the health benefits plan.

c. The provisions of this section shall apply to all health benefits plans in which the carrier has reserved the right to change the premium. (cf: P.L.1999, c.106, s.7)

8. Section 8 of P.L.1999, c.106 (C.26:2J-4.20) is amended to read as follows:

8. a. Every [enrollee agreement] contract delivered, issued, executed or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Health and Senior Services, on or after the effective date of this act shall provide health care services for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the [agreement] contract.

In addition, if the contract provides health care services for a disorder that is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders and is not a biologically-based mental illness, the contract shall provide health care services for that disorder under the same terms and conditions as provided for any other sickness under the contract; however, coverage for alcohol and drug addiction treatment shall be subject to the provisions of section 20 of P.L. , c. (C.)(pending before the Legislature as this bill).

"Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Same terms and conditions" means that the health maintenance organization cannot apply different copayments, deductibles or health care services limits to biologically-based or other mental health care services, as applicable, than those applied to other medical or surgical health care services.

b. Nothing in this section shall be construed to change the manner in which a health maintenance organization determines:

(1) whether a mental health care service meets the medical necessity standard as established by the health maintenance organization; or

(2) which providers shall be entitled to reimbursement or to be participating providers, as appropriate, for mental health services under the [enrollee agreement] contract.

c. The provisions of this section shall apply to [enrollee agreements] in which the health maintenance organization has reserved the right to change the premium. (cf: P.L.1999, c.106, s.8)

9. Section 9 of P.L.1999, c.106 (C.34:11A-15) is amended to read as follows:

9. An employer in this State who provides health benefits coverage to his employees or their dependents for treatment of biologically-based or other mental illness shall annually, and upon request of an employee at other times during the year, notify his employees whether the employees' coverage for treatment of [biologically-based] mental illness is subject to the requirements of this act. (cf: P.L.1999, c.106, s.9)

10. Section 5 of P.L.1961, c. 49 (C.52:14-17.29) is amended to read as follows:

5. (A) The contract or contracts purchased by the commission pursuant to section 4 shall provide separate coverages or policies as follows:

(1) Basic benefits which shall include:

(a) Hospital benefits, including outpatient;

(b) Surgical benefits;

(c) Inpatient medical benefits;

(d) Obstetrical benefits; and

(e) Services rendered by an extended care facility or by a home health agency and for specified medical care visits by a physician during an eligible period of such services, without regard to whether the patient has been hospitalized, to the extent and subject to the conditions and limitations agreed to by the commission and the carrier or carriers.

Basic benefits shall be substantially equivalent to those available on a group remittance basis to employees of the State and their dependents under the subscription contracts of the New Jersey "Blue Cross" and "Blue Shield" Plans. Such basic benefits shall include benefits for:

(i) Additional days of inpatient medical service;

(ii) Surgery elsewhere than in a hospital;

(iii) X-ray, radioactive isotope therapy and pathology services;

(iv) Physical therapy services;

(v) Radium or radon therapy services;

and the extended basic benefits shall be subject to the same conditions and limitations, applicable to such benefits, as are set forth in "Extended Outpatient Hospital Benefits Rider," Form 1500, 71(9-66), and in "Extended Benefit Rider" (as amended), Form MS 7050J(9-66) issued by the New Jersey "Blue Cross" and "Blue Shield" Plans, respectively, and as the same may be amended or superseded, subject to filing by the Commissioner of Banking and Insurance; and

(2) Major medical expense benefits which shall provide benefit payments for reasonable and necessary eligible medical expenses for hospitalization, surgery, medical treatment and other related services and supplies to the extent they are not covered by basic benefits. The commission may, by regulation, determine what types of services and supplies shall be included as "eligible medical services" under the major medical expense benefits coverage as well as those which shall be excluded from or limited under such coverage. Benefit payments for major medical expense benefits shall be equal to a percentage of the reasonable charges for eligible medical services incurred by a covered employee or an employee's covered dependent, during a calendar year as exceed a deductible for such calendar year of \$100.00 subject to the maximums hereinafter provided and to the other terms and conditions authorized by this act. The percentage shall be 80% of the first \$2,000.00 of charges for eligible medical services incurred subsequent to satisfaction of the deductible and 100% thereafter. There shall be a separate deductible for each calendar year for (a) each enrolled employee and (b) all enrolled dependents of such employee. Not more than \$1,000,000.00 shall be paid for major medical expense benefits with respect to any one person for the entire period of such person's coverage under the plan, whether continuous or interrupted except that this maximum may be reapplied to a covered person in amounts not to exceed \$2,000.00 a year. Maximums of \$10,000.00 per calendar year and \$20,000.00 for the entire period of the person's coverage under the plan shall apply to eligible expenses incurred because of [mental illness or functional nervous disorders] any mental illness or functional nervous disorder that is not included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders, and such may be reapplied to a covered person, [except as provided] in accordance with the provisions of P.L.1999, c.441 (C.52:14-17.29d et al.). The same provisions shall apply for retired employees and their dependents. Under the conditions agreed upon by the commission and the carriers as set forth in the contract, the deductible for a calendar year may be satisfied in whole or in part by eligible charges incurred during the last three months of the prior calendar year.

