An evaluation of mental health parity, “Timothy’s law” — Planning sessions to review methodologies to evaluate the impact of New York’s law mandating minimum coverage for mental health treatment. The law stipulates that the evaluation include, at a minimum, an assessment of the comprehensive costs of providing the coverage, the rate at which individuals elect to enroll in the expanded coverage, and the number of illnesses and types treated under the expanded coverage. Topics for the evaluation included how to define valid comparison groups, how to separate effects of parity from carve-outs, how to address self-insured firms not subject to the parity law, and whether the law will impact diagnoses provided on claims forms (i.e., diagnosis creep). Invited experts included Richard Frank, Ph.D.; Sherry Glied, Ph.D.; and Thomas McGuire, Ph.D. To see a copy of the legislative report, please see below.
Report by the Superintendent of Insurance
On the Cost and Effectiveness of New York’s 2006 Mental Health Parity Legislation ("Timothy’s Law")

May 2009

New York State Insurance Department
Eric Dinallo, Superintendent
EXECUTIVE SUMMARY

A. Background

In December 2006, New York State took a step toward achieving parity in mental health benefits for New Yorkers with the passage of “Timothy’s Law” (Chapter 748 of the Laws of 2006, as amended by Chapter 502 of the Laws of 2007). Timothy’s Law requires that, as of January 1, 2007, insurers issuing group or school blanket health insurance policies or contracts in New York must include certain minimum mental health benefits and coverage levels. Generally, for mental, nervous or emotional disorders, insurers must offer inpatient care of not less than thirty days per year and outpatient care of not less than twenty visits per year at the same cost sharing limits as applicable to other health coverages (the “30/20 benefit”). Timothy’s Law further requires that large group policies or contracts (over 50 employees) and school blanket policies also provide additional coverage above the basic 30/20 minimum benefit levels for treatment of adults and children with biologically based mental illnesses (“BBMI”) and for treatment of children with serious emotional disturbances (“SED”). The added level of BBMI/SED coverage is not required in small group policies or contracts (50 or fewer employees), but insurers are required to offer it on a “make available” basis (i.e., if requested by a small group purchaser). The premium cost to small employers for the 30/20 benefit is fully subsidized by an appropriation from the State’s General Fund. The BBMI and SED “make available” benefits are not subsidized. Unless extended, Timothy’s Law sunsets on December 31, 2009.

B. Purpose of this Report and Conduct of Evaluation

Timothy’s Law requires the Superintendent of the Insurance Department (“Superintendent”), in consultation with the Office of Mental Health (“OMH”), to conduct a study on the effectiveness of mental health parity addressing, among other things, the cost of the new mandates and their impact on policyholders. The Insurance Department entered into a Memorandum of Understanding with OMH, whereunder a team of experts from the Department of Health Care Policy of the Harvard Medical School (“Harvard Research Team”) and Columbia University’s School of Public Health were assembled to assist the Superintendent in conducting portions of the study. The Department and OMH, in consultation with Harvard and Columbia, decided that the larger focus of this report would be on the impact of Timothy’s Law on small group policies because the 2008 federal parity act could require large groups to offer mental health benefits beyond those required under Timothy’s Law.

The Insurance Department, in consultation with OMH, determined that the evaluation would be divided into two principal parts: (1) a detailed claims/cost analysis to be conducted by the Harvard Research Team; and (2) a survey of all insurers to gather industry-wide statistics, to be conducted by Alicare, Inc., the Administrator of the State subsidy for the 30/20 benefit. In addition, in 2007, the Insurance Department required all insurers to provide a detailed actuarial memorandum outlining the cost of the current mental health benefits provided and the anticipated cost of the benefits to be provided in order to comply with the 30/20 provisions of the law. The Department used the data in these filings to determine the average cost (value) of 30/20 benefits
in policies prior to the Law and the value of the benefits added as a result of the mandate. In addition, Alicare, Inc.’s survey portion of the study has been completed and the results are contained in this report. Additional claims data analysis by the Harvard Research Team and work on the survey of consumers and brokers by the Columbia Research Team will continue and be reported in a supplement to this report which is anticipated to be released in June.

This report is intended to provide the Governor, the Legislature and other interested parties with a cost and impact summary covering the first year of the mandate and to provide a basis for the ongoing discussion of mental health parity in New York in consideration of the December 31, 2009, expiration of Timothy’s Law.

C. Key Issues the Study Seeks to Address

This evaluation and report seek to address the following issues:

- how much the basic 30/20 mandate expanded access to mental health benefits;
- how much value consumers received in added benefits and/or reduced cost sharing;
- what percentage of groups or persons received more coverage after the mandate;
- what percentage of the 30/20 benefits were already purchased by employers in existing contracts prior to the mandate and what percentage represented new, added benefits;
- what was the overall cost of the 30/20 mandate and the cost of the portion already contained in existing contracts versus the cost of the added benefits;
- a comparison of the type and number of illnesses for which coverage has been provided during the study period;
- how many small groups purchased the optional “make available” BBMI/SED benefits; and
- what is the impact of the recent federal parity legislation on State mental health mandates.

D. Major Findings

1. **Timothy’s Law Has Expanded Coverage of Mental Health Benefits.** Since the passage of Timothy’s Law, more New Yorkers are receiving higher levels of mental health coverage.

   **30/20 Benefits.** The percentage of New Yorkers with full 30/20 benefits more than doubled in both the large group and small group markets. Prior to Timothy’s Law, approximately 99% of all small groups and large groups offered some type of mental health benefits, but only 42% offered full 30/20 benefits. After Timothy’s Law, 100% of all small and large groups offered full 30/20 benefits, with cost sharing levels equal to those for other health benefits provided under the same policies.

   **BBMI/SED Benefits.** The percentage of New Yorkers with full BBMI/SED benefits increased in both large groups (where BBMI/SED benefits are mandated) and in small groups (where BBMI/SED is a “make available” benefit). In the large group market (employers with over 50 employees), the number of those with full BBMI/SED benefits increased from 11% to 100%. In the small group market (employers with 50 or fewer employees), the number of those with full BBMI/SED benefits increased from 9.6% to 43.7%. The increase in small group BBMI/SED coverage may be due in part to the savings employers realized with the State subsidizing the 30/20 benefit, or the
increased visibility of the BBMI/SED benefits resulting from the requirement that these benefits be offered to all small employers.

