WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance (AC-In)

File Naming Example:

Record of Comm. Proceedings ... RCP

- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

COMMITTEE NOTICES ...

- *Committee Hearings ... CH* (Public Hearing Announcements)
- **

- *Committee Reports ... CR*
- **

- *Executive Sessions ... ES*
- **

- *Record of Comm. Proceedings ... RCP*
- **

- -

INFORMATION COLLECTED BY COMMITTEE CLERK FOR AND AGAINST PROPOSAL

- *Appointments ... Appt*
- **

Name:

- *Clearinghouse Rules ... CRule*
- **

- *Hearing Records ... HR* (bills and resolutions)
- **05hr_ab0252_AC-In_pt01**

- *Miscellaneous ... Misc*
- **

ASSEMBLY BILL Nº 252

REPRESENTATIVE NISCHKE

Assembly Bill 252

An Act to amend 632.89 (2) (b) 1., 632.89 (2) (c) 2. b., 632.89 (2) (d) 2. and 632.89 (2) (dm) 2.; and to create 632.89 (1) (am) and 632.89 (2) (f) of the statutes; relating to: increasing the limits for insurance coverage of nervous or mental health disorders or alcoholism or other drug abuse problems. (FE)

2005

03-18. A. Introduced by Representatives Lehman, Benedict, Berceau, Black, Grigsby, Kreibich, Ott, Parisi, Pocan, Pope-Roberts, Shilling, Seidel, Sheridan and Zepnick; cosponsored by Senators Hansen, Miller, Risser, Stepp, Wirch and Harsdorf.

Analysis by the Legislative Reference Bureau

Under current law, a group health insurance policy (called a "disability insurance policy" in the statutes) that provides coverage of any inpatient hospital services must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of the lesser of: 1) the expenses of 30 days of inpatient services; or 2) $7,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $6,300 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage of any outpatient hospital services, it must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of $2,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $1,800 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage of any inpatient or outpatient hospital services, it must cover the cost of transitional treatment arrangements (services, specified by rule by the commissioner of insurance, that are provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services) for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of $3,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $2,700 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage for both inpatient and outpatient hospital services, the total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems need not exceed $7,000, or the equivalent benefits measured in services rendered, in a policy year.

This bill changes the minimum amount of coverage that must be provided for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems on the basis of the change in the consumer price index for medical services since the coverage amounts in current law were enacted. Inpatient services must be covered in the minimum amount of the lesser of: 1) the expenses of 30 days of

inpatient services; or 2) $18,300 minus the applicable cost sharing or, if there is no cost sharing under the policy, $16,500 in equivalent benefits measured in services rendered. Outpatient services must be covered in the minimum amount of $3,100 minus the applicable cost sharing or, if there is no cost sharing under the policy, $2,800 in equivalent benefits measured in services rendered. Transitional treatment arrangements must be covered in the minimum amount of $4,700 minus the applicable cost sharing or, if there is no cost sharing under the policy, $4,200 in equivalent benefits measured in services rendered. The total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems need not exceed $18,300, or the equivalent benefits measured in services rendered, in a policy year.

The table below provides information on treatment category, current minimum coverage amount, year of enactment, and the proposed coverage amounts based on the increase in the federal cost-of-living for medical coverage "indexed" since the enactment of the current coverage amounts.

Treatment Current Minimum
Coverage Amount
Year
Enacted
Proposed
Coverage Amounts
Inpatient
Cost-sharing
No cost-sharing
$7,000*
$6,300
1985
1985
$18,300*
$16,500
Outpatient
Cost-sharing
No cost-sharing
$2,000*
$1,800
1992
1992
$ 3,100*
$ 2,800
Transitional
Cost-sharing
No cost-sharing
$3,000*
$2,700
1992
1992

$ 4,700*
$ 4,200
All services $7,000 1985 $18,300
*Minus cost-sharing
The bill also requires the Department of Health and Family Services to report annually to the governor and legislature on the change in coverage limits necessary to conform with the change in the federal consumer price index for medical costs. For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

2003

AB839

ASSEMBLY BILL 839

An Act to amend 632.89 (2) (b) 1., 632.89 (2) (c) 2. b., 632.89 (2) (d) 2. and 632.89 (2) (dm) 2.; and to create 632.89 (1) (am) and 632.89 (2) (f) of the statutes; relating to: increasing the limits for insurance coverage of nervous or mental health disorders or alcoholism or other drug abuse problems. (FE)

2004

02-16-04. A. Introduced by Representative J. Lehman; cosponsored by Senator Hansen.