Any service determined by regulation of the commission to be an "eligible medical service" under the major medical expense benefits coverage which is performed by a duly licensed practicing psychologist within the lawful scope of his practice shall be recognized for reimbursement under the same conditions as would apply were such service performed by a physician.

(B) Benefits under the contract or contracts purchased as authorized by this act may be subject to such limitations, exclusions, or waiting periods as the commission finds to be necessary or desirable to avoid

inequity, unnecessary utilization, duplication of services or benefits otherwise available, including coverage afforded under the laws of the United States, such as the federal Medicare program, or for other reasons.

Benefits under the contract or contracts purchased as authorized by this act shall include those for the treatment of alcoholism where such treatment is prescribed by a physician and shall also include treatment while confined in or as an outpatient of a licensed hospital or residential treatment program which meets minimum standards of care equivalent to those prescribed by the Joint Commission on [Hospital] Accreditation of Healthcare Organizations. No benefits shall be provided beyond those stipulated in the contracts held by the State Health Benefits Commission.

(C) The rates charged for any contract purchased under the authority of this act shall reasonably and equitably reflect the cost of the benefits provided based on principles which in the judgment of the commission are actuarially sound. The rates charged shall be determined by the carrier on accepted group rating principles with due regard to the experience, both past and contemplated, under the contract. The commission shall have the right to particularize subgroups for experience purposes and rates. No increase in rates shall be retroactive.

(D) The initial term of any contract purchased by the commission under the authority of this act shall be for such period to which the commission and the carrier may agree, but permission may be made for automatic renewal in the absence of notice of termination by the commission. Subsequent terms for which any contract may be renewed as herein provided shall each be limited to a period not to exceed one year.

(E) The contract shall contain a provision that if basic benefits or major medical expense benefits of an employee or of an eligible dependent under the contract, after having been in effect for at least one month in the case of basic benefits or at least three months in the case of major medical expense benefits, is terminated, other than by voluntary cancellation of enrollment, there shall be a 31-day period following the effective date of termination during which such employee or dependent may exercise the option to convert, without evidence of good health, to converted coverage issued by the carriers on a direct payment basis. Such converted coverage shall include benefits of the type classified as "basic benefits" or "major medical expense benefits" in subsection (A) hereof and shall be equivalent to the benefits which had been provided when the person was covered as an employee. The provision shall further stipulate that the employee or dependent exercising the option to convert shall pay the full periodic charges for the converted coverage which shall be subject to such terms and conditions as are normally prescribed by the carrier for this type of coverage.

(F) The commission may purchase a contract or contracts to provide drug prescription and other health care benefits or authorize the purchase of a contract or contracts to provide drug prescription and other health care benefits as may be required to implement a duly executed collective negotiations agreement or as may be required to implement a determination by a public employer to provide such benefit or benefits to employees not included in collective negotiations units. (cf: P.L.1999, c.441, s.3)

11. Section 1 of P.L.1999, c.441 (C.52:14-17.29d) is amended to read as follows:

1. As used in this act:

"Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness including, but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State.

"Same terms and conditions" means that a carrier cannot apply different copayments, deductibles or benefit limits to biologically-based or other mental health benefits, as applicable, than those applied to other medical or surgical benefits. (cf: P.L.1999, c.441, s.1)

12. Section 2 of P.L.1999, c.441 (C.52:14-17.29e) is amended to read as follows:

2. a. The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act that provides hospital or medical expense benefits shall provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract.

In addition, the State Health Benefits Commission shall ensure that every such contract, which provides coverage for a disorder that is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders and is not a biologically-based mental illness, shall provide coverage for that disorder under the same terms and conditions as provided for any other sickness under the contract.

b. Nothing in this section shall be construed to change the manner in which a carrier determines:

(1) whether a mental health care service meets the medical necessity standard as established by the carrier; or

(2) which providers shall be entitled to reimbursement for providing services for mental illness under the contract.

c. The commission shall provide notice to employees regarding the coverage required by this section in accordance with this subsection and regulations promulgated by the Commissioner of Health and Senior Services pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The notice shall be in writing and prominently positioned in any literature or correspondence and shall be transmitted at the earliest of:

(1) the next mailing to the employee;

(2) the yearly informational packet sent to the employee; or

(3) July 1, 2000.