2. **Timothy’s Law Added Some Cost to Health Insurance Premiums.**

   **30/20 Benefits.** The 30/20 small group mandate increased monthly costs approximately $1.04 per member per month (“PMPM”), or less than one half a percent of the total monthly cost. Prior to Timothy’s Law, the PMPM cost of existing 30/20 benefits for small groups was approximately $4.76. After Timothy’s Law, the cost of the full 30/20 benefit for small groups was $5.80, or less than 2% of the average total monthly policy cost which is approximately $312.00 PMPM. The $1.04 increase is less than one half of one percent in the average total monthly policy cost. On a global basis, the total cost of the 30/20 benefit in policies purchased by employers prior to Timothy’s Law was $80 million (at 2008 price levels). After Timothy’s Law, the total cost was $100 million, which is about 1/70th of total 2008 small group premium of approximately $7 billion.

   **BBMI/SED Benefits.** The weighted average cost of BBMI/SED benefits in small group policies based on carrier submissions received in 2007 was approximately $1.70 PMPM, or less than one percent of the average total monthly policy cost. It should be noted that carrier pricing for these benefits included antiselection factors, which are added by carriers when a benefit is offered on an optional basis, usually resulting in more persons in need of the benefit opting for the coverage. Were BBMI/SED benefits mandated on all policies, the average cost would be substantially lower. Under that scenario, the Insurance Department projects the average cost out through 2010 at just under $1.50 PMPM, or less than one half of one percent of the total monthly policy cost.

3. **Small Employers Had Little Reaction to the Mandate’s Cost or Benefit Changes.**
   A survey of 200 small firms across the State inquired of the groups’ opinions of Timothy’s Law. 18.5% of firms responded that Timothy’s Law expands mental health benefits and increases costs. The remaining 81.5% noted it either expanded mental health benefits and had no effect on costs (39.5%), expanded mental health benefits and reduced costs (4%) or had never heard of Timothy’s Law (38%).

4. **Federal Parity’s Impact in New York is Dependent on Timothy’s Law Continuation.**
   The new federal mental health and addiction parity law, effective for plans commencing after October 3, 2009, requires that if a large group health plan provides both surgical and medical benefits and benefits for mental health conditions, the coverage for mental health conditions may be no more restrictive than the surgical and medical benefits (i.e. the mental health benefits must be provided at parity with the surgical and medical benefits). Because Timothy’s Law requires that all large group health plans that provide surgical and medical benefits must also include mental health benefits, Timothy’s Law triggers the federal parity requirement, thereby increasing the 30/20 benefit requirement to a full parity requirement. However, since the federal law does not require large group health plans to provide mental health benefits, if Timothy’s Law is not continued beyond its December 31, 2009 sunset, mental health benefits would not be required in large group policies at all.

In addition to the areas discussed above, a comparison of the type and number of illnesses for which coverage was provided during the study period is currently underway and will be reported in the supplement to this Report anticipated in June.
REPORT

1. BACKGROUND

A. Timothy’s Law Coverage Mandate

Chapter 748 of the Laws of 2006, as amended by Chapter 502 of the Laws of 2007, commonly referred to as “Timothy’s Law,” became effective on January 1, 2007. Timothy’s Law requires insurers to provide coverage for inpatient and outpatient mental health services in group health insurance policies or contracts and school blanket policies issued or renewed in New York State on or after January 1, 2007. The Law does not apply to standardized individual enrollee direct payment contracts or Healthy New York contracts. The Law was put into effect for an initial three-year period and, absent an extension, will sunset on December 31, 2009. The intent of the Law, as stated in Section 1 of Chapter 748 of the Laws of 2006, was to strengthen and enhance existing protections in federal law to ensure that mental health coverage is provided by insurers and health maintenance organizations on terms comparable to other health care and medical services coverage.

To accomplish this goal, the Law requires that from the first policy issuance or renewal (anniversary) date on or after January 1, 2007, group health insurance policies or contracts and school blanket policies subject to Timothy’s Law must include broad based coverage for the diagnosis and treatment of mental, nervous or emotional disorders or ailments, however defined in the insurers’ contracts, at least equal to the coverage provided for other health conditions, and shall include benefits for inpatient care, as further defined in the Law, limited to not less than thirty days of active treatment in any year, and benefits for outpatient care limited to not less than twenty visits in any year (the “30/20 benefit”). The Law further requires that insurers that provide coverage for inpatient hospital care shall provide coverage comparable to its medical care coverage for adults and children with biologically based mental illness (“BBMI”) and comparable coverage for children with serious emotional disturbances (“SED”). In other words, BBMI and SED coverage goes beyond the 30/20 general coverage mandate specified in the Law. These benefits include coverage for adults and children with biologically based conditions, including schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, bulimia and anorexia, in addition to coverage for treatment of children with serious emotional disturbances. The Law provides that the additional BBMI and SED coverage requirements shall not apply to any small group purchaser (50 or fewer employees), but requires that insurers must make available, and if requested by a small group purchaser, provide BBMI and SED coverage comparable to its medical care coverage.

B. Small Group Subsidy

Out of concern for the potential burden that the added premium cost of the 30/20 benefit might impose on small businesses in the State, the Law provided that the Superintendent of Insurance would develop and implement a methodology to fully cover small employers’ cost for the newly mandated benefit, and that such methodology would be financed from monies from the General Fund. Insurance Department actuaries estimated that approximately $100,000,000 would be
needed to cover the cost of subsidizing the premiums of the approximately 1.7 million persons covered under small group health insurance policies in New York over an initial 15 month phase-in period from January 1, 2007, to March 31, 2008. The Legislature appropriated that amount for the initial period and has since appropriated approximately $90,000,000 for the second fiscal year of the program (April 1, 2008 – March 31, 2009). The Superintendent developed a reimbursement methodology which pays insurers directly for the premium cost of the added 30/20 benefit. (Administratively, direct payment to insurers on a quarterly basis was considered more efficient than paying the approximately 300,000 small employers a monthly amount to then remit to their respective insurers for the coverage.) Insurers are required to submit detailed justification for their per member per month (“PMPM”) charge for the mandated benefits to Department actuaries for review. The subsidies are thus on a “prior approval” basis. If, after review, Department actuaries are satisfied that the proposed reimbursement amounts are reasonable, insurers are notified. The insurers then submit quarterly reimbursement requests based on the number of small group enrollees they cover each quarter multiplied by the approved rate. The quarterly requests are collected by an administrator under contract with the Insurance Department (Alicare, Inc.), which tabulates quarterly total disbursements, certifies quarterly reimbursement summary schedules to the Insurance Department for payment by the Office of the State Comptroller, and audits the submissions on an annual basis. All valid reimbursement requests for the first fifteen-month period have been paid, totaling approximately $90,000,000. For the fiscal year from April 1, 2008 – March 31, 2009, three quarters reimbursement requests have been received. Based on those quarters, it appears the full fiscal year will total between $95 and $100 million.