02-16-04. A. Read first time and referred to committee on Insurance. **701**

03-02-04. A. Refused to withdraw from committee on Insurance and take up, Ayes 38, Noes 59. . . **764**

03-23-04. A. Fiscal estimate received.

03-31-04. A. Failed to pass pursuant to Senate Joint Resolution 1. . . . . **913**

2003

SB72

SENATE BILL 72

An Act to amend 632.89 (2) (b) 1., 632.89 (2) (c) 2. b., 632.89 (2) (d) 2. and 632.89 (2) (dm) 2.; and to create 632.89 (1) (am) and 632.89 (2) (f) of the statutes; relating to: increasing the limits for insurance coverage of nervous or mental health disorders or alcoholism or other drug abuse problems. (FE)

2003

03-13-03. S. Introduced by JOINT LEGISLATIVE COUNCIL.

03-13-03. S. Read first time and referred to committee on Health, Children, Families, Aging and Long Term Care. **117**

07-22-03. S. Public hearing held.

08-01-03. S. Fiscal estimate received.

09-04-03. S. Executive action taken.

09-15-03. S. Report passage recommended by committee on Health, Children, Families, Aging and Long Term Care, Ayes 5, Noes 4. . . . . **365**

09-15-03. S. Available for scheduling.

2004

03-02-04. S. Motion to withdraw from committee on Senate Organization and place on the calendar of 3-4-2004, laid on the table, Ayes 18, Noes 15. . . . . **657**

03-17-04. S. Fiscal estimate received.

03-31-04. S. Failed to pass pursuant to Senate Joint Resolution 1. . . . . **749**

ADDITIONAL BACKGROUND INFORMATION

Submitted by Catherine Beilman
Chair, Legislative Committee
NAMI Wisconsin

There have been several recent studies confirming that parity is cost effective and good public policy. The Coalition presents this new information as a supplement to our original Background Information.

There are now 34 states with parity laws.

Federal Employees Health Benefits Program (FEHBP)

The Office of Personnel Management (OPM) that oversees the Federal Employee Health Benefits Program now requires (as of January 1, 2001) **health insurance plans participating in the FEHBP to provide *full parity for mental health and substance abuse coverage.*** FEHBP is the world's largest employer-sponsored health insurance program offering coverage to approximately 9.5 million federal employees, retirees and their families.

Excerpts from 4 recent studies:

1. Washington Business Group on Health (WBGH) **(selected to assist the U.S. Office of Personnel Management in the transition of the Federal Employee Health Benefit Program to full mental health and substance abuse parity).** WBGH provided the OPM with an analysis of the experiences, best practices and recommendations from some of its large employer members who provide parity or near-parity mental health and substance abuse benefits to their employees and their families.

- *" ... employers provide generous mental health and substance abuse benefits to their employees and their families because they are convinced that doing so is essential to the corporate 'bottom line'"*

- A 1998 study by the UNUM Life Insurance Company and Johns Hopkins University found that employer plans with good access to outpatient mental health services have **lower psychiatric disability claims** costs than plans with more restrictive arrangements (Salkever, 1998, also, Frank, 1999)

- Employers were able to provide generous mental health and substance abuse benefits, contain and in some cases reduce costs, and at the same time improve their employees access to quality mental health and substance abuse care.

- The costs of providing appropriate treatment for mental and addictive disorders must be measured in a larger context that also considers disability costs, employee absenteeism and lost productivity.