The commission shall also ensure that the carrier under contract with the commission, upon receipt of information that a covered person is receiving treatment for a biologically-based or other mental illness, shall promptly notify that person of the coverage required by this section. (cf: P.L.1999, c.441, s.2)

13. Section 1 of P.L.1977, c.115 (C.17:48-6a) is amended to read as follows:

1. No group or individual contract providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless such contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in connection with [the treatment of alcoholism] alcohol and drug addiction treatment when such treatment is [prescribed by a doctor of medicine] determined to be necessary by a physician or State-licensed addictions professional based upon an assessment that utilizes patient placement criteria adopted by the American Society of Addiction Medicine and determines appropriate levels of treatment placement. Such benefits shall be provided [to the same extent] under the same terms and conditions as provided for any other [sickness] disease or illness under the contract.

"Alcohol and drug addiction treatment" includes, but is not limited to, any of the following items or services provided for alcohol or drug addiction treatment: inpatient or outpatient treatment, including detoxification, screening and assessment, case management, medication management, psychiatric consultations and individual, group and family counseling, and relapse prevention; non-hospital residential treatment; and prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for alcohol or drug addiction.

"Same terms and conditions" means that the hospital service corporation cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to alcohol and drug addiction treatment services than those applied to other medical or surgical expense benefits.

Every contract shall include such benefits for [the treatment of alcoholism] alcohol and drug addiction treatment as are hereinafter set forth:

a. Inpatient or outpatient care in a [licensed hospital] health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.);

b. Treatment at a detoxification facility licensed pursuant to [P.L.1975, c.305] section 8 of P.L.1975, c.305 (C.26:2B-14); and

c. [Confinement as an inpatient or outpatient at a licensed, certified, or state approved residential treatment facility, under a program which meets minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation] Participation as an inpatient at a residential facility licensed pursuant to N.J.A.C.8:42A-1.1 et seq. or as an outpatient in a State-approved outpatient treatment facility that meets minimum standards of care as set forth by the Department of Health and Senior Services.

Treatment [or confinement] at any facility shall not preclude further or additional treatment at any other eligible facility; provided, however, that the benefit days used do not exceed the total number of benefit days provided for any other [sickness] disease or illness under the contract. (cf: P.L.1977, c.115, s.1)

14. Section 1 of P.L.1977, c.117 (C.17:48a-7a) is amended to read as follows:

1. No group or individual contract providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless such contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in connection with [the treatment of alcoholism] alcohol and drug addiction treatment when such treatment is [prescribed by a doctor of medicine] determined to be necessary by a physician or State-licensed addictions professional based upon an assessment that utilizes patient placement criteria adopted by the American Society of Addiction Medicine and determines appropriate levels of treatment placement. Such benefits shall be provided [to the same extent] under the same terms and conditions as provided for any other [sickness] disease or illness under the contract.

"Alcohol and drug addiction treatment" includes, but is not limited to, any of the following items or services provided for alcohol or drug addiction treatment: inpatient or outpatient treatment, including detoxification, screening and assessment, case management, medication management, psychiatric consultations and individual, group and family counseling, and relapse prevention; non-hospital residential treatment; and prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for alcohol or drug addiction.

"Same terms and conditions" means that the medical service corporation cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to alcohol and drug addiction treatment services than those applied to other medical or surgical expense benefits.

Every contract shall include such benefits for [the treatment of alcoholism] alcohol and drug addiction treatment as are hereinafter set forth:

a. Inpatient or outpatient care in a [licensed hospital] health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.);

b. Treatment at a detoxification facility licensed pursuant to [P.L.1975, c.305] section 8 of P.L.1975, c.305 (C.26:2B-14); and

c. [Confinement as an inpatient or outpatient at a licensed, certified, or state approved residential treatment facility, under a program which meets minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation] Participation as an inpatient at a residential facility licensed pursuant to N.J.A.C.8:42A-1.1 et seq. or as an outpatient in a State-approved outpatient treatment facility that meets minimum standards of care as set forth by the Department of Health and Senior Services.

Treatment [or confinement] at any facility shall not preclude further or additional treatment at any other eligible facility; provided, however, that the benefit days used do not exceed the total number of benefit days provided for any other [sickness] disease or illness under the contract. (cf: P.L.1977, c.117, s.1)

15. Section 34 of P.L.1985, c.236 (C.17:48E-34) is amended to read as follows:

34. No group or individual contract providing health service coverage shall be delivered, issued, executed, or renewed in this State, or approved for issuance or renewal in this State by the commissioner, on or after the effective date of this act, unless the contract provides benefits to any subscriber or other person covered thereunder for expenses incurred in connection with [the treatment of alcoholism] alcohol and drug addiction treatment when such treatment is [prescribed by a doctor of medicine] determined to be necessary by a physician or State-licensed addictions professional based upon an assessment that utilizes patient placement criteria adopted by the American Society of Addiction Medicine and determines appropriate levels of treatment placement. Benefits shall be provided [to the same extent] under the same terms and conditions as provided for any other [sickness] disease or illness under the contract.