C. Study Mandate

Timothy’s Law required the Superintendent, in consultation with the Office of Mental Health (“OMH”), to conduct a two year study on the effectiveness of mental health parity, including but not limited to:

(i) a comprehensive analysis of the costs associated with providing coverage pursuant to Timothy’s Law;
(ii) the number of policyholders and group contract holders which have elected to purchase other mental health coverage required to be made available pursuant to this act; and
(iii) a comparison of the type and number of illnesses for which coverage has been provided during the study period.

From mid-2007 through the date of the report, the Superintendent consulted regularly with OMH and related parties, receiving advice and suggestions as to areas/issues on which to focus. OMH, via the OMH-funded Evidence Based Practice Technical Assistance Center (EBP-TAC) at New York State Psychiatric Institute and Columbia University Department of Psychiatry, has worked extensively with various health policy researchers who are experts in the area of mental health parity. After considerable discussion, the Insurance Department entered into a Memorandum of Understanding with OMH, whereunder the EBP-TAC assembled a team of experts from the Department of Health Care Policy of the Harvard Medical School (“Harvard Research Team”) and Columbia University’s School of Public Health to assist the Superintendent in conducting portions of the study. To be sure to cover all the areas the study called for, the Insurance Department also engaged Alicare, Inc., the Administrator of the State subsidy for the 30/20 benefit, to conduct a separate analysis of the impact of the new mandates on all insurers, via a survey questionnaire addressing, among other things, the comparative benefit levels before and after Timothy’s Law.
2. CONDUCT OF EVALUATION

The evaluation was divided into two principal parts: (i) a detailed claims/cost analysis to be conducted by the Harvard Research Team, and (ii) a survey of all insurers to gather industry-wide statistics, to be conducted by Alicare, Inc. In addition, the Insurance Department performed a detailed analysis of the net claims cost of specified carriers to determine the value of new benefits added under the mandate, and provided data and supplemental information from various sources available to the Department, including the Health Insurance Data Exhibits (HIDE reports) and rate filings prepared by the insurers and filed with the Department.

Harvard Research Team’s Claims Analysis - The Harvard Research Team reviewed detailed mental health claims data, looking at utilization changes, costs changes and other agreed areas. The Harvard Team indicated that the best approach to ensure consistency in carriers’ categorization of claims as mental health claims would be to collect data on all claims paid by selected insurers and then apply the necessary algorithms to the data files to isolate payments for mental health services and drugs related to the treatment of mental illnesses and to quantify utilization trends, cost changes and so forth from that data. The Insurance Department initiated the data collection process in the 3rd Quarter of 2008, requesting data from five major insurers in the New York market (Empire, Excellus, GHI, Independent Health, and Oxford). The insurers were asked to provide detailed claims data for the period 2006, 2007 and six months of 2008 for those groups that both remained insured by the insurer for the entire period and which had a renewal date of January, February or March. The insurers were also requested to provide benefit design descriptions to the Harvard Research Team.

Full claims detail of major New York insurers over a two and one half year period represents an enormous volume of data, and the data was not stored consistently from one insurer to the next. As a result, the Harvard Research Team encountered some difficulties in gathering, categorizing and sorting the data, and the analyses are not fully complete. This report will be supplemented based on this additional analysis in June.

Columbia Interviews of Small Employers and Insurance Brokers - In consultation with OMH, researchers at the Mailman School of Public Health at Columbia University provided advice and assistance in broadening the analysis, initiating a survey/interview study of consumers’ and brokers’ knowledge of and reaction to the mandates.

Insurance Department Analysis and Data - In 2007, all insurers were required by the Insurance Department to provide a detailed actuarial memorandum outlining the cost of the current mental health benefits provided and the anticipated cost of the benefits to be provided in order to comply with the 30/20 provisions of the law. For the study, the Insurance Department provided detailed analyses of data in these filings which was used in determining the average cost (value) of 30/20 benefits in existing policies prior to the Law and the value of benefits added as a result of the mandate (i.e., the 80%:20% ratio discussed in “Major Findings”). The Small Group Subsidy filing, including the actuarial memorandum, is described in Circular Letter No. 3 (2007) dated January 31, 2007, which is included in the appendix. In addition, in order to obtain subsidy reimbursements for the 30/20 benefits prescribed by Timothy’s Law, insurers are required to submit, on a quarterly basis, detailed listings of their covered small groups, including number of
lives covered, by month, and the approved monthly per person subsidy. The memo from the
Insurance Department describing the data required is included in the appendix.

**Alicare, Inc. Industry-Wide Survey** - The Alicare, Inc. survey sought to determine, among
other things: how many groups had no mental health benefits before Timothy’s Law went into
effect; how many groups had some benefits or full benefits; how much of the State funding went
to pay existing benefits versus new benefits; how insurers offered the “make available” BBMI
and SED benefits (opt in or opt out method); the range of premiums for the make available
benefits; and, how the method the make available benefits were offered may have influenced
buyers’ decisions. The survey, initiated in the 3rd Quarter of 2008, requested data from all
insurers pertaining to their large and small group coverage for the years 2006, 2007 and the first
nine months of 2008. Data included detailed listings of covered lives by group and a
classification of the group’s mental health coverage related to the 30/20 and make available
provisions of Timothy’s Law as well as cost information pertaining to those benefits. The request
for data (dated October 13, 2008) is included in the Appendix. All insurers provided data with
the exception of Atlantis Health Plans, United Health Care and Aetna Health, Inc.