2. Surgeon-General David Satcher's "Mental Health: A Report of the Surgeon General" 1999

- Mental illness can now be diagnosed and treated as precisely and effectively as other medical disorders.

- Substance abuse is a major co-occurring problem for adults with mental disorders. Evidence supports combined treatment, although there are substantial gaps between what research recommends and what typically is available in communities.

- Implementing parity has resulted in negligible cost increases where the care has been managed.

- In the United States today, the highest rate of suicide – an all-too-common consequence of unrecognized or inappropriately- treated depression – is found in older males.

- An alarming number of children and adults with mental illness are in the criminal justice system inappropriately.

3. Price Waterhouse, Coopers 2000 Report has consolidated and updated various studies and reports that analyze the most recent cost data and actual experience results of states (and states as employers) that have implemented mental health parity coverage.

- *" Studies that are quoted by opponents of mental health parity typically use questionable or unreasonable assumptions to generate high cost estimates."*

- *"Mental health parity is affordable and in many cases will lower the cost of overall healthcare."*

- *"To date, there are **no examples** where mental health parity has been enacted in a state and costs have dramatically increased."*

- *"To date, there are **no examples** where mental health parity has been enacted in a state and a measurable increase in uninsured has been detected."*

4. National Advisory Mental Health Council Report , June 2000

- Recent research supports and expands earlier findings that implementing parity results in a minimal, if any, increase in total health costs.

- A recently updated simulated model by the Hay Group estimates an approximately 1.4% increase (down from 3.6%) in total health insurance premium costs when parity is implemented.

- Most children and adolescents who need mental health/substance abuse services do not receive them (Burns et al 1999).

Congressional Budget Office Report (CBO) May, 1996

A frequent quote from this report:

"Parity could result in 400,000 fewer workers having employment-based coverage."

Not quoted is the following sentence:

*"Those estimates are highly uncertain because of large margins of error in the study on which they are based. **Indeed, the possibility that the parity amendment would have no effect at all on the number of covered workers is within the margin of error."***

Is S.B. 157 a New Mandate? NO

S.B. 157 would require that the **existing law (Wisconsin Statute 632.89)** requiring $7,000 coverage for "nervous and mental disorders and alcohol and other drug abuse" be amended to require insurance coverage that is no less restrictive than coverage for physical illnesses..

This is not a new mandate.

PART I

KEY PROVISIONS OF COMMITTEE RECOMMENDATIONS

The Joint Legislative Council recommends the following proposals of the Special Committee on Mental Health Parity for introduction in the 2003-04 Session of the Legislature:

SENATE BILL 71, RELATING TO TREATMENT OF PRESCRIPTION DRUG COSTS, DIAGNOSTIC TESTING, AND PAYMENTS UNDER MANDATED INSURANCE COVERAGE OF TREATMENT FOR NERVOUS AND MENTAL DISORDERS AND ALCOHOLISM AND OTHER DRUG ABUSE PROBLEMS, AND GRANTING RULE-MAKING AUTHORITY

- Specifies that the statutory minimum coverage limits required for the treatment of nervous or mental disorders and alcoholism and other drug abuse problems do not include costs incurred for related prescription drugs or diagnostic testing.

- Provides that the statutory minimum coverage limits apply to the actual payments or reimbursement made by an insurer if the payment or reimbursement amounts are less than the amounts charged by a provider.

SENATE BILL 72, RELATING TO INCREASING THE LIMITS FOR INSURANCE COVERAGE OF NERVOUS OR MENTAL HEALTH DISORDERS OR ALCOHOLISM OR OTHER DRUG ABUSE PROBLEMS

- Increases the statutory minimum coverage limits under group health insurance policies for the treatment of nervous or mental disorders and alcoholism and other drug abuse problems by the amount of change in the federal Department of Labor's indexed cost-of-living for medical services since the inception of the required coverage limits.

- Requires the Department of Health and Family Services (DHFS) to annually report to the Governor and the Legislature on revising the coverage limits based on the change in the federal Consumer Price Index for medical costs.