"Alcohol and drug addiction treatment" includes, but is not limited to, any of the following items or services provided for alcohol or drug addiction treatment: inpatient or outpatient treatment, including detoxification, screening and assessment, case management, medication management, psychiatric consultations and individual, group and family counseling, and relapse prevention; non-hospital residential treatment; and prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for alcohol or drug addiction.

"Same terms and conditions" means that the health service corporation cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to

alcohol and drug addiction treatment services than those applied to other medical or surgical expense benefits.

Every contract shall include benefits for [the treatment of alcoholism] alcohol and drug addiction treatment as follows:

a. Inpatient or outpatient care in a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.);

b. Treatment at a detoxification facility licensed pursuant to section 8 of P.L.1975, c.305 (C.26:2B-14); and

c. [Confinement as an inpatient or outpatient at a licensed, certified, or state approved residential treatment facility, under a program which meets minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation] Participation as an inpatient at a residential facility licensed pursuant to N.J.A.C.8:42A-1.1 et seq. or as an outpatient in a State-approved outpatient treatment facility that meets minimum standards of care as set forth by the Department of Health and Senior Services.

Treatment [or confinement] at any facility shall not preclude further or additional treatment at any other eligible facility, if the benefit days used do not exceed the total number of benefit days provided for any other [sickness] disease or illness under the contract. (cf: P.L.1985, c.236, s.34)

16. Section 1 of P.L.1977, c.118 (C.17B:26-2.1) is amended to read as follows:

1. No health insurance [contract] policy providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, unless such [contract] policy provides benefits to any [subscriber] insured or other person covered thereunder for expenses incurred in connection with [the treatment of alcoholism] alcohol and drug addiction treatment when such treatment is [prescribed by a doctor of medicine] determined to be necessary by a physician or State-licensed addictions professional based upon an assessment that utilizes patient placement criteria adopted by the American Society of Addiction Medicine and determines appropriate levels of treatment placement. Such benefits shall be provided [to the same extent] under the same terms and conditions as provided for any other [sickness] disease or illness under the [contract] policy.

"Alcohol and drug addiction treatment" includes, but is not limited to, any of the following items or services provided for alcohol or drug addiction treatment: inpatient or outpatient treatment, including detoxification, screening and assessment, case management, medication management, psychiatric consultations and individual, group and family counseling, and relapse prevention; non-hospital residential treatment; and prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for alcohol or drug addiction.

"Same terms and conditions" means that the insurer cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to alcohol and drug addiction treatment services than those applied to other medical or surgical expense benefits.

Every [contract] policy shall include such benefits for [the treatment of alcoholism] alcohol and drug addiction treatment as are hereinafter set forth:

a. Inpatient or outpatient care in a [licensed hospital] health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.);

b. Treatment at a detoxification facility licensed pursuant to [P.L.1975, c.305] section 8 of P.L.1975, c.305 (C.26:2B-14); and

c. [Confinement as an inpatient or outpatient at a licensed, certified, or state approved residential treatment facility, under a program which meets minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation] Participation as an inpatient at a residential facility licensed pursuant to N.J.A.C.8:42A-1.1 et seq. or as an outpatient in a State-approved outpatient treatment facility that meets minimum standards of care as set forth by the Department of Health and Senior Services.

Treatment [or confinement] at any facility shall not preclude further or additional treatment at any other eligible facility; provided, however, that the benefit days used do not exceed the total number of benefit days provided for any other [sickness] disease or illness under the [contract] policy. (cf: P.L.1977, c.118, s.1)

17. Section 1 of P.L.1977, c.116 (C.17B:27-46.1) is amended to read as follows:

No group health insurance [contract] policy providing hospital or medical expense benefits shall be delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the

Commissioner of Banking and Insurance, or on after the effective date of this act, unless such [contract] policy provides benefits to any [subscriber] insured or other person covered thereunder for expenses incurred in connection with [the treatment of alcoholism] alcohol and drug addiction treatment when such treatment is [prescribed by a doctor of medicine] determined to be necessary by a physician or State-licensed addictions professional based upon an assessment that utilizes patient placement criteria adopted by the American Society of Addiction Medicine and determines appropriate levels of treatment placement. Such benefits shall be provided [to the same extent] under the same terms and conditions as provided for any other [sickness] disease or illness under the [contract] policy.

"Alcohol and drug addiction treatment" includes, but is not limited to, any of the following items or services provided for alcohol or drug addiction treatment: inpatient or outpatient treatment, including detoxification, screening and assessment, case management, medication management, psychiatric consultations and individual, group and family counseling, and relapse prevention; non-hospital residential treatment; and prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for alcohol or drug addiction.

"Same terms and conditions" means that the insurer cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to alcohol and drug addiction treatment services than those applied to other medical or surgical expense benefits.