In addition to the survey, Alicare reviewed other data insurers are required to submit to comply
with Timothy’s Law, including the detailed actuarial memorandum and quarterly detailed listings
of insurers’ covered small groups, including number of lives covered, by month, and the
approved monthly per person subsidy.

Information from the Actuarial Memorandum from the following insurers was extracted in order
to prepare the charts and tables provided in this report:

- Aetna Health, Inc.
- Aetna Life Ins. Co.
- Capital District Physicians Health Plan
- CDPHP Universal Benefits
- Empire HealthChoice Assurance
- Empire HealthChoice HMO
- GHI
- Health Net of New York
- Independent Health Association
- Oxford Health Insurance
- Oxford Health Plans

In addition, the Insurance Department’s Health Insurance Data Exhibits (“HIDE reports”) provided the number of lives covered in the small group market for 2008.

### 3. CURRENT MARKET CHARACTERISTICS

#### A. Small Group Market

The small group market is served by 42 insurers (or reporting entities) in the state and covered
approximately 1.7 million people during 2008, according to the Insurance Department’s Health
Insurance Data Exhibits (“HIDE”). A number of reporting entities serve a common parent
corporation. There are 18 corporate parents serving the state in the small group market. The
largest 5 corporate parents cover approximately 1.2 million people.

The Table below shows the distribution of groups, certificate holders and insured lives by region. For this study we used the zip codes/regions specified in an Insurance Department Regulation that requires regional breakdowns (11 N.Y.C.R.R. Part 361). It should be noted that the total number of covered lives totals only about 1.5 million instead of 1.7 million. This difference is due to some insurers not reporting due to bankruptcy or technical difficulties and due to the fact that the
total small group population per the Department’s HIDE reports include Healthy New York and conversion policies.

### Distribution By Region

#### 2008 – Small Group Market

<table>
<thead>
<tr>
<th>Region</th>
<th>Groups</th>
<th>Certificate Holders</th>
<th>Insured Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany</td>
<td>15,117</td>
<td>57,185</td>
<td>105,430</td>
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<tr>
<td>Buffalo</td>
<td>14,387</td>
<td>66,673</td>
<td>125,252</td>
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<tr>
<td>Mid Hudson</td>
<td>18,378</td>
<td>46,734</td>
<td>87,856</td>
</tr>
<tr>
<td>New York</td>
<td>194,833</td>
<td>516,821</td>
<td>970,032</td>
</tr>
<tr>
<td>Rochester</td>
<td>12,575</td>
<td>56,005</td>
<td>112,133</td>
</tr>
<tr>
<td>Syracuse</td>
<td>7,780</td>
<td>57,528</td>
<td>109,018</td>
</tr>
<tr>
<td>Utica-Watertown</td>
<td>4,456</td>
<td>18,048</td>
<td>32,556</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>267,526</td>
<td>818,994</td>
<td>1,542,277</td>
</tr>
</tbody>
</table>

The Table below shows the distribution of groups, certificate holders and insured lives by type of carrier – Article 43, HMO or Indemnity.

### Distribution By Insurer Type

#### 2008 – Small Group Market

<table>
<thead>
<tr>
<th>Type of Company</th>
<th>Groups</th>
<th>Certificate Holders</th>
<th>Insured Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article 43</td>
<td>52,105</td>
<td>210,951</td>
<td>406,735</td>
</tr>
<tr>
<td>HMO</td>
<td>97,469</td>
<td>270,878</td>
<td>523,982</td>
</tr>
<tr>
<td>Insurance Company</td>
<td>117,951</td>
<td>337,165</td>
<td>611,560</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>267,526</td>
<td>818,994</td>
<td>1,542,277</td>
</tr>
</tbody>
</table>

The Table below shows the distribution of insured lives by type of insurer and by type of policy.

### Distribution of Insured Lives By Insurer and Policy Type

#### 2008 – Small Group Market

<table>
<thead>
<tr>
<th>Policy Type</th>
<th>Art. 43</th>
<th>HMO</th>
<th>Indemnity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPO</td>
<td>179,825</td>
<td>0</td>
<td>289,593</td>
<td>469,418</td>
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<tr>
<td>HDP</td>
<td>12,694</td>
<td>0</td>
<td>19,910</td>
<td>32,604</td>
</tr>
<tr>
<td>HMO</td>
<td>64,577</td>
<td>402,822</td>
<td>0</td>
<td>467,459</td>
</tr>
<tr>
<td>IND</td>
<td>38,915</td>
<td>0</td>
<td>36,622</td>
<td>71,537</td>
</tr>
<tr>
<td>POS</td>
<td>19,896</td>
<td>121,100</td>
<td>174,822</td>
<td>315,818</td>
</tr>
</tbody>
</table>
PPO 90,828 0 94,571 185,399  
Other 0 0 42 42  
Total 406,735 523,982 611,560 1,542,277

Policy types are as follows:

  - EPO – Exclusive Provider Organization
  - HDP – High Deductible Plan
  - HMO – HMO
  - IND – Indemnity
  - POS – Point of Service
  - PPO – Preferred Provider Organization
  - Other – Not specified by carrier

B. Large Group Market

The large group market is served by 35 insurance carriers (or reporting entities) in the State and covered approximately 3.4 million people during 2008. A number of reporting entities serve a common parent corporation. There are 14 corporate parents serving the State in the large group market. The largest 5 corporate parents cover approximately 2.3 million people.

The Table below shows the distribution of groups, certificate holders and insured lives and by region. For this study we used the zip codes/regions specified in an Insurance Department Regulation that requires regional breakdowns (11 N.Y.C.R.R. Part 361).

