Mental and Emotional Disorders
Mental Health Insurance Study Report
MARCH, 2005

PRODUCED BY:
STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
DIVISON OF INSURANCE

Illinois Department of Financial and Professional Regulation

Division of Insurance

ROD R. BLAGOJEVICH
Governor

FERNANDO E. GRILLO
Secretary

DEIRDRE K. MANNA
Acting Director
Division of Insurance

To: Rod R. Blagojevich, Governor

Members of the General Assembly

From: Deirdre K. Manna, Acting Director of Division of Insurance
Department of Financial and Professional Regulation

Re: Mental Health Insurance Study

To comply with 20 ILCS 1405/1405-30, the Department of Financial and Professional Regulation, Division of Insurance, is pleased to submit the Mental Health Insurance Study.

Pursuant to 20 ILCS 1405/1405-30 the Division of Insurance was to conduct a study of the affects of the mandates contained in 215 ILCS 5/370c covering the years 2002 through 2004. The study was to analyze the cost and benefits derived from the implementation of the coverage requirements for treatment of mental disorders and “serious mental illness” as defined within Section 370c of the Illinois Insurance Code.

The report was to include an analysis of the effect of the coverage requirements on the cost of insurance and health care, the results of the treatment to patients, any improvements in care of patients, and any improvements in the quality of life of patients.

The attached report contains the Division's analysis of the survey results submitted by affected insurers.

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EXECUTIVE SUMMARY

This report is the Division of Insurance's response to the directive contained in 20 ILCS 1405/1405-30 passed by the General Assembly to report to the Governor and the General Assembly a study and analysis of mental health insurance.

The first section of the report contains a statement of the statutory requirements with which the Department was charged. It also describes the "must offer" requirement for coverage of treatment of mental disorders on which the Department was to report.

The second section explains the Department's methodology in conducting a survey of insurers effected by the Illinois law. Based on the statutory requirements, the Department designed its questionnaire to be sent to insurers to obtain the following information:

1. The number of covered lives;
2. Total earned premiums;
3. Total incurred claims;

The third section is the Department's analysis of the feedback it received from the 43 responses for the period studied.

The final section contains the Department's conclusion and assessment of the information gleaned from all sources. An analysis of the data revealed that most insurers writing large group business were providing mental health coverage prior to the enactment of 215 ILCS 5/370c. This was apparent from the data collected for the year 2001 and precluded our establishing a prior benchmark. Over the four periods studied there was no significant change in the number of lives insured, the percent of premium attributed to mental health benefits or the cost of claims.

The small group insurers also indicated that they were offering mental health coverage prior to the enactment of the legislation. During the periods studied 3 insurers that did not provide data for 2001 showed data in later periods, indicating new entries into the small group market.

Despite the Department's attempt to assess the costs and effects of coverage as mandated in the Act, the information obtained from insurers (and other resources) does not add enough significant data to reach conclusions on the benefits derived by enactment of this legislation. However, no apparent negitive effects were observed.

SECTION I: STATUTORY REQUIREMENTS

Illinois Insurance Code (215 ILCS 5/370c) requires all insurers excluding Health Maintenance Organizations (HMOs) with authority to deliver, issue for delivery or renew or modifies group accident and health insurance, to offer coverage for treatment of mental disorders.

The Act provides two separate levels of coverage. 215 ILCS 5/370c(a)(1) provides that an insurer, writing group A & H policies, shall offer to the applicant or group policyholder subject to the insurers standards of insurability, coverage for reasonable and necessary treatment and services for mental, emotional or nervous disorders or conditions, other than serious mental illnesses, up to the limits provided in the policy for other disorders or conditions.

Under 215 ILCS 5/370c(b)(1) insurer, writing group A & H policies, shall provide coverage under the policy for treatment of serious mental illness under the same terms and conditions as coverage for hospital or medical expenses related to other illnesses and diseases. Further, the insured must provide the same durational limits, amount limits, deductibles, and coinsurance requirements as are provided for other illnesses and diseases. The mandate for this coverage does not apply to employers with fifty or fewer employees.