SENATE BILL 72

Background

Under current law, if a group health insurance policy provides coverage of any inpatient hospital treatment, it must provide coverage for the treatment of nervous and mental disorders or AODA problems for not less than the lesser of the expenses of 30 days as an inpatient in the hospital or $7,000, or $6,300 if the plan contains no cost-sharing provisions. If the policy provides coverage for outpatient services, it must provide coverage for outpatient services for the treatment of nervous and mental disorders or AODA problems of not less than $2,000, or $1,800 if the plan contains no cost sharing provisions. If the policy provides coverage for inpatient or outpatient hospital treatment, it must provide coverage for transitional treatment arrangements for the treatment of nervous and mental disorders or AODA problems of not less than $3,000, or $2,700 if the plan contains no cost sharing provisions.

The minimum coverage amount for inpatient hospital treatment was enacted in 1985. The minimum coverage amounts for outpatient services and for transitional treatment services were each enacted in 1992.

Description of Bill

This bill increases the coverage limits under group health insurance policies for treatment for nervous and mental disorders and for AODA problems. Specifically, the various coverage amounts would be increased by the amount of change in the federal Department of Labor, Bureau of Labor Statistics indexed cost-of-living for medical services since the inception of the required coverage amounts. The table below provides information on treatment category, current minimum coverage amount, year of enactment, and the proposed coverage amounts based on the increase in the federal cost-of-living for medical coverage "indexed" since the enactment of the coverage amounts.

Treatment	*Current Minimum Coverage Amount*	*Year Enacted*	*Proposed Coverage Amounts*
Inpatient			
Cost-sharing	$7,000 minus cost-sharing	1985	$16,800
No cost-sharing	$6,300	1985	$15,100
Outpatient			
Cost-sharing	$2,000 minus cost-sharing	1992	$3,100
No cost-sharing	$1,800	1992	$2,800
Transitional			
Cost-sharing	$3,000 minus cost-sharing	1992	$4,600
No cost-sharing	$2,700	1992	$4,100

Treatment	*Current Minimum Coverage Amount*	*Year Enacted*	*Proposed Coverage Amounts*
All services	$7,000	1985	$16,800

The bill requires DHFS to annually report to the Governor and Legislature on the change in coverage limits necessary to conform with the change in the federal Consumer Price Index for medical costs.

The bill also contains a delayed initial applicability provision which states the new coverage amounts will first apply to policies issued, renewed, or modified on the first day of the 13th month beginning after the bill becomes law.

Coalition for Fairness

in Mental Health and Substance Abuse Insurance

To achieve
mental health and substance abuse parity
in health insurance
in the state of Wisconsin.

121 South Hancock Street, Madison WI 53703 • Phone 608-251-1450 • Fax 608-251-5480 • Email wispsych@execpc.com

THE $7,000 CAP ON MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS HAS NOT BEEN INCREASED SINCE THE LAW WAS ENACTED IN 1985.

The Coalition for Fairness in Mental Health and Substance Abuse Insurance includes more than 2 million Wisconsin citizens who belong to faith communities, AARP, labor unions, consumer groups, families, civic and professional organizations. The Coalition urges you to pass the compromise bills, SB 71 and SB 72. It's time to be fair!

Senate Bill 71

- SB 71 does not change current practice. The bill merely codifies into law practices that are already standard in the insurance industry.