### Distribution By Region

#### 2008 – Large Group Market

<table>
<thead>
<tr>
<th>Region</th>
<th>Groups</th>
<th>Certificate Holders</th>
<th>Insured Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany</td>
<td>2,064</td>
<td>181,466</td>
<td>365,852</td>
</tr>
<tr>
<td>Buffalo</td>
<td>3,905</td>
<td>214,842</td>
<td>453,033</td>
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<tr>
<td>Mid Hudson</td>
<td>1,214</td>
<td>69,953</td>
<td>140,622</td>
</tr>
<tr>
<td>New York</td>
<td>10,045</td>
<td>659,138</td>
<td>1,281,765</td>
</tr>
<tr>
<td>Rochester</td>
<td>3,077</td>
<td>182,960</td>
<td>386,413</td>
</tr>
<tr>
<td>Syracuse</td>
<td>1,018</td>
<td>148,120</td>
<td>303,234</td>
</tr>
<tr>
<td>Utica-Watertown</td>
<td>564</td>
<td>62,223</td>
<td>124,168</td>
</tr>
<tr>
<td>Total</td>
<td>21,887</td>
<td>1,518,702</td>
<td>3,055,087</td>
</tr>
</tbody>
</table>

4. OPERATIONAL OVERVIEW

Timothy’s Law provides that policies must provide the 30/20 benefits in new or renewed policies issued to small groups (50 lives or less) from the first policy anniversary date on or after January 1, 2007, and that the premium for those benefits will be subsidized by the State from that date forward. Implementation of the Law and payment of subsidies therefore began incrementally throughout 2007 at the renewal date of each insured group in 2007. The Superintendent developed a reimbursement methodology which pays insurers directly for the premium cost of the added 30/20 benefit. Administratively, direct payment to insurers on a quarterly basis was
considered more efficient than paying the approximately 300,000 small employers a monthly amount to then remit to their respective insurers for the coverage. The amount of the subsidy is based on the number of enrolled members and each insurer’s projected Net Claims Cost of the 30/20 benefits provided in its policies plus an allowance of 5% to pay for administration expenses (in 2008, the Superintendent lowered the administrative expense allowance to 3%). The methodology requires that insurer reimbursement rates be submitted to the Insurance Department on a “prior approval” basis. Department Circular Letter No. 3 (2007), set forth the level of detail insurers were required to provide to Department actuaries to justify reimbursements. Each insurer was required to submit an Actuarial Memoranda to the Department’s Health Bureau including a detailed description of existing benefits and new benefits, including applicable co-payments, deductibles and coinsurance amounts. In addition, a detailed explanation and justification of the derivation of rates, including the methods and assumptions used, the underlying experience data used and modifications made thereto, the utilization frequencies, the average cost and the net claims cost (NCC) were all required. Once insurers received their approved reimbursement amount, they were required to lower their premium rates billed to groups for the total cost of the 30/20 benefits, including the portion that was already contained in existing policies, and to refund to insured groups amounts already paid for the existing benefits which they had already billed the groups before they were able to incorporate the new rates into billing systems. This situation arose because Timothy’s Law was enacted on December 22, 2006, with an effective date of January 1, 2007, so most billings for the early months of 2007 went out at then current rates before the insurers had received approvals of the reductions. Detailed instructions for calculating amounts insurers were required to refund for premiums already collected were published in Supplement No. 2 to Circular Letter No. 3 (2007). Most insurers were able to modify their billing systems to reflect the adjustments required by Timothy’s Law by July or August of 2007. In total, $32.6 million in refunds were paid out to small groups in 2007 for benefits mandated under Timothy’s Law that were already in existing contracts upon renewal in 2007. As noted elsewhere in this Report, approximately 80% of the total 30/20 benefits were already in existing contracts.

The following chart shows the number of insured lives eligible for the subsidy beginning with their renewal date in 2007 through the fourth quarter of 2008.
The table below summarizes the results of the 30/20 subsidy under Timothy’s Law. Note that the number of persons covered by the mandate grew through 2007 as groups renewed coverage until the total reached just under 1.7 million. The quarterly subsidy is approximately $24 million per quarter and closely tracks the claims reported for 2008. For 2007, the subsidy exceeded the claims. This is in part due to the lag between the time in which claims are incurred and reported and when it is ultimately paid. Also, there would have been delays in the implementation of the new benefits and their subsequent communication to members and use by those members due to the extremely limited time period between passage of the Law and its implementation.

### New York State Subsidy of 30/20 Benefits Under Timothy's Law

<table>
<thead>
<tr>
<th>Year</th>
<th>Quarter</th>
<th>Average Insured Lives</th>
<th>Total Subsidy</th>
<th>Cumulative Subsidy</th>
<th>PMPM Subsidy Claims/Period</th>
<th>Cumulative Claims for Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>Q1</td>
<td>642,736</td>
<td>8,507,846</td>
<td>8,507,846</td>
<td>4.41</td>
<td>N/R</td>
</tr>
<tr>
<td></td>
<td>Q2</td>
<td>988,284</td>
<td>13,629,359</td>
<td>22,137,206</td>
<td>4.60</td>
<td>N/R</td>
</tr>
<tr>
<td></td>
<td>Q3</td>
<td>1,347,837</td>
<td>21,609,149</td>
<td>43,746,355</td>
<td>4.63</td>
<td>14,094,663</td>
</tr>
<tr>
<td></td>
<td>Q4</td>
<td>1,596,402</td>
<td>22,945,044</td>
<td>66,691,399</td>
<td>4.81</td>
<td>21,342,361</td>
</tr>
<tr>
<td>2008</td>
<td>Q1</td>
<td>1,660,385</td>
<td>23,241,792</td>
<td>23,241,792</td>
<td>4.64</td>
<td>21,371,398</td>
</tr>
<tr>
<td></td>
<td>Q2</td>
<td>1,667,463</td>
<td>23,964,384</td>
<td>47,206,176</td>
<td>4.82</td>
<td>23,991,765</td>
</tr>
<tr>
<td></td>
<td>Q3</td>
<td>1,666,148</td>
<td>24,136,246</td>
<td>71,342,422</td>
<td>4.83</td>
<td>23,948,367</td>
</tr>
<tr>
<td></td>
<td>Q4</td>
<td>1,653,395</td>
<td>23,965,036</td>
<td>95,307,458</td>
<td>4.83</td>
<td>24,274,154</td>
</tr>
</tbody>
</table>

### 5. SUMMARY OF MAJOR FINDINGS AND SUPPORTING DATA

Following is a summary of all findings through April 1, 2009, including the Major Findings from the Executive Summary (A-E below).

#### A. Expansion of Coverage - 30/20 Benefit

In both the large group and small group markets, the percentage of persons with full coverage of the 30/20 benefit before Timothy’s Law was 42%. With the mandate, it is 100%, with cost sharing levels equal to those for other health benefits provided under the same policies.