“Serious mental illness” as defined by 215 ILCS 5/370c(b)(2) means the following psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

(A) schizophrenia;
(B) paranoid and other psychotic disorders;
(C) bipolar disorders (hypomanic, manic, depressive, and mixed);
(D) major depressive disorders (single episode or recurrent);
(E) schizoaffective disorders (bipolar or depressive);
(F) pervasive developmental disorders;
(G) obsessive-compulsive disorders;
(H) depression in childhood and adolescence; and
(I) panic disorder.

Section 20 ILCS 1405/1405-30, Illinois Revised Statutes required the Division of Insurance to conduct an analysis and report the results to the Governor and General Assembly.

The report was to include the years 2002, 2003, and 2004 and additionally required, "an analysis of the effect of the coverage requirements on the cost of insurance and health care, the results of the treatments to patients, any improvements in care of patients, and any improvements in the quality of life of patients."

As of August 2002, there were 33 states that had enacted parity laws that surpassed the provisions of the Federal parity law. The attached exhibit shows the states and describes the benefits provided. Nineteen states provide full parity, while 14 provide partial limited parity.

Exhibit I.1: Overview of State Mental Health/Substance Abuse Parity Laws That Exceed the Federal Parity Law, as of August 2002

	Year Law or Amendment Enacted	*Mandated Benefit*[a]	*Broad Definition of Mental Illness*[b]	*Covers Substance Abuse*
Total Number of States	33	30	12	14
Vermont	1997	✓	✓	✓
Arkansas	1997, 2001	✓	✓	
California	1999	✓		
Colorado	1997	✓		
Connecticut	1999	✓	✓	✓
Delaware	1998, 2001	✓		✓
Georgia	1998		✓	✓
Hawaii	1999	✓		
Illinois	2001	✓		
Indiana	1999, 2001	h		✓
Kansas	2001	✓		
Kentucky	2000		✓	✓
Louisiana	1999	✓	✓	
Maine	1995	j		
Maryland	1994	✓	✓	✓
Massachusetts	2000	✓		k
Minnesota	1995	l	✓	✓
Missouri	1999			✓
Montana	1999, 2001	✓		✓
Nebraska	1999	✓		
Nevada	1999	✓		
New Hampshire	1994	✓		
New Jersey	1999	✓		
New Mexico	2000	✓	✓	
North Carolina	1997	✓	✓	✓
Oklahoma	1999	✓		
Pennsylvania	1998	✓		
Rhode Island	1994, 2001	✓	✓	✓
South Carolina	2000	✓		✓
South Dakota	1998	✓		
Tennessee	1998	✓	✓	
Texas	1997	o		
Virginia	1999	✓		✓
Federal Mental Health Parity Act	1996		p	

Source: Adapted from Gitterman, Daniel, Richard Scheffler, Marcia Peck, Elizabeth Ciemans, and Darcy Gruttadero. "A Decade of Mental Health Parity: The Regulation of Mental Health Insurance Parity in the United States, 1990–2000." NIMH Grant MH-18828-11. Berkeley: University of California, July 2000. Updated based on State parity legislative information from the General Accounting Office, "Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited," GAO/HEHS-00-95, May 2000; the National Association for the Mentally Ill (NAMI), August 2001; and the NCSL Health Policy Tracking Service "Mental Health Parity" brief, December 2001.

Exhibit I.1 continued

	Prohibits Limits on Inpatient Days and Outpatient Visits[c]	*Requires Financial Parity*[d]	*Covers Small Employers*[e]	*Covers Policies or Employers Regardless of Cost Increases*
Total Number of States	23	27	17	25
Vermont	✓	✓	✓	✓
Arkansas	f	✓	✓	
California	✓	✓	✓	
Colorado	✓	✓	✓	✓
Connecticut	✓	✓	✓	✓
Delaware	✓	✓	✓	✓
Georgia		✓	✓	✓
Hawaii	✓	✓		
Illinois	g	✓		✓
Indiana	✓	✓	i	
Kansas	✓			✓
Kentucky	✓	✓		✓
Louisiana		✓		
Maine	✓	✓		✓
Maryland		✓	✓	✓
Massachusetts	✓	✓	✓	✓
Minnesota	✓	✓	✓	✓
Missouri			✓	✓
Montana	✓	✓	✓	✓
Nebraska	✓			✓
Nevada		m		
New Hampshire	✓	✓	✓	✓
New Jersey	✓	✓	✓	✓
New Mexico	✓	✓	✓	
North Carolina	✓	✓	i	✓
Oklahoma	✓			
Pennsylvania		n		✓
Rhode Island		✓	✓	✓
South Carolina	✓	✓	i	
South Dakota	✓		✓	✓
Tennessee				
Texas	✓	✓		✓
Virginia	✓	✓		✓
Federal Mental Health Parity Act				