Senate Bill 72

- SB 72 IS NOT A PARITY BILL. It is a major compromise. The bill merely calculates a long-overdue cost-of-living increase based on the federal consumer price index for health services.
- The Legislative Council Study Committee on Parity crafted SB 71 and SB 72. The Joint Legislative Council Committee endorsed the proposals as a bi-partisan compromise.
- Based on data from states with parity laws, the financial statement from the Office of the Commissioner of Insurance estimates that SB 72 would increase premiums only .15-.50 %. Since SB 72 is NOT parity, any actual increases would be considerably **BELOW** the OCI estimates!
- PricewaterhouseCoopers, LLP, has analyzed data from states that have mental health and substance abuse parity laws. Despite the dire predictions of opponents, to date the actuarial firm has found **NO** examples where parity has resulted in dramatic increases in cost. In addition, they have found **NO** examples where parity has resulted in any measurable increase in the number of uninsured.
- Most children and adolescents who need mental health/substance abuse services do not receive them. (National Advisory Mental Health Council Report, June 2000)
- An alarming number of children and adults with mental illness are in the criminal justice system inappropriately. (Mental Health: A Report of the Surgeon General)
- Families often must turn to counties and court ordered services so that their children will receive the services they need but cannot afford.
- When privately-insured individuals exhaust their benefits, they turn to the public sector for treatment, which increases costs to federal, state and local governments. Washington County analyzed its data and extrapolated the results statewide, resulting in an estimate of $40 million of cost to the state due to persons who had private insurance.
- SB 72 would not become law until 2005. With our economy already on the upswing, there is no excuse for delaying implementation of this significant compromise proposal. It's time for workers in Wisconsin to receive at least a cost-of-living increase in their coverage.

We urge you to vote "YES" on SB 71 and SB 72.

Co-Chairs

Catherine Beilman
NAMI-WI

Sarah Bowen
WI Psychological Assn.

Bill Stone
WI Assn for Alcohol & Other Drug Abuse

Mental Health Parity

"Just the Facts"

PricewaterhouseCoopers, L.L.P. has consolidated and updated various studies and reports that analyze the most recent cost data and actual experience results of states (and states as employers) that have implemented Mental Health Parity coverage. The data relates to aggregate state-wide results following state mandated parity, to the State Employee Health Benefit Plans, and finally to the Federal Employee Health Benefit Plan.

Recent and historical cost projections for mental health parity at the federal and state level are also provided. These projected costs are calculated by a wide variety of sources (PricewaterhouseCoopers, UCLA/Rand Research Center, Congressional Budget Office, Milliman & Robertson, and others). The studies specifically analysing mental health parity are remarkably similar in their conclusions that mental health parity with reasonable cost management is affordable.

Studies that are quoted by opponents of mental health parity typically use questionable or unreasonable assumptions to generate high cost estimates. The most common error in the high cost studies is that case management and/or other utilization controls will not be allowed under mental health parity. As stated by the UCLA/Rand Research Center, "...policy decisions were often based on incorrect assumptions and outdated data that led to dramatic overestimates."

By consolidating the data and experience studies into a single source, it is hoped that this book will provide documentation and identification of needed facts to demonstrate the recurring theme emanating from study after study – mental health parity is affordable and in many cases will lower the cost of overall healthcare.

"Just the Facts" can be a tool for bebunking the myths of high costs and mental health as the black-hole of expenses. To date, there are **no examples** where mental health parity has been enacted in a state and costs have dramatically increased. There are **no examples** where mental health parity has been enacted in a state and a measurable increase in uninsured has been detected. For those who doubt the results of the past few years – read this material, forget the myths of the past, and learn **"Just the Facts."**

This document was prepared for the American Psychological Association's 2000 State Leadership Conference. Ultimately this material should be useful to both proponents and opponents, for academics and the general public, and for state and federal policymakers. The debate over mental health parity is an appropriate one with policy arguments on both sides. It seems unnecessary to argue misrepresentations of the costs when **"Just the Facts"** will do.

Coalition for Fairness

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BACKGROUND INFORMATION

INTRODUCTION

The Coalition for Fairness in Mental Health and Substance Abuse Insurance in Wisconsin has prepared this background information to explain the need for a law and regulations that require mental health and substance abuse insurance coverage that is no more restrictive than coverage of physical illnesses.

The Mental Health Parity Act of 1996 (PL 104-204) requires that, beginning **January 1, 1998**, annual and lifetime dollar limits for mental health care must be equal to annual and lifetime limits for physical illnesses for all US group health plans that offer mental health benefits and serve more than 50 employees. Under this law:

- Insurers may charge higher deductibles and copays for persons with mental illnesses,
- The law does not require companies to provide mental health benefits,
- Companies may restrict hospital stays and outpatient visits,
- Companies whose costs increase 1% or more due to parity may ask to be exempt from the law,
- Substance abuse is not covered,
- The law is due to sunset September 30, 2001.