Insurers were asked to classify the level of coverage provided to each group into one of three categories: No mental health coverage; some mental health coverage but not enough coverage to satisfy the 30/20 provisions of Timothy’s Law; and sufficient coverage to satisfy the 30/20 provisions of Timothy’s Law. The results for 2006 (pre Timothy’s Law) are shown in the chart below. After Timothy’s Law, all coverage provided would have to meet the 30/20 provisions.

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Small Group Market</th>
<th>Large Group Market</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2006 Insured Lives</td>
<td>Per Cent of Total</td>
</tr>
<tr>
<td>No Coverage</td>
<td>10,972</td>
<td>0.7%</td>
</tr>
<tr>
<td>Less Than 30/20</td>
<td>873,752</td>
<td>57.2%</td>
</tr>
<tr>
<td>30/20 or better</td>
<td>642,991</td>
<td>42.1%</td>
</tr>
</tbody>
</table>
B. Expansion of Coverage – Make Available BBMI/SED Benefits

In the large group market, the percentage of persons with the full BBMI/SED benefits increased from 11% to a mandated 100%. In the small group market, BBMI/SED is not mandated, yet the percentage of persons with full BBMI/SED benefits increased from 9.6% to 43.7%. This may be due in part to the savings employers realized with the State subsidizing the 30/20 benefit, or the increased visibility of the BBMI/SED benefits resulting from the requirement that these benefits be offered to all small employers.

Insurers were asked to classify the level of coverage pertaining to the BBMI/SED benefits provided to each group into one of three categories: No coverage, some coverage but less than required by Timothy’s Law and sufficient coverage to satisfy Timothy’s Law. The results for 2006 (pre Timothy’s Law) are shown in the chart below.

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Small Group Market</th>
<th>Large Group Market</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2006 Insured Lives</td>
<td>Per Cent of Total</td>
</tr>
<tr>
<td>No Coverage</td>
<td>953,347</td>
<td>62.4%</td>
</tr>
<tr>
<td>Less Than Required</td>
<td>428,228</td>
<td>28.0%</td>
</tr>
<tr>
<td>Full Benefits</td>
<td>146,095</td>
<td>9.6%</td>
</tr>
<tr>
<td>Total</td>
<td>1,527,670</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>1,565,803</td>
<td>56.6%</td>
</tr>
<tr>
<td></td>
<td>923,614</td>
<td>33.0%</td>
</tr>
<tr>
<td></td>
<td>307,199</td>
<td>11.0%</td>
</tr>
<tr>
<td>Total</td>
<td>2,796,616</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

After Timothy’s Law, all coverage provided by large groups would have to meet the BBMI/SED provisions. However, small groups were required to be given the option of purchasing the coverage. The coverage could be included as a standard benefit in the plan design itself (“Benefits in Plan”) or as a rider. The results of 2008 selections are shown below.

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>2008 Insured Lives</th>
<th>Per Cent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rider Declined</td>
<td>867,721</td>
<td>56.3%</td>
</tr>
<tr>
<td>Rider Accepted</td>
<td>254,425</td>
<td>16.5%</td>
</tr>
<tr>
<td>Benefits In Plan</td>
<td>420,131</td>
<td>27.2%</td>
</tr>
<tr>
<td>Total</td>
<td>1,542,277</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

C. Percentage Increase in 30/20 Benefits in the Small Group Market

The value of the 30/20 benefit mandated under Timothy’s Law, as measured by the net claim cost reimbursed by insurers for such benefits, increased from about $80 million in policies purchased
by small employers prior to Timothy’s Law to approximately $100 million in policies purchased after the mandate, an increase of 25% in basic mental health benefits in small group policies.

All insurers were required to submit a description and estimated cost of their existing mental health benefits prior to implementation of Timothy’s Law as well as the same information after modification in order to comply with Timothy’s Law. The before-and-after premiums for mental health benefits were compared for 11 of the larger insurers. These eleven insurers provide coverage for 1.1 million New Yorkers in the small group market out of a total of about 1.7 million. All policies were divided into one of five categories based on the ratio of the cost of the mental health benefits provided prior to enactment of Timothy’s Law to the cost of the 30/20 benefit required under the Law. The categories are identified and described below:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>Policies which provided no mental health coverage prior to enactment of Timothy’s Law</td>
</tr>
<tr>
<td>1%-49%</td>
<td>Policies which provided mental health coverage valued at between 1% and 49% of the value of 30/20 coverage</td>
</tr>
<tr>
<td>50%-74%</td>
<td>Policies which provided mental health coverage valued at between 50% and 74% of the value of 30/20 coverage</td>
</tr>
<tr>
<td>75%-99%</td>
<td>Policies which provided mental health coverage valued at between 75% and 99% of the value of 30/20 coverage</td>
</tr>
<tr>
<td>100%+</td>
<td>Policies which provided mental health coverage at least as valuable as the 30/20 level of coverage required after enactment of Timothy’s Law</td>
</tr>
</tbody>
</table>

The chart below shows the number of insured members by category.

The following table shows the number of insured members by category, the percentages in each category, the ratio of the prior net claims cost (NCC) to the 30/20 NCC, and then the average Prior NCC and the average 30/20 NCC.
Small Group Market

<table>
<thead>
<tr>
<th>Category</th>
<th>Insured Lives at 3/07</th>
<th>Percentage of Lives in Category</th>
<th>Average Ratio of Prior NCC to 30/20 NCC</th>
<th>Average Prior NCC</th>
<th>Average 30/20 NCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>26,891</td>
<td>2%</td>
<td>0%</td>
<td>$ 0.00</td>
<td>$ 1.84</td>
</tr>
<tr>
<td>0-49%</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
<td>$ 0.00</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>50-74%</td>
<td>426,773</td>
<td>39%</td>
<td>65%</td>
<td>$ 4.71</td>
<td>$ 7.27</td>
</tr>
<tr>
<td>75-99%</td>
<td>396,892</td>
<td>36%</td>
<td>91%</td>
<td>$ 4.87</td>
<td>$ 5.36</td>
</tr>
<tr>
<td>100+%</td>
<td>259,273</td>
<td>23%</td>
<td>100%</td>
<td>$ 5.08</td>
<td>$ 4.90</td>
</tr>
<tr>
<td>Total/Avg</td>
<td>1,109,829</td>
<td>100%</td>
<td>80%</td>
<td>$ 4.76</td>
<td>$ 5.80</td>
</tr>
</tbody>
</table>

Based on the sampling of larger carriers’ small group policies, prior to the Law 2% of insureds had no mental health benefits, 75% had over 50% but less than the full 30/20 benefit, and 23% had benefits at least equal to the 30/20 level required under the law. Thus, the Timothy’s Law 30/20 mandate resulted in an improvement in coverage for all but the 23%, or about 77% of all persons insured in the small group market in New York.