[a] A "mandated benefit" refers to State statutes that require health insurance policies to include certain benefit provisions. A typical provision states that a group health plan shall provide benefits for diagnosis and mental health treatment under the same terms and conditions as provided for physical illnesses. States that are not checked under this column have either a "mandated benefit offering" or a "mandated, if offered" provision. The "mandated benefit offering" provision requires sellers to offer certain types of mental health coverage, with the decision of whether to purchase coverage left to the buyers. Alabama, Georgia, and Missouri have "mandated benefit offering" provisions. The "mandated, if offered " provision does not require the employer or insurer to offer mental health coverage; however, if the employer offers coverage, then the coverage must comply with parity provisions. Indiana, Kentucky, and Nebraska have "mandated, if offered" provisions.

[b] "Broad definition of mental illness" is defined as encompassing all the disorders listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Health Disorders* and/or the

Exhibit I.1 continued

International Classification of Diseases Manual. For States that are not checked in this column, some narrow their laws' scope by requiring coverage only for "biologically based" illness or "serious mental illness," most commonly defined as schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, schizo-affective disorder, and delusional disorder. Alternatively, some States—as well as the Federal Mental Health Parity Act—allow health plans to define the scope of the mental health benefit.

[c] States that are not checked in this column permit a disparity in the terms and conditions required for mental health coverage compared to other physical health conditions (for example, allowing a cap on the number of inpatient days and/or outpatient visits for mental health coverage that differs from that for other physical illnesses).

[d] States that are not checked in this column permit a disparity between the cost sharing for mental health services and physical health services.

[e] States that are not checked in this column exempt small employers, most commonly defined as employers with either 25 or fewer employees or 50 or fewer employees.

[f] Arkansas: S. 716 (2001) prohibits health plans from imposing limits on coverage for mental health treatment offered by employers with 50 or fewer employees. This law allows groups of 51 or more employees to impose an annual maximum of 8 inpatient/partial hospitalization days together with 30 outpatient days.

[g] Illinois: S. 1341 requires "group health benefit plans to provide coverage based upon medical necessity for the following treatment of mental illness in each calendar year: 45 days of inpatient treatment and 35 visits for outpatient treatment, including group and individual outpatient treatment, and prohibits a lifetime limit on the number of inpatient treatment days and outpatient visits covered by the plan. Plans must include the same amount limits, deductibles, copayments, and coinsurance factors for serious mental illness as for physical illness."

[h] Indiana: Statute specifies a "mandated benefit" for State employee plans and a "mandated offering" for group and individual plans.

[i] Indiana, North Carolina, and South Carolina: The parity statute applies to health plans offered to State employees.

[j] Maine: The statute mandates coverage for group plans and requires a mandated offering for individual policies.

[k] Massachusetts: Parity for substance abuse applies only in cases of co-occurring mental illness and substance abuse disorders.

[l] Minnesota: The statute mandates coverage for health maintenance organizations (HMOs) and "mandated, if offered" for individual and group plans.

[m] Nevada: Annual and lifetime dollar limits must be equal to other illnesses; cost sharing for copayments and coinsurance must not be more than 150 percent of out-of-pocket expenses for medical and surgical benefits.

[n] Pennsylvania: Statute requires parity in annual and lifetime dollar limits but only specifies that cost sharing "must not prohibit access to care."

[o] Texas: Statute requires "mandated benefits" for group and HMO plans and a "mandated offering" for groups of 50 or fewer.

[p] The Federal Mental Health Parity Act allows health plans to define the covered illnesses.