Every [contract] policy shall include such benefits for [the treatment of alcoholism] alcohol and drug addiction treatment as are hereinafter set forth:

a. Inpatient or outpatient care in a [licensed hospital] health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.);

b. Treatment at a detoxification facility licensed pursuant to [P.L.1975, c.305] section 8 of P.L.1975, c.305 (C.26:2B-14); and

c. [Confinement as an inpatient or outpatient at a licensed, certified, or state approved residential treatment facility, under a program which meets minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation] Participation as an inpatient at a residential facility licensed pursuant to N.J.A.C.8:42A-1.1 et seq. or as an outpatient in a State-approved outpatient treatment facility that meets minimum standards of care as set forth by the Department of Health and Senior Services.

Treatment [or confinement] at any facility shall not preclude further or additional treatment at any other eligible facility; provided, however, that the benefit days used do not exceed the total number of benefit days provided for any other [sickness] disease or illness under the [contract] policy. (cf: P.L.1977, c.116, s.1)

18. (New section) Every individual health benefits plan that provides hospital or medical expense benefits, and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), on or after the effective date of this act, shall provide coverage for expenses incurred in connection with alcohol and drug addiction treatment when such treatment is determined to be necessary by a physician or State-licensed addictions professional based upon an assessment that utilizes patient placement criteria adopted by the American Society of Addiction Medicine and determines appropriate levels of treatment placement. Such benefits shall be provided under the same terms and conditions as provided for any other disease or illness under the plan.

"Alcohol and drug addiction treatment" includes, but is not limited to, any of the following items or services provided for alcohol or drug addiction treatment: inpatient or outpatient treatment, including detoxification, screening and assessment, case management, medication management, psychiatric consultations and individual, group and family counseling, and relapse prevention; non-hospital residential treatment; and prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for alcohol or drug addiction.

"Same terms and conditions" means that the carrier cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to alcohol and drug addiction treatment services than those applied to other medical or surgical expense benefits.

Every plan shall include such benefits for alcohol and drug addiction treatment as are hereinafter set forth:

a. Inpatient or outpatient care in a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.);

b. Treatment at a detoxification facility licensed pursuant to section 8 of P.L.1975, c.305 (C.26:2B-14); and

c. Participation as an inpatient at a residential facility licensed pursuant to N.J.A.C.8:42A-1.1 et seq. or as an outpatient in a State-approved outpatient treatment facility that meets minimum standards of care as set forth by the Department of Health and Senior Services.

Treatment at any facility shall not preclude further or additional treatment at any other eligible facility; provided, however, that the benefit days used do not exceed the total number of benefit days provided for any other disease or illness under the plan.

19. (New section) Every small employer health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), on or after the effective date of this act, shall provide coverage for expenses incurred in connection with alcohol and drug addiction treatment when such treatment is determined to be necessary by a physician or State-licensed addictions professional based upon an assessment that utilizes patient placement criteria adopted by the American Society of Addiction Medicine and determines appropriate levels of treatment placement. Such benefits shall be provided under the same terms and conditions as provided for any other disease or illness under the plan.

"Alcohol and drug addiction treatment" includes, but is not limited to, any of the following items or services provided for alcohol or drug addiction treatment: inpatient or outpatient treatment, including detoxification, screening and assessment, case management, medication management, psychiatric consultations and individual, group and family counseling, and relapse prevention; non-hospital residential treatment; and prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for alcohol or drug addiction.

"Same terms and conditions" means that the carrier cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to alcohol and drug addiction treatment services than those applied to other medical or surgical expense benefits.

Every plan shall include such benefits for alcohol and drug addiction treatment as are hereinafter set forth:

a. Inpatient or outpatient care in a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.);

b. Treatment at a detoxification facility licensed pursuant to section 8 of P.L.1975, c.305 (C.26:2B-14); and

c. Participation as an inpatient at a residential facility licensed pursuant to N.J.A.C.8:42A-1.1 et seq. or as an outpatient in a State-approved outpatient treatment facility that meets minimum standards of care as set forth by the Department of Health and Senior Services.

Treatment at any facility shall not preclude further or additional treatment at any other eligible facility; provided, however, that the benefit days used do not exceed the total number of benefit days provided for any other disease or illness under the plan.

20. (New section) Every contract for health care services, which is delivered, issued, executed or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Health and Senior Services, on or after the effective date of this act, shall provide health care services for alcohol and drug addiction treatment when such treatment is determined to be necessary by a physician or State-licensed addictions professional based upon an assessment that utilizes patient placement criteria adopted by the American Society of Addiction Medicine and determines appropriate levels of treatment placement. Such health care services shall be provided under the same terms and conditions as provided for any other disease or illness under the contract.