As you can see from the above loopholes, the Mental Health Parity Act of 1996 was only a first step.

Parity legislation has been enacted in ~~27~~ 35 states.

Federal employees will have an advantage over other individuals. The US Office of Personnel Management (OPM), which oversees the Federal Employee Health Benefits Program (FEHBP), the world's largest employer-sponsored health insurance program, offering coverage to approximately 10 million Americans, now requires health insurance plans participating in the FEHBP to provide full parity for mental health and substance abuse coverage for federal employees and their families by 2001.

* * * * *

I. The current system is unfair

- All individuals pay a premium for their insurance coverage. Not to cover mental illnesses and substance abuse equally with other illnesses is discriminatory.
- Persons with mental disorders and substance abuse problems are subsidizing persons with other illnesses. These disorders should not be singled out for less coverage.
- This is a civil rights issue. Persons with mental illness or substance abuse problems should have the same insurance coverage as those with other illnesses.

II. Treatment is effective

- According to the National Institute of Mental Health, the current success rate for the treatment of clinical depression is 80-90%, whereas the overall success rate for cardiovascular disease is only 45-50%. A study reported in the 1997 AMA Archives of General Psychiatry concluded that treatment of major depression is as effective for children as for adults.

- A new generation of medications recently approved and under development makes the treatment of mental illnesses even more effective. For example, the treatment efficacy rate for schizophrenia is now 60%.
- According to Thomas McLellan of the University of Pennsylvania, long-term drug treatment is as effective as long-term treatment for chronic diseases.

III. Employers are beginning to view parity as smart business policy

- Black and Decker, Compaq, EEX, Exxon, Lubrizol, Pitney Bowes, Prime Tanning, Sun Microsystems and Texas Instruments provide parity to their employees. (NAMI Advocate, Aug/Sept, 1998)

IV. Parity is smart public policy

- As an increasing number of people receive treatment, the overall costs to society will be reduced. According to the latest report of the National Advisory Mental Health Council (May, 1998), "untreated persons with mental illnesses end up in juvenile court, the jail system, in the public sector, and on disability."
- Data from the Epidemiologic Catchment Area (ECA) study indicate that 55% of persons with substance abuse problems had some type of mental illness. (Journal of the American Medical Association)
- Four out of every five runaway youths suffer from depression (US Select Committee on Children, Youth & Families)
- Suicide is the 3rd leading cause of death for 15-24 year olds (approximately 5,000 young people) and the 6th for 5-15 year olds. (American Academy of Child & Adolescent Psychiatry, 1995)
- According to Brown University addiction director Norman Hoffman, drug treatment can cut crime by 80%.
- Publicly financed MH/SA services are provided primarily to people who have serious mental illnesses or severe substance abuse disorders. Because most of these individuals are unable to work or can work only part-time, they have no access to private insurance. Therefore, they are not affected by parity.
- Another study suggests that financial incentives that limit access to care may shift costs to disability claims. (Salkever, 1998)
- When privately insured individuals exhaust their benefits they turn to the public sector for treatment, which increases costs to federal, state and local governments. One study estimated that 20% of public reimbursements are for clients who have had private health insurance. (Lewin-VHI, 1994)

V. Immediate costs are low

- Rand Corporation Study (November 12, 1997)
  - Equalizing annual limits for both physical and mental illnesses will increase costs by only about $1 per employee per year under managed care.
  - Removing limits on inpatient days and outpatient visits will increase costs by less than $7 per enrollee per year.
  - The main beneficiaries will be families with children who, under current conditions, are more likely than adult users to exceed their annual benefit limits and go uninsured for the remainder of the year.