SECTION II: METHODOLOGY

In order to obtain the Illinois specific data for the years required by 20 ILCS 1405/1405-30, the Division of Insurance surveyed affected insurers to ascertain their experience with the new mandated offer.

As provided by the Act, (215 ILCS 5/370c), the requirement to offer coverage for treatment of mental disorders to "…every insurer which delivers, issues for delivery, or renews or modifies group A & H policies on an expense-incurred basis…" Therefore, every insurer, regardless of whether writing accident and health insurance or property and casualty insurance, having authority to issue accident and health policies in Illinois, was surveyed by the Division of Insurance.

The Department designed the survey to conform to the requirements of 20 ILCS 1405/1405-30 (a) that stated the survey is to include "...an analysis of the effect of the coverage requirements on the cost of insurance and health care, the results of the treatments to patients, any improvements in care of patients, and any improvements in the quality of life of patients." A copy of the survey document is included in the Appendix. The Department asked insurers to provide the following information for the years 2001, 2002, 2003, and through 09/2004 in the survey:

1. The number of covered lives;
2. Total earned premiums;
3. Total incurred claims;

The questions that we hoped to answer were as follows: (1) Did insurers provide any mental health benefits prior to the mandates in 215 ILCS 5/370c? (2) Did the existing coverage include the mandated benefits or did these benefits increase the coverage levels? (3) Did the mandates effect employer/employee participation? (4) To what degree was the cost of health insurance affected by these mandated benefits? (5) What was the affect on claim costs incurred because of the mandated benefits?

An analysis was preformed comparing the numbers, both within year, and across years. The result of this observational analysis is reported in Section III of this report. The data supplied by the insurers is relied upon as being correct because the Division was and is not able to audit the submissions.

SECTION III: ANALYSIS

The Division of Insurance received a total of 188 responses. There were generally three types of responses received for the survey. The first type was from companies indicating that the mandate was not applicable due to the type of policies the company sold (usually property and casualty or reinsurance only). The second type of response was from companies indicating they had incorporated the requirements of the statute as a standard benefit in its policies and, therefore, the company was not able to provide specific data to respond to the survey. Finally, responses were received from companies containing data for the survey.

The table below shows the response rate for the survey. It includes the three types of responses the Division of Insurance received.

TOTAL SURVEYS SENT	1174
TOTAL RESPONSES	188
TOTAL NA* RESPONSES	143
TOTAL NR* RESPONSES	986
TOTAL RESPONSES WITH DATA	45

*NA-Not applicable responses
*NR-Treatment for mental disorders added as standard benefit

As noted earlier, a significant percentage of responding insurers affected by the mandate already covered costs for treatment associated with mental disorders prior to the Act going into effect. As such, these insurers had no way to distinguish what affect the Act had on covered persons. Of the 32 large group writers reporting business in 2001, our base year, only two reported not covering serious mental illness as mandated in Section 370c(b)(1) of the Illinois Insurance Code. For the same period two of the 28 small group writers responding indicated that their insureds did not have coverage for mental illness as defined in Section 370c(a)(1) of the Code.

In 2001, as in 2004, there were 32 companies writing large group business, although three new companies had entered the market and three of the original companies had left. There were 31 companies writing small group business with four new companies entering the market and one of the original companies leaving.

Table III.1

Year	2001	2002	2003	2004
Large Group	32	32	33	32
Small Group	28	30	33	31

Although there has been some changing of insurers in the make-up of both the large and small group market from 2001 through September 2004 nothing of significance is noted.

Because we only have nine months of data for the year 2004 it is not possible to compare earlier participation levels to those for 2004. The numbers, however, do indicate a growth in participation in all three year since the effective date of the mandated benefits, 2002, 2003 and 2004. This is true for both the large group, 51 or greater employees, and the small group market.