(NOTE: The 23% with full coverage cited above is less than the 42% cited in the chart in Section 6A, “Expansion of Coverage – 30/20 Benefit.” The reason for the difference is that the 23% is based on cost data submitted by carriers, and includes only those that actually paid 100% of the Timothy’s Law premium levels before the effective date of the law, while the 42% is based on a survey of carriers who we believe reported groups with close to full coverage (e.g. 97%, 98%...) as fully covered. For purposes of this report, we accept that survey result of 42% as the percentage with, essentially, full coverage prior to the Law.)

Although there was an improvement in coverage for a significant number of people, the value of that improvement was less significant. Approximately 80% of the value of the 30/20 benefit Statewide was already provided under existing plans prior to the enactment of Timothy’s Law.

The average prior NCC increases with category level although the averages are very close to each other (within 10%) for each level. The average 30/20 NCC, however, declines with increasing coverage level from 50-74% to 75-99% to 100%. This suggests that those policies in the lower categories are there only in part because of weakness in mental health benefits and perhaps more so because the relative richness in the level of benefits other than mental health that the policy provides. In other words, most insured policies with mental health benefits had comparable levels of coverage prior to Timothy’s Law. Those policies falling in the lower category levels are there because the other benefits provided under the policy were so much richer. As a result of this type of distribution, the state subsidy of the 30/20 benefits tends to provide a higher subsidy for the richer benefit plans compared to the less expensive plans.

It should also be noted that the 2% with no mental health coverage (0% category) still have a low level of coverage after Timothy’s Law in absolute terms. That is because the value of their average 30/20 NCC is much lower than for other policies. This suggests that the policies without mental health coverage provided very low levels of coverage for all benefits in the first place and still only provide a low level of coverage even after application of the 30/20 provisions of the law.
D. 30/20 Small Group Mandate Cost and BBMI/SED Cost as a Percentage of Total Policy Cost

After implementation of Timothy’s Law, the per member per month (“PMPM”) cost of the 30/20 benefit is $5.80, or about 2% of an average benefit cost of $312.00 PMPM for all benefits in small group policies. The cost of the portion of the 30/20 mandate representing new, added benefits is $1.04 PMPM, or less than 1/2 of 1% of the total policy benefits’ costs. On a global basis, the $100 million is about 1/70th of the total 2008 small group premium of approximately $7 billion, and the $20 million subsidy of the incremental increase in benefits is about 1/350th of total 2008 small group premium.

The charts that follow show the distribution of the PMPM cost of the 30/20 benefits and the BBMI/SED benefits separately for the small group and large group markets. The average 30/20 benefit cost for 2008 was $4.77 PMPM for small group and $5.73 PMPM for large group. (Note: Insurers were required to submit to the Department rate manual pages and detailed justification of their rates for the 30/20 benefits for small group. The Department rejected some of the higher rates reported and permitted a lower rate for purposes of the 30/20 premium and subsidy. The $4.77 PMPM is based on 30/20 benefit approved rates while the more conservative $5.80 estimate cited in the preceding paragraph is based on the cost data.)

The average cost for BBMI/SED benefits based on the survey was $2.60 PMPM for small groups and $2.22 PMPM for large groups. These amounts are under 1% of total claim cost of plans covering these groups. Insurers were not required to submit BBMI/SED rates for review but were asked to make their best estimate of the BBMI/SED benefit premium for purposes of this study. Documentation was not requested and there was no formal review or audit. Consequently, the 30/20 benefit premiums have a stronger underlying basis than the BBMI/SED benefit premiums. This would partly explain the greater dispersion of the BBMI/SED benefit premiums in contrast to the dispersion of the 30/20 benefit premiums. Another explanation might be the anti-selection that arises when a benefit is optional as opposed to mandated, which can result in a relatively larger percentage of persons with illnesses covered by the benefit purchasing the coverage than the percentage of the general population that purchase it.

The Department’s Supervising Actuary in the Albany Health Bureau conducted a separate analysis of what BBMI/SED benefits would cost if such benefits were mandated and antiselection were not, therefore, a factor. The Actuary notes that antiselection concerns may have caused insurers to set initial rates at very conservative (high) levels. The Actuary projects the cost of BBMI/SED by 2010 at approximately $1.50 PMPM under a scenario where these are mandated benefits, or under one half one percent of total monthly policy costs. Further detailed analysis of actual costs in the large group market where BBMI/SED benefits are already mandated will more precisely quantify the cost of the BBMI/SED benefit were it a mandate in the small group market. The Harvard Team is expected to report its findings on this analysis in June 2009.
No. of Members by 30/20 Premium per member
(2008 - Small Group)
No. of Members by M/A Premium Range
(Large Group - 2008)
E. Survey of Small Employers’ and Brokers’ Reactions to Mandate

A survey of 200 small firms across the State inquired of the group’s opinions of Timothy’s Law, with the following results:

- 18.5% of firms responded that Timothy's Law expanded mental health benefits and increases costs;
- 39.5% responded that Timothy's Law expanded mental health benefits and had no effect on costs;
- 4% reported that Timothy's Law expanded mental health benefits and reduced costs; and
- 38% had never heard of Timothy's Law.

In total, 18.5% believed the mandate increased cost. It would appear that some of those may have not recalled that the entire 30/20 benefit was subsidized, so the only real cost increases they could have experienced would have arisen where they opted to purchase additional BBMI/SED benefits. 81.5% believed Timothy’s Law did not increase cost or were not specifically aware of Timothy’s Law.