- National Advisory Mental Health Council Interim Report on Parity Costs (April 29, 1997):
  - Earlier concern about potentially high financial costs caused by parity were based on fee-for-service models that are no longer valid in a market dominated by managed care and likely to become even more so.
  - Maryland: In Maryland's managed care environment, the cost of parity was low. The proportion of the total medical premium attributable to the mental health benefit actually decreased by 0.2 % after the implementation of full parity.
  - Texas: In 1992 parity legislation covering severe mental disorders and substance abuse was implemented for Texas state employees. At the same time, managed care for mental health and substance abuse services was introduced. During the next five years under parity, managed care reduced the per member per month (PMPM) cost of mental health services for these employees by more than 50%. ... A generally positive evaluation of this experience with state employees is reflected in the recent enactment of parity legislation covering the entire state, effective in 1997.
  - In 1981, among those employees with any medical coverage, 58% had coverage for inpatient mental health care that was comparable to coverage for inpatient care of other illnesses. By 1993 that proportion had steadily declined to only 16%. In the domain of outpatient care, the small proportion of comparable coverage in 1981 — only 10% — had declined to 4% by 1993.

- Lewin Study (April 8 1997):
    - In a survey of New Hampshire insurance providers, no cost increases were reported as a result of a state law requiring health insurance parity for severe mental illnesses.
- Quotes from Nicholas K. Zittell, editor in chief of the Medical Tribune, NY. (December 19, 1997).
    - There is an emerging body of evidence that inextricably links the presence of a mental health disorder with the risk or progression of a physical complaint.
    - According to a 1993 report in The Journal of Clinical Psychiatry, the annual costs of depression due to hospitalization and the inability to work is $45 to $50 billion, a figure second only to expenditures to diagnose and treat heart disease.
    - The old adage "you can pay me now or pay me later" truly applies.
- Report prepared by Mathematica Policy Research, Inc., for the Substance Abuse and Mental Health Services Administration (SAMHSA) of the US Department of Health and Human Services, dated March, 1998, reached the following conclusions after conducting an analysis of state MH/SA parity laws and case studies in five states:
    - State parity laws have had a small effect on premiums.
    - Employers have not attempted to avoid parity laws by becoming self-insured, and they do not tend to pass on the costs of parity to employees.
    - Costs for MH/SA services have not shifted from the public to the private sector.
    - Including substance abuse would increase premiums 0.2%.
- From the National Advisory Mental Health Council report dated May, 1998:
    - In systems already using managed care, implementing parity results in a minimal (less than 1 %) increase in total health care costs during a 1 year period. In systems not using managed care, introducing parity with managed care results in a substantial (30 to 50 %) reduction in total mental health costs.
    - New, more sophisticated actuarial models of the costs of parity show that, in general, as the overall proportion of the population in managed care increases, the projected cost of parity declines.
    - Maryland: The cost of introducing parity in Maryland was low. Additional data received during the past year from Maryland indicate that, after an initial increase following implementation of parity, PMPM (per member per month) mental health/substance abuse costs dropped back toward pre-parity baseline levels.
    - In summary, based on new knowledge derived from empirical case studies and updated actuarial cost-prediction models, the costs of parity are controllable.
- A study at Yale (Rosenheck et al) examined the effects of managed care over time on employees of a large national corporation. The study compared 3-year trends in mental health and general health services, as well as trends in employee absenteeism and work performance. During this period access to mental health services decreased by 41% in outpatient settings and 4% in inpatient settings, resulting in a 44% decrease in mental health costs. Persons whose access to mental health services was reduced showed significantly reduced work performance over time (down by 5.1%), increased absenteeism (sick leave up by 21.9%), and increased general health costs (up by 36.6%) compared with other employees. These trends offset any savings in mental health specialty health costs and resulted in no net economic benefit or loss to the company. These findings raise concern that in the 3-year shift to general health services rather than mental health services, employees may have received less appropriate and less effective treatment, resulting in a decline in work function.
- NIMH contracted with the Hays/Huggins Company to update the Mental Health Benefits Value Comparison Actuarial Model to estimate the premium costs of mental health services under HMOs and managed behavioral carve-out plans based on benefit design and newer managed care approaches. In implementing full parity, the cost would be:
    - traditional fee for service plan — 4% to 5% total benefit increase in cost
    - point of service plan — 3% increase in cost
    - HMO or managed care carve-outs — less than 1% increase

In conclusion, the Wisconsin Legislature should pass a new law and regulations that require mental health and substance abuse insurance coverage that is no more restrictive than coverage of physical illnesses.