Large Group Respondents:

When looking at the Earned Premium (EP) and Claims as reported by the companies it seems that a benefit level greater than the mandated coverage is provided by a majority of the insurers. The EP reported for all mental health benefits exceeds the EP for the mandated benefits, when these benefit premiums are broken down, in all years reported (2001 – 2004). The EP for all mental health benefits compared to the total health insurance earned premium, for the years studied, are $.0167, $.0181, $.0195 and $.0201 for each $1.00 of health insurance premium earned for the years 2001, 2002, 2003 and 2004 respectively. The EP for combined Section 370c(a)(1) and Section 370c(b)(1) are $.0082, $.0099, $.0112 and $.0119 for the years 2001 thru 9/2004 for each $1.00 of health insurance premium earned. This is presented below in dollars and as a percentage of the earned premium.

Table III.2

Year	2001		2002		2003		2004	
Total Health Insurance	$2250.1		$2753.4		$3197.3		$2473.8	
All MH Benefits	$37.5		$49.9		$62.3		$49.8	
Sec. 370c Benefits		$18.6		27.3		$35.8		$29.5
Percentages	1.67%	.82%	1.81%	.99%	1.95%	1.12%	2.01%	1.19%

All dollars ($) are in millions. The data presented for 2004 is for nine months only.

Comparing the total mental health claims incurred for the four periods reported to the total health claims incurred for the same periods we find the following percentages 1.78, 1.80,1.66 and 1.59 respectively. These are represented in dollars in the chart below. Here again, for every $1.00 of health insurance claims incurred in the years 2001 thru 9/2004, the portion incurred for all mental health insurance claims was $.0178 in 2001, $.018 was incurred in 2002, $.0166 was incurred in 2003 and $.0159 was incurred in 2004 to date. The data represented 31 companies – data determined to be usable through observational verification.

Table III.3

Year	**2001**	**2002**	**2003**	**2004**
Total Claims	$1,798.4	$2,224.2	$2,551.6	$1,875.3
M/H Claims	$32.1	$40.0	$42.4	$29.8
Percentage	1.78%	1.80%	1.66%	1.59%

The data presented for 2004 is for nine months only.

There were 27 companies that reported usable claims data under Section 370c(a)(1) and Section 370c(b)(1). The reduction in the number of companies is primarily because a number of the insurers could not, or did not break out one or both of the Section 370c claims incurred. Comparing this data to the total mental health claims incurred, (M/H Claims in Table III.3 divided by the amount of 370c(a)(1) or 370c(b)(1) claims incurred) by these same companies we find that the Section 370c(a)(1) claims represent $.42 of each $1.00 of total mental health claims incurred for 2001, $.39 of these claims for 2002, $.38 of these claims for 2003 and $.39 of the claims for 2004 through September. For the mandated Section 370c(b)(1) claims (serious mental illness), we found the following amounts incurred $.32, $.36, $.39 and $.42 for the same periods respectively. A simple observational comparison of this data would imply that the two benefits, at least to date, have provided approximately the same dollars in claims. The data presented below shows that portion of each mental health claim incurred dollar that is attributed to each Section 370c mandated benefit and to the total for these benefits.

Table III.4

Year	**2001**	**2002**	**2003**	**2004**
370C(a)(1) Claims	$.42	$.39	$.39	$.39
370C(b)(1) Claims	$.32	$.36	$.39	$.42
Total 370c Claims	$.74	$.75	$.78	$.81

For each $1.00 of mental health benefit incurred by the reporting insurers the Section 370c, when broken into subparagraph (a)(1) and subparagraph (b)(1) benefits, accounted for the amount shown. The data presented for 2004 is for nine months only.

Small Group Respondents:

Only two of the 28 responding small group insurers for 2001 indicated that they did not cover any type of mental health benefits. These same insurers still did not report any covered lives having mental health benefits as of September 2004. Thirty-one insurers reported data for the 2004 period with 3 companies indicating that they had zero insureds covered under any type of mental health benefit. Several of the reporting companies could not break out the Section 370c(a)(1) mental health benefit from other mental health benefits offered.

When looking at the earned premiums (EP) for health benefits there were several companies that were unable to break the mental health earned premiums apart from the total health benefit premiums. This required that some adjustment be made to the data when presenting it in tabular or graphic form. For the 2001 period, four of the companies providing mental health benefits could not separate the EP for mental health from the other health premium. In 2004 five companies could not do the break out of premiums.