"Alcohol and drug addiction treatment" includes, but is not limited to, any of the following items or services provided for alcohol or drug addiction treatment: inpatient or outpatient treatment, including detoxification, screening and assessment, case management, medication management, psychiatric consultations and individual, group and family counseling, and relapse prevention; non-hospital residential treatment; and prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for alcohol or drug addiction.

"Same terms and conditions" means that the health maintenance organization cannot apply different copayments, deductibles or benefit limits, including day or visit limits or annual or lifetime dollar limits, to alcohol and drug addiction treatment services than those applied to other health care services.

Every contract shall include such health care services for alcohol and drug addiction treatment as are hereinafter set forth:

a. Inpatient or outpatient care in a health care facility licensed pursuant to P.L.1971, c. 136 (C.26:2H-1 et seq.);

b. Treatment at a detoxification facility licensed pursuant to section 8 of P.L.1975, c.305 (C.26:2B-14); and

c. Participation as an inpatient at a residential facility licensed pursuant to N.J.A.C.8:42A-1.1 et seq. or as an outpatient in a State-approved outpatient treatment facility that meets minimum standards of care as set forth by the Department of Health and Senior Services.

Treatment at any facility shall not preclude further or additional treatment at any other eligible facility; provided, however, that the benefit days used do not exceed the total number of benefit days provided for any other disease or illness under the contract.

21. (New section) An employer in this State who provides health benefits coverage to his employees or their dependents for alcohol or drug addiction treatment shall annually, and upon request of an employee at other times during the year, notify his employees whether the employees' coverage for alcohol or drug addiction treatment is subject to the requirements of section 1 of P.L.1977, c.115 (C.17:48-6a), section 1 of P.L.1977, c.116 (C.17B:27-46.1); section 1 of P.L.1977, c.117 (C.17:48A-7a), section 1 of P.L.1977, c.118 (C.17B:26-2.1), section 34 of P.L.1985, c.236 (C.17:48E-34), or sections 18 through 20 of P.L. , c. (C.) (pending before the Legislature as this bill).

22. This act shall take effect on the 90th day after enactment and shall apply to policies or contracts issued or renewed on or after the effective date.

STATEMENT

This bill provides for expanded coverage of mental health services and substance abuse treatment for the citizens of this State.

Specifically, the bill expands the mental health coverage provisions of P.L.1999, c.106 and P.L.1999, c.441 to require that health insurers, as well as contracts purchased by the State Health Benefits Commission, which provide coverage for a disorder that is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders, and is not a biologically-based mental illness, provide coverage for that disorder under the same terms and conditions as provided for any other sickness.

The coverage requirement of these statutes is currently limited to biologically-based mental illness, which is defined as a "mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism."

The Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition, which is published by the American Psychiatric Association and is the principal diagnostic reference used by mental health professionals in the United States, includes a broader range of mental and nervous disorders than biologically-based mental illnesses alone. The manual includes disorders which are diagnosed in childhood (such as attention-deficit/hyperactivity disorder, Tourette's syndrome and autism), schizophrenia and psychotic disorders, cognitive disorders (such as delirium and dementia), mood disorders (such as bipolar and major depressive disorders), anxiety-related disorders (such as agoraphobia and post-traumatic stress disorder), eating disorders (such as anorexia nervosa and bulimia), substance-related disorders (alcohol and drug dependence), and personality disorders (such as antisocial personality disorder and paranoia).

In addition, the bill generally mandates the provision of health insurance coverage for alcohol and drug addiction treatment in New Jersey.

Specifically, the bill requires those health insurers who are not already mandated by State law to provide coverage for the treatment of alcohol addiction to provide such coverage. (The existing statutory requirement to provide coverage for alcoholism treatment applies to hospital, medical and health service

corporations and commercial health insurers, but not to individual and small employer health benefits plans and health maintenance organizations.)

In addition to expanding the statutory mandate to cover alcohol addiction treatment, the bill requires hospital, medical and health service corporations, individual and small and large group commercial health insurers and health maintenance organizations to also provide coverage for drug addiction treatment under the same terms and conditions as for other diseases or illnesses.

The bill defines "alcohol and drug addiction treatment" to include, but not be limited to, any of the following items or services provided for alcohol or drug addiction treatment: inpatient or outpatient treatment, including detoxification, screening and assessment, case management, medication management, psychiatric consultations and individual, group and family counseling, and relapse prevention; non-hospital residential treatment; and prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for alcohol or drug addiction.

The bill takes effect on the 90th day after enactment and applies to policies or contracts issued or renewed on or after the effective date.