Insurance brokers offered some specifics on their customers’ reactions to the Law, including:

- A broker in the Southern Tier called the law “…a drop in the bucket—zero impact,” and added that he had “…yet to see any groups that we shop insurance for that view it as a major coverage issue.”
- One Rochester area broker registered “…no employer complaints—and no praise either.”
- Another Rochester area broker identified “…some effect, but not drastic. Most employers offered some mental health benefits before Timothy’s Law, sometimes as riders, but now all are in and some carriers have beefed up the coverage.”
- A Manhattan broker stated, “had not seen any issues with it; the law rarely comes up.”
- A Long Island broker noted, “Mental health just isn’t a big issue in my policies. What people care about is first, the costs, second, the benefits, and third, the physician network- these three key things. Mental health coverage is peripheral in terms of benefits and seldom comes up. In my 14 years of doing this there were maybe one or two cases where mental health was a big issue.”

In addition, some brokers offered their own opinions of what they thought of the Law. For example, some had positive reactions:

- A Rochester area broker called it a “great law, because people who need the care can get it now.” His firm “now quotes rates with extended mental health coverage—it’s only 70 cents extra per person per month, which is such a good value that’s not worth NOT doing it. A couple of clients who used it wouldn’t have been covered otherwise. We put it in automatically and only take it out if someone asks. But no one balks.”
- Another Rochester broker said much the same thing—“It’s a good thing, a big step forward because it makes more resources available to those who need them. Now plans are required to have these services, it’s not up to the employer or insurer.” He then captured what is probably the bottom line, both analytically and politically—“It’s not a big hit for non-users [diffused costs], but the benefit is big for those in need [concentrated benefits].”
Brokers offered some complaints as well. In most instances, these complaints were related to the overall cost of all health insurance mandates. However, a few brokers offered more specific comments:

- One suggested that the inflexibility of mandated mental health parity unduly abridges consumer choice.
- Another explained that, “More often than not people don’t need mental health coverage. They look over the options with us and say ‘I won’t need x, y, and z, so can I take that out to lower the price’?”
- A Long Island broker contended that the mandate impacted the unsubsidized market of groups of 50 and more workers. “If benefits are a la carte, you can take things out and bring prices down. If it's all mandated, there’s no more a la carte: you can upgrade, but not drop, so there are fewer variables to play with.”

In summary, the survey appeared to indicate that by and large Timothy’s Law did not have a significant impact or produce any notable negative reactions from small employers. While there was some concern from brokers for added costs, the concern appeared to be more for the overall increases in health care costs than the impact of Timothy’s Law.

F. Impact of Federal Parity Law on State Mental Health Mandate for Large Group Market

On October 3, 2008, the new federal mental health and addiction parity law, entitled The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, was enacted into law. Federal mental health parity, which will become effective starting for plan years that commence after October 3, 2009, will impact only the large group market in New York. Federal mental health parity does not mandate that group health plans provide coverage for mental health conditions. It does require that if a group health plan provides surgical and medical benefits and also includes coverage for mental health conditions, the coverage for the mental health conditions may be no more restrictive in terms of cost sharing, treatment limitations and out-of-network benefits than the surgical and medical benefits in the plan. The term “treatment limitations” includes frequency of treatment, number of visits, days of coverage, etc.

Once the federal law becomes effective, however, large group policies or contracts issued in New York may not be in compliance with the federal law if they contain only the Timothy’s Law benefits. Generally, large group policies or contracts in New York have both surgical and medical benefits and mental health benefits due to Timothy’s Law, and therefore trigger the federal law. As such, large group policies or contracts will no longer have the ability to limit the inpatient coverage for mental health conditions to 30 days per year, unless inpatient coverage under the policy or contract for other conditions is generally limited to 30 days per year. Likewise, these policies or contracts will no longer be permitted to limit outpatient treatment for mental health conditions to 20 visits per year, unless the policy or contract generally limits outpatient care to 20 visits per year. Therefore, as long as New York continues to have a mental health mandate, large group policies or contracts will have to provide mental health benefits at parity with the other benefits contained in the policy or contract and not just for BBMI/SED as is currently the case. New York law would set the “floor,” which plans may have to go beyond under federal law.

However, if Timothy’s Law sunsets and is not renewed or replaced with any other mental health mandate, large employers would not be required to purchase mental health benefits. If the policy or contract contains no mental health benefits, then the federal law is not triggered.
Finally, although not directly related to Timothy’s Law, it should be noted that the federal law includes coverage for substance abuse as well as mental health conditions. As such, large group policies or contracts issued in New York that provide substance abuse benefits – and most do because of New York’s outpatient substance abuse mandate – will be required to provide these benefits on par with other benefits in the policy or contract. In addition, since federal parity does not differentiate between inpatient and outpatient services, the current New York mandate for outpatient substance abuse treatment will, in effect, change New York’s “make available” outpatient substance abuse coverage to a mandated coverage at full parity with other inpatient services.

Conclusion

Timothy’s Law has considerably increased mental health parity in both the small group and large group markets in New York. In the small group market, Timothy’s Law resulted in a 25% increase in the basic 30/20 benefits (subsidized by the State) and an increase in the number of insureds purchasing the unsubsidized BBMI/SED benefits, from under 10% prior to the law to about 44% after the law went into effect. In the large group market, both the 30/20 benefits and BBMI/SED benefits are mandated under Timothy’s Law and both therefore increased to 100% coverage.

The added premium cost of the 30/20 benefit mandate over the cost of benefits small employers were already purchasing before the law is estimated to be a nominal fraction (under one half of one percent) of total monthly policy cost. The total cost of the optional BBMI/SED benefits in the small group market is under one percent of total monthly cost. Under a scenario where BBMI/SED benefits were mandated in the small group market, eliminating antiselection, the Insurance Department projects the cost would drop to under one half of one percent of monthly policy costs. The cost under this scenario will be more precisely quantified in the supplement to this report, which is anticipated to be released in June.

Consumers and brokers generally did not view the mandates as a significant issue relative to cost or their overall purchasing decision.

The recently enacted federal parity law and Timothy’s Law are interdependent in the large group market. Absent the requirements established by Timothy’s Law, large employers could opt out of the federal parity rules entirely, but with both laws in place, Timothy’s Law mandates trigger federal parity rules, and those rules in turn strengthen and increase the Timothy’s Law’s mandates.