Over the four periods review for this report the amount of earned premium for all mental health benefits was compared to the total health insurance EP for the small group insurers reporting usable data. The data reported indicated that for each $1.00 of health insurance EP the mental health EP amounted to $.0176 for 2001, $.0185 for 2002, $.0191 for 2003 and $.0185 for 2004 through September. For the same periods the percent of Section 370c(a)(1) EP compared to all mental health EP was 62%, 58.2%, 56.3% and 87.6%. This would seem to indicate that the mental health benefits being provided were greater than those found in Section 370c(a)(1). The table below shows the data in millions of dollars.

Table III.5

	2001	**2002**	**2003**	**2004**
Total EP	$1,423.2	$1,689.9	$1,909.9	$1,529.1
All M/H EP	$25.0	$31.3	$36.4	$28.3
370C(a)(1) EP	$15.5	$18.2	$20.5	$24.8

The data presented for 2004 is for nine months only.

On the claims side, comparing the total mental health claim benefits incurred for the four periods report to the total health claim benefits incurred for the same periods we find that claims for mental health benefits are $.0183, $.0197, $.0170 and $.0162 of each $1.00 of the total health insurance benefit incurred respectively. These amounts are represented in the chart below. The data represented 28 companies – data determined to be usable through observational verification.

There were 18 companies that reported usable claims data under the Section 370c(a)(1) category. Comparing this data to the total mental health claims incurred by these same companies we find that for each mental health benefit claims incurred dollar reported the Section 370c(a)(1) benefit represent 63.9 cents, 64.9 cents, 65.8 cents and 60.8 cents of the total for 2001, 2002, 2003 and 2004 through September respectively. Again, this data is presented in the below graphic in dollar amounts.

Table III.6

	2001		2002		2003		2004	
Total claims	$1166.6		$1231.2		$1395.3		$978.3	
Total M/H claims	$21.3		$24.2		$23.7		$15.8	
Percent		1.83%		1.97%		1.70%		1.62%
All 370C(a)(1) claims	$13.6		$15.7		$15.6		$9.6	
Percent		63.9%		64.9%		65.8%		60.8%

The data presented for 2004 is for nine months only.

The legislation stated that the study should include "---the results of the treatments to patients, any improvements in care of patients, and any improvements in the quality of life of patients." This information is not generally available from insurers and it would be extremely difficult and perhaps subjective to try and determine improvements in care and quality of life.

Based upon the limited data reviewed for this study, it appears that a substantial number of the group health insurance carriers writing indemnity products were providing some type of mental health coverage prior to the effective date of 215 ILCS 5/370c in 2002. Neither the aggregate number of insurers or insureds have decreased over the period studied, both actual have shown a slight increase. Earned premiums have increased over the period but the claims have also increased at approximately the same rate. However, the data collected is not sufficient to identify the drivers of the premium increase.

SECTION IV: CONCLUSION

The literature the Division of Insurance reviewed does not provide any solid conclusions and it is difficult to assess the costs and affects that might be found in Illinois even if they were specified for other states. The study conducted in Vermont is by far the most comprehensive and still does not comment to any firm conclusions.

The Division of Insurance's review of the information as provided in this report, which included a review of each response provided for the survey as well as review of pertinent literature, is unable to add a great deal to the overall body of knowledge on the topic.

Based upon the limited data reviewed for this study, it appears that a substantial number of the group health insurance carriers writing indemnity products were providing some type of mental health coverage prior to the effective date of 215 ILCS 5/370c in 2002. Neither, the aggregate number of insurers or insureds have decreased over the period studied, both actual shown a slight increase. Earned premiums have increased over the period but the claims have also increased at approximately the same rate. However, the data collected is not sufficient to identify the drivers of the premium increase.

Regardless, nothing the Division reviewed indicated the coverage would be cost prohibitive. As information was limited to the three-year survey period, the Division of Insurance is unable to make an argument that the cost increase is significant enough to dissuade employer groups from purchasing coverage or that the cost increase is minimal and therefore would not have a noticeable impact on the overall coverage in the market place.