"Review and Evaluation of Proposed Legislation Entitled: 'An Act to Provide Equitable Coverage for Substance Abuse' Senate Bill No. 872." June 2004

Rosenbach, Margo, et.al, U.S. Department of Health and Human Services, "Effects of The Vermont Mental Health and Substance Abuse Parity Law", 2003

Schiraldi, V. and Ziedeners, J., "Costs and Benefits? The Impact of Drug Imprisonment in New Jersey", Policy Report, October 2003

Schoenbaum, Michael, et. al., "Health Plan Choice and Information about Out-of-Pocket Costs: An Experimental Analysis", April 1, 2001, Inquiry, Volume 38, Issue 1

Shepard, Donald S, PhD, "Determinants of Cost of Substance Abuse Treatment", presentation at the 130th Meeting of APHA, www.apha.confex.com/apha/130am/techprogram/paper_51271.htm

"Shoveling Up: The Impact of Substance Abuse on State Budgets", The National Center on Addiction and Substance Abuse at Columbia University, January 2001

Sturm, R. "How Expensive is Unlimited Mental Health Care Coverage Under Managed Care?", JAMA, November 12, 1997, Vo.1278, No.18 as reported in "Assessment of Delaware Mental Health Parity.", March 2001.

Sturm, R, Pacula, L., "State Mental Health Parity Laws: Cause or Consequences in Use?" Health Affairs, Vol. 19, No. 5 as reported in "Assessment of Delaware Mental Health Parity

Surgeon General, "Mental Health: A Report of the Surgeon General", 1999, www.surgeongeneral.gov/library/mentalhealth

Testimony from CT Senator Toni N. Harp before American Bar Association Standing Committee on Substance Abuse and Join Together for Discrimination Policy Panel Report

US Census Bureau, "Statistical Abstract of the United States: 2003", Table 17

Varmus, H. "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." National Institute of Mental Health, April 1997 as reported in "The Cost of Full Parity: One to Two Percent, or Less, Period."

Written testimony by Marie D. Verna, February 27, 2003

Appendix C: A333 Benefit Cost Estimates

Estimate of Impact on Premium Mental Health Parity for Biologically Based and Non-Biologically Based Conditions

1. Estimated Percentage of BBMI Claims as Percentage of Total Mental Health Claims ¹	89%
2. Mental Health & Substance Abuse Claims as a Percentage of Total Health Claims ²	5%
3. Mental Health Claims as a Percentage of of Mental Health & Substance Abuse Claims ²	88%
4. Estimated BBMI Claims as a Percentage of Total Claims (Line 2 x Line 3)	4.4%
5. Estimated Total Mental Health Claims Including Non-BBMI Claims (Line 4 / Line 1)	4.9%
6. Estimated Additional Mental Health Claims Due to Non-BBMI Claims (Line 5 - Line 4)	0.5%
7. Mental Health Claims as Percentage of Total Health Claims under Managed Care ³	2.3%
8. Estimated Total Mental Health Claims Including Non-BBMI Claims (Line 7 / Line 1)	2.6%
9. Estimated Additional Mental Health Claims Due to Non-BBMI Claims (Line 8 - Line 7)	0.3%

¹Source: National Mental Health Information Center

²Source: Assessment of Delaware Mental Health Parity

³Source: Effects of the Vermont Mental Health and Substance Abuse Parity Law

**Estimate of Impact on Premium
Substance Abuse Parity**

1. Mental Health & Substance Abuse Claims as a Percentage of Total Health Claims ¹	5%
2. Substance Abuse Claims as a Percentage of of Mental Health & Substance Abuse Claims ¹	12%
3. Estimated Substance Abuse Claims as a Percentage of Total Claims (Line 1 x Line 2)	0.6%
4. Percentage Increase of Substance Abuse Claims As a Result of Parity ¹	17%
5. Estimated Additional Substance Abuse Claims Due to Parity (Line 3 x Line 4)	0.1%
6. Percentage Increase of Substance Abuse Claims As a Result of Parity ²	26%
7. Estimated Additional Substance Abuse Claims Due to Parity (Line 3 x Line 6)	0.2%

¹Source: Assessment of Delaware Mental Health Parity

²Source: National Mental Health Information Center

Appendix B: References

Addiction Treatment Providers of New Jersey, testimony of Executive Director Jim O'Brien, www.charityadvantage.com/atpnj/Testimony.asp

American Academy of Child and Adolescent Psychiatry, "AACAP State Parity Update", October 2003, www.aacap.org

Apgar, K. "Large Employer Experiences and Best Practices in Design, Administration and Evaluation of Mental Health and Substance Abuse Benefits—A Look at Parity in Employer-Sponsored Health Benefit Programs." Washington Business Group on Health, March 2000

Biddle, Christopher, "NJ Employers Hit with 13% Spike in 2003 Health Costs", 2004 Health Benefit Survey

Bruni, Maria, PhD, Jacob, Beth-Anne, Robb, Sylvan, Office of Alcoholism & Substance Abuse, "The Effectiveness of Substance Abuse Treatment in Illinois: Results of the Illinois Statewide Outcomes Project", September 2001

Centers for Medicare and Medicaid, "Your Medicare Coverage", www.medicare.gov

Cook, Julie, "Opting Out", Human Resource Executive, August 19, 2004.