Tuesday April 17th 1-2 PM. Sponsors of Bill
225 NW

Coalition for Fairness

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ORGANIZATIONAL MEMBERS
Representing More than 2 Million Wisconsin Residents
April 2001

AARP

AFL-CIO
(representing 250,000 Union members/families)

AFSCME WI Council 40

AFSCME Council 24-WI State Employees Union

AFSCME Council 48 of Milwaukee

Anorexia Nervosa & Associated Disorders

Archdiocese of Milwaukee, Social Concerns Office

Associated Counseling & Recovery-Fond du Lac

Aurora Behavioral Health Services

Autism Society of WI

Bay Area Agency on Aging-MH/SA Task Force

Bulimia Education & Support Training

Catholic Health Assn of WI

Chemical Dependency Consortium of Dane Co

CNR Health

Coalition for Wisconsin Health
(representing 89 organizations)

Consumer Satisfaction Team

Consumers of Positive Effect

Cornucopia

Cyber Phoenix Project

Dennis Hill Harm Reduction Ctr

Depressive/Manic Depressive Assn
(SE WI, La Crosse Area, Menomonee Falls)

Earth Angels Training Program

Elkhart Psychological Services

Employee Assistance Professionals Assn-SC WI

Encompass-Effective Mental Health Services

First Congregational Church Forum-Madison

Friendships Unlimited

Gathering Place

Genesis 1990

Grand Avenue Club

Grassroots Empowerment Project

Great Lakes Inter-Tribal Council

Hearts 'n Hands Ctr for Mental Health

Independence First

Interfaith Conference of Greater Milwaukee

Intnatl Assn of Psychosocial Rehab Services-WI

Jewish Family Services

Lutheran Office for Public Policy in WI

Mental Health Association
(Sheboygan, Milwaukee, Waukesha Co)

Mental Health Center-Dane Co

Mental Health Coalition-Dane Co

Mental Health Consortium-Dane Co

Mental Health Consumer Network

Milwaukee Area Health Education Center

Milwaukee Coalition on Mental Illness

Milwaukee Jewish Council

Natl Alliance for the Mentally Ill-WI
(representing 31 affiliates)

Natl Association of Social Workers-WI Chapter

New Horizons North-Community Support

North Country Independent Living

Northwest Counseling Services

Nova Counseling Services-Oshkosh

Open Gate

Racine Co Clubhouse-Harbor House

Reach Counseling Services-Menasha

Regional Employee Assistance Services

Rogers Memorial Hospital

Rosebud & Friends

Shorewood Association of Commerce

Sixteenth Street Community Health Ctr

Society's Assets

Southern Service Ctr for Independent Living

Stowell Associates

Substance Abuse Services Network

Systemic Perspectives

Tellurian UCAN, Inc

The Partners Advocacy

Transitional Living Services

United Cerebral Palsy of WI

Voices of Hope Consumer Group

Waukesha Memorial Hospital Behavioral Health

WI Alcohol & Drug Treatment Providers Assn

WI Alcohol, Drug & Disability Assn

WI Assn for Alcohol and Other Drug Abuse

WI Assn of Family & Children's Agencies

WI Assn of Marriage & Family Therapists

WI Catholic Conference
(representing 1.6 million WI Catholics)

WI Citizen Action

WI Coalition Against Domestic Violence

WI Coalition for Advocacy

WI Coalition of Independent Living Centers

WI Correctional Service

WI Council on Mental Health

WI Family Ties

WI Federation of Nurses/Health Professionals

WI Federation of Teachers

WI Interfaith IMPACT

WI Jewish Conference

WI Nursing Association

WI Psychiatric Association

WI Psychological Association

WI Society of Addiction Medicine

WI State Medical Society