Overall, the Division believes that for a report to provide conclusive evidence of the benefits, costs and effects of mandated mental health benefits as set forth in 215 ILCS 5/370c, the report should be based upon a longer study period and possibly include multi-state data. The data studied should possibly include case study material, physician and patient information, claim file information and employer questionnaires. Further, a study of this magnitude should probably be conducted by an independent research facility utilizing health professionals and/or specialists doing the health assessments.

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Illinois Mental Health Study Survey

Illinois Department of Financial and Professional Regulation

Division of Insurance

ROD R. BLAGOJEVICH
Governor

FERNANDO E. GRILLO
Secretary

DEIRDRE K. MANNA
Acting Director
Division of Insurance

November 4, 2004
(Revised 11-9-04)

To: Company Presidents
All companies (Life, A & H and Liability) Writing Group Health Insurance Business

From: Donald M. Wulf, Assistant Deputy Director
217-785-2228

Re: Mental Health Insurance Study

The Illinois General Assembly mandates, pursuant to 20 ILCS 1405/1405-30, that a study be conducted into the costs and benefits derived from the implementation of the coverage requirements for treatment of mental disorders established under Sec 370c of the Illinois Insurance Code. This study is to cover the years 2002, 2003, and 2004 and shall be presented to General Assembly and the Governor on or before March 1, 2005.

We recognize that small group (2 to 50 lives) and large group (>50 lives) contracts are treated differently within Section 370c and have provided a separate set of questions for each type of insurance contract. Based upon on the type of policy(s) you write, your company is to answer one or both sets of questions. These questions are to be completed and returned to Ms. Yoko Chism at the Illinois Department of Financial and Professional Regulation, Division of Insurance, 320 W. Washington St. Springfield, Illinois 62767-0001, or e-mail to ychism@ins.state.il.us, no later than December 15, 2004.

We realize that the year 2004 will not have ended by the due date of the questionnaire and request that you provide the information as of the ending of the third quarter of 2004. Where comparisons are necessary, you are also requested to provide information for the year ending 2001.

Thank you for assisting the Division of Insurance with this study. If any questions arise, please feel free to contact me.

Instructions

<u>Small group</u>: Mandated Offer of Mental Health Benefits (215 ILCS 5/370c)

For each year (2001, 2002, 2003, 2004 through the 3rd quarter) please provide the following information:

Number of covered lives:
The average number of lives covered by small employer group health insurance policies during the year. For each year, this is calculated by adding the number of lives covered as of 12/31 of the previous year and the number of lives as of 12/31 of the year in question and then dividing by 2. (For 2004, use 9/30 as the year-end date.)

Number of covered lives – All Mental Health benefits:
The average number of lives covered under small group contracts that had any kind of mental health benefit.

Number of covered lives – Benefits offered under 215 ILCS 5/370c(a)(1):
The average number of lives covered under small group contracts that were covered by the mental health benefits mandated to be offered to small employers.

Total Earned Premiums:
Total Earned Premiums for all small employer group health insurance policies.

Total Earned Premiums – Attributable to All Mental Health benefits:
Total of all earned premiums charged to small employer groups for all types of mental health benefits.

Total Earned Premiums – Attributable to benefits offered under 215 ILCS 5/370c(a)(1):
Total of all earned premiums charged to small employer groups for the mental health benefits that are mandated to be offered to small employer groups.

Total Incurred Claims:
Total Incurred Claims for all small employer group health insurance policies.

Total Incurred Claims – Attributable to All Mental Health benefits:
Total Incurred Claims for all small employer groups attributable to all types of mental health benefits.

Total Incurred Claims – Attributable to benefits offered under 215 ILCS 5/370c(a)(1):
Total Incurred Claims for all small employer groups attributable to the mental health benefits that are mandated to be offered to small employer groups.

<u>Large Group</u>: Mandated Mental Health Benefits (215 ILCS 5/370c)

For each year (2001, 2002, 2003, 2004 through the 3rd quarter) please provide the following information:

Number of covered lives:
The average number of lives covered by large group health insurance policies during the year. For each year, this is calculated by adding the number of lives covered as of 12/31 of the previous year and the number of lives as of 12/31 of the year in question and then dividing by 2. (For 2004, use 9/30 as the year-end date.)