Division of Pensions and Benefits, Bill Comments

Dang, Jagdish, MD, et. al., New Jersey Psychiatric Association Task Force to Assess Mental Health Needs and Services in New Jersey and the NJPA Mental Health Services Committee, "Mental Health Needs and Services in New Jersey", May 2004

Dolan, Sherry and Chiappo, Joseph, Office of Policy Development and Treatment Services, Intoxicated Driving Program Unit, Division of Addiction Services, New Jersey Department of Human Services, "Intoxicated Driving Report 2003 Statistical Summary Report", July 2004

E-mail message from Dianne Longley, Special Projects Director, Life, Health and Licensing, Texas Department of Insurance to Gale Simon, Assistant Commissioner, Life & Health, New Jersey Department of Banking and Insurance, December 9, 2004.

E-mail from Joy Long, Indiana Department of Insurance to Gale Simon, Assistant Commissioner, Life & Health, New Jersey Department of Banking and Insurance, November 9, 2004.

Giesa, Kurt, FSA, et.al, William M. Mercer, Inc., "Assessment of Delaware Mental Health Parity", Delaware Health Care Commission, March 2001

GAO-99-147, "PRIVATE HEALTH INSURANCE-Impact of Premium Increases on Number of Covered Individuals Is Uncertain, June 11, 1999
<http://frwebgate.access.gpo.gov/cgi-bin/useftp.cgi?IPaddress=162.140.64.88&filename=he99147t.pdf&directory=/diskb/wais/data/gao>

GAO-03-1133, "PRIVATE HEALTH INSURANCE-Federal and State Requirements Affecting Coverage Offered by Small Businesses", September 2003
<http://www.gao.gov/new.items/d031133.pdf>

HealthPlace Addictions Community, "Substance Abuse Overview", www.healthplace.com/communities/addictions/site/substance_abuse_overview.htm

Higa, M., The Auditor, State of Hawaii, Study of Proposed Mandatory Parity in Health Insurance Coverage for Additional Serious Mental Illness and Substance Abuse, April 2004

Jim O'Brien, Executive Director of Addiction Treatment Providers of New Jersey, November 24, 2004 letter to New Jersey Mandated Health Benefits Advisory Commission

John Hulick, Director of NCADD New Jersey, November 20, 2004 letter to Carol Miksad

Joint Interim Task Force on Mental Health and Chemical Dependency Treatment, State of Oregon, A Publication of Legislative Administration Committee Services, December 2000

Kamradt, Bruce, "Wraparound Milwaukee: Aiding Youth With Mental Health Needs", Juvenile Justice Journal, Volume VII, Number 1, April 2000

Mammo, Abate, New Jersey Department of Human Services, Division of Addictive Services, "Need for Alcohol and Drug Treatment in New Jersey, 1993"

Maxfield, Myles, Achman, Lori, Cook, Anna, U.S. Department of Health and Human Services, "National Estimates of Mental Health Insurance Benefits"

McLellan, et.al, "Drug Dependence, a Chronic Medical Illness, Implications for Treatment, Insurance and Outcomes Evaluation, JAMA, December 4, 2000, Vol. 284, No.13

Michele Guhl, President of NJ AHP, December 16, 2004 letter to Carol Miksad

National Conference of State Legislators, "Mental Health and Substance Abuse Parity", December 2002

National Council on Alcoholism and Drug Dependence New Jersey, "Access to Quality Treatment"

National Mental Health Association, "Can't Make the Grade", 2003

National Mental Health Association, "Mental Health Month 2004 – General Mental Health Facts and Stats", www.nmha.org/may/fastfacts.cfm

National Mental Health Information Center, "The Cost and Effects of Parity for Mental and Health Substance Abuse Insurance Benefits" www.mentalhealth.samhsa.gov/_scripts/prinpage.aspx

New England Journal of Medicine, Sounding Board (Vol. 345, No. 23), December 6, 2001, "Will Parity in Coverage Result in Better Mental Health Care"
http://content.nejm.org/cgi/search?sortspec=Score%2Bdesc%2BPUBDATE_SORTDATE%2Bdesc&andorexactfulltext=and&where=fulltext&excludeflag=TWEEK_element&hits=20&searchterm=Will+Parity+in+Coverage

NJBIA Blasts Costly Healthcare Bill at Assembly Health Committee Hearing", NJBIA News, February 27, 2002

New Jersey Psychiatric Association written testimony, February 2, 2002

New Jersey School Boards Association Position Statement Opposing A-2487, January 27, 2003

Press Release by Mercer Human Resource Consulting, "Employers Will Cut Health Benefits to Slow Cost Growth in 2005", September 26, 2004.

Orange, A., "The Effectiveness of the 12-Step Program", <http://www.orange-papers.org/orange-effectiveness.html>