Number of covered lives – All Mental Health benefits:
The average number of lives covered by large group contracts that had any kind of mental health benefit.

Number of covered lives – Benefits offered under 215 ILCS 5/370c(a)(1):
The average number of lives covered under large group contracts that were covered by the mental health benefits mandated.

Number of covered lives – Benefits offered under 215 ILCS 5/370c(b)(1):
The average number of lives covered under large group contracts that were covered by the mental health benefits mandated.

Total Earned Premiums:
Total Earned Premiums for all large group health insurance policies.

Total Earned Premiums – Attributable to All Mental Health benefits:
Total of all earned premiums charged to large groups for all types of mental health benefits.

Total Earned Premiums – Attributable to benefits offered under 215 ILCS 5/370c(a)(1):
Total of all earned premiums charged to large groups for the mental health benefits that are mandated.

Total Earned Premiums – Attributable to benefits mandated by 215 ILCS 5/370c(b)(1):
Total of all earned premiums charged to large groups for the mental health benefits that are mandated.

Total Incurred Claims:
Total Incurred Claims for all large group health insurance policies.

Total Incurred Claims – Attributable to All Mental Health benefits:
Total Incurred Claims for all large groups attributable to all types of mental health benefits.

Total Incurred Claims – Attributable to benefits offered under 215 ILCS 5/370c(a)(1):
Total Incurred Claims for all large groups attributable to the mental health benefits that are mandated.

Total Incurred Claims – Attributable to benefits mandated by 215 ILCS 5/370c(b)(1):
Total Incurred Claims for all large groups attributable to the mental health benefits that are mandated to be provided for large groups.

***SMALL* GROUP HEALTH INSURANCE POLICIES**

	2001	2002	2003	9/2004
NUMBER OF COVERED LIVES:				
NUMBER OF COVERED LIVES: ALL MENTAL HEALTH BENEFITS				
NUMBER OF COVERED LIVES: BENEFITS OFFERED UNDER 215 ILCS 5/370c(a)(1)				
TOTAL EARNED PREMIUMS:				
TOTAL EARNED PREMIUMS: ATTRIBUTABLE TO ALL MENTAL HEALTH BENEFITS				
TOTAL EARNED PREMIUMS: ATTRIBUTABLE TO BENEFITS OFFERED UNDER 215 ILCS 5/370c(a)(1)				
TOTAL INCURRED CLAIMS:				
TOTAL INCURRED CLAIMS: ATTRIBUTABLE TO ALL MENTAL HEALTH BENEFITS				
TOTAL INCURRED CLAIMS: ATTRIBUTABLE TO BENEFITS OFFERED UNDER 215 ILCS 5/370c(a)(1)				

***LARGE* GROUP INSURANCE POLICIES**

	2001	2002	2003	9/2004
NUMBER OF COVERED LIVES:				
NUMBER OF COVERED LIVES: ALL MENTAL HEALTH BENEFITS				
NUMBER OF COVERED LIVES: BENEFITS OFFERED UNDER 215 ILCS 5/370c(a)(1)				
NUMBER OF COVERED LIVES: BENEFITS UNDER 215 ILCS 5/370c(b)(1)				
TOTAL EARNED PREMIUMS:				
TOTAL EARNED PREMIUMS: ATTRIBUTABLE TO ALL MENTAL HEALTH BENEFITS				
TOTAL EARNED PREMIUMS: ATTRIBUTABLE TO BENEFITS OFFERED BY 215 ILCS 5/370c(a)(1)				
TOTAL EARNED PREMIUMS: ATTRIBUTABLE TO BENEFITS UNDER BY 215 ILCS 5/370c(b)(1)				
TOTAL INCURRED CLAIMS:				
TOTAL INCURRED CLAIMS: ATTRIBUTABLE TO ALL MENTAL HEALTH BENEFITS				
TOTAL INCURRED CLAIMS: ATTRIBUTABLE TO BENEFITS OFFERED UNDER 215 ILCS 5/370c(a)(1)				
TOTAL INCURRED CLAIMS: ATTRIBUTABLE TO BENEFITS UNDER 215 ILCS 5/370c(b)(1)